



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

October 18, 2017

Lori Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

Dear Ms. Bentzler:

Enclosed you will find an amended Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies that incorporates the revision based on the Informal Dispute Resolution decision. Please resubmit the facility's Plan of Correction for the deficiencies listed and return the Form CMS-2567 by October 31, 2017. This amended Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form (if applicable) will become the facility's survey of record.

If you have any questions, comments or concerns, please contact this office at (208) 334-6626, option 5. Thank you for your participation in this process.

Sincerely,

DEBRA RANSOM, R.N., R.H.I.T, Chief
Bureau of Facility Standards



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August 29, 2017

Lori Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

Dear Ms. Bentzler:

On **August 11, 2017**, a survey was conducted at Twin Falls 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) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Lori Bentzler, Administrator
August 29, 2017
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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 **September 8, 2017**. Failure to submit an acceptable PoC by **September 8, 2017**, may result in the imposition of penalties by October 13, 2017.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS):

- Civil Monetary Penalty

Lori Bentzler, Administrator
August 29, 2017
Page 3 of 4

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 7, 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.

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 9, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

Lori Bentzler, Administrator
August 29, 2017
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- 2001-10 Long Term Care Informal Dispute Resolution Process
- 2001-10 IDR Request Form

This request must be received by **September 8, 2017**. If your request for informal dispute resolution request is received after **September 8, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

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

David Scott, RN, Supervisor
Long Term Care

DS/lj
Enclosures

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

PRINTED: 10/23/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2017
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
(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>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from August 7, 2017 to August 11, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Leader Linda Kelly, RN Cecilia Stockdill, RN Dennis Burlingame, RN Rachel Moorhead-Lopez, LSW</p> <p>This report reflects changes resulting from the Informal Dispute Resolution (IDR) process completed on October 17, 2017.</p> <p>Survey Definitions:</p> <p>ADL - Activities of Daily Living BIMS -Brief Interview for Mental Status BM - Bowel Movement BP - blood pressure bpm - beats per minute cm - centimeter CQS - Clinical Quality Specialist CNA - Certified Nursing Assistant COPD - Chronic Obstructive Pulmonary Disease CVA - Cerebral Vascular Accident DON - Director of Nursing DM - Diabetes Mellitus DS - Dietary Staff DTI - Deep Tissue Injury HTN - Hypertension HR - heart rate HS - bedtime H&P - History and Physical</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

09/08/2017

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 I&A - Incident and Accident LAL - Low Air Loss LN - Licensed Nurse LPN - Licensed Practical Nurse MAR - Medication Administration Record MASD - Moisture Associated Skin Damage MDS - Minimum Data Set Mg - milligram ml - milliliter mmHg - millimeters pressure of mercury NPO - nothing by mouth RN - Registered Nurse PO - by mouth POC - plan of care PRN - as needed PU -pressure ulcer SDC - Staff Development Coordinator SBAR - Situation, Background, Assessment, Recommendation TAP - Turn and position TAR - Treatment Administration Record T3 -Tylenol with codeine #3	F 000			
F 208 SS=F	483.15(a)(1)-(7) PROHIBITING CERTAIN ADMISSION POLICIES (a) Admissions policy. (1) The facility must establish and implement an admissions policy. (2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and	F 208		10/6/17	

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F 208	Continued From page 2 (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property. (3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources. (4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,- (i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued	F 208			

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F 208	<p>Continued From page 3 stay on the request for and receipt of such additional services; and</p> <p>(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.</p> <p>(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.</p> <p>(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.</p> <p>(7) A nursing facility that is a composite distinct part as defined in § 483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's Admission Agreement, and staff interview, it was determined the facility failed to ensure the Admission Packet fully informed residents prior to or at the time of admission of their rights in the</p>	F 208	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Twin Falls Center does not admit that the deficiency listed on this form exists, nor</p>		

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F 208	<p>Continued From page 4</p> <p>facility. This was true for 13 of 13 residents (#'s 1-9 and #'s 14-17) residing in the facility and all other residents residing in the facility. This deficient practice created the potential for residents not to be aware of their rights regarding lost or stolen items. Findings include:</p> <p>The facility's 2017 Welcome Packet documented, "Notice: [the facility] is not responsible for any items that are lost or stolen during your stay," which was contradictory to federal regulation regarding the facility's responsibility for lost or stolen items.</p> <p>CFR 483.15(a)(2)(iii) documented, "The facility must not request or require residents or potential residents to waive potential facility liability for losses of personal property."</p> <p>On 8/11/17 at 12:45 pm, the Clinical Quality Specialist and Administrator stated they would correct the admission packet to mirror federal regulation.</p>	F 208	<p>does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F208</p> <p>Specific Residents Identified</p> <p>Residents #1, #2, #3, #4, #5, #6, #8, #9, #14, #16, #17 and all other residents residing in the facility and/or their designated representative will be notified of their rights related to lost or stolen items on or before 10/6/17 by the Center Executive Director or designee of the updated admission agreement which includes their rights regarding lost or stolen items. Documentation of this notification will be placed in the resident's financial record by the Center Executive Director or designee on or before 10/6/17. There were no adverse effects to the residents.</p> <p>Resident #7 discharged on 8/15/17 and Resident #15 discharged on 8/17/17 from the facility.</p>		

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F 208	Continued From page 5	F 208	<p>Identification of Other Residents</p> <p>All residents residing in the facility and/or their designated representative will be notified of their rights regarding lost or stolen items on or before 10/6/17 by the Center Executive Director or designee of the updated admission agreement which includes their rights regarding lost or stolen items. Documentation of this notification will be placed in the resident's financial record by the Center Executive Director or designee on or before 10/6/17. There were no adverse effects to the residents.</p> <p>Systemic Changes</p> <p>Business Office staff will be educated on or before 10/6/17 by the Center Executive Director regarding the updated addendum to the admission packet regarding resident rights for lost or stolen items.</p> <p>Beginning 9/1/17, the admission packet will include an addendum regarding resident rights related to lost or stolen items. This addendum will be reviewed with any new admission/ responsible party by the designated business office staff member.</p> <p>Monitoring</p>		

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F 208	Continued From page 6	F 208	Beginning the week of 10/7/17, audits of 4 newly admitted residents will be completed by the Center Executive Director or designee weekly for 4 weeks and then monthly x 2 months to ensure that residents and or/ their representative has received the updated addendum to the admission packet regarding residents rights for lost or stolen items. Results of the audits will be reported to the QAPI Committee monthly for 3 months for review and remedial interventions. The Center Executive Director is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months. Date of Compliance 10/6/17		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his	F 225		10/6/17	

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F 225	<p>Continued From page 7</p> <p>or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.</p> <p>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.</p> <p>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p>	F 225			

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F 225	<p>Continued From page 8</p> <p>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interview, and policy review, it was determined the facility failed to thoroughly investigate abuse allegations involving staff and residents. This was true for 1 of 2 residents reviewed for abuse/neglect investigations (Resident #11) and had the potential for harm if residents were left unprotected from abusive and/or neglectful treatment by staff. Findings Include:</p> <p>The facility's Abuse Prohibition Policy, revised 7/1/13, documented, "The [abuse/neglect] investigation [and] report must include the following, at a minimum, interviews of all pertinent staff and witnesses ... have witnesses sign a written statement ... in cases of injury of unknown source, interviews of all staff having possible contact with the patient/resident over the 24 hours prior to injury ..."</p> <p>A Grievance/Concern Form involving Resident #11 and dated 4/8/17 documented, "... initially started off with a complaint of abuse against the bald man ask [sic] if he was rough but she stated that 'He turned me on my left side where it hurts,' he wanted to put a diaper on and resident said 'no,' staff 'Bald' man stated 'it make [sic] my job easier' ... clarified this statement later in the day the resident ... stated this a [sic] more of a</p>	F 225	<p>F225</p> <p>Specific Residents Identified</p> <p>Resident #11 discharged on 4/21/17 from the facility.</p> <p>Identification of Other Residents</p> <p>Abuse /neglect investigations for the last 60 days of other residents in the facility will be reviewed by the Center Executive Director or designee on or before 10/6/17 to ensure that written interviews of all pertinent staff and witnesses have been completed and signed per policy. Follow up will be completed including attempt to obtain missing statements as indicated.</p> <p>Systemic Changes</p> <p>Center Executive Director and Center Nurse Executive will be educated by Regional Staff on or before 10/6/17 regarding the requirement of investigations related to abuse/neglect including written and signed interviews of</p>		

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F 225	<p>Continued From page 9 mistreatment."</p> <p>A Summary of Investigation-Physical Abuse Allegation, dated 4/8/17, documented, "[Resident #11] reported to her husband that the bald CNA [Certified Nursing Assistant - CNA #3] turned her on her left side when it hurts when he was changing her." The Summary documented, "[Resident #11] reported that 'the bald guy was rude-he had an attitude. I had peed the bed and he wanted to put a diaper on me because it would make his job easier. He went too fast when he was pushing me side to side cleaning me up.'" The Summary documented no other staff members provided statements regarding Resident #11's allegation.</p> <p>Resident #11 was admitted to the facility with diagnoses that included neoplasm related pain, reduced mobility, difficulty walking, muscle wasting, and atrophy, malignant neoplasm of the thyroid gland, pathological fracture in left femur, and weakness.</p> <p>An Initial Nursing Assessment, dated 4/8/17, documented Resident #11's pain was "sharp, aching," and worsened by "movement, activity, and position[ing]."</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 4/14/17, documented Resident #1 was cognitively intact; required extensive assistance of at least two staff for bed mobility, transfers, dressing, toileting, and personal hygiene; and experienced bilateral range-of-motion impairment of the lower extremities.</p>	F 225	<p>pertinent staff and witnesses.</p> <p>Beginning 10/7/17, the executive director or designee will review reportable investigations for completeness including ensuring that signed statements are in place prior to closing/filing of the event.</p> <p>Monitoring</p> <p>Beginning the week of 10/7/17, reviews of each reportable investigation will be completed at the morning clinical meeting for 12 weeks by the facility interdisciplinary team to ensure completeness. Results of the audits will be reported to the QAPI Committee monthly for 3 months for review and remedial intervention. The Center Executive Director is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p> <p>Date of Compliance</p> <p>10/6/17</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 10</p> <p>The facility's staffing schedule for 4/8/17 documented 3 CNAs, including CNA #3, worked the day shift, four CNAs worked evening shift, and two CNAs worked the night shift. The Investigation Summary did not include statements from any of these staff members regarding Resident #11's allegation.</p> <p>On 8/9/17 at 3:30 pm, the Administrator stated, "There were 3 CNAs on the hall at the time [of the alleged abuse]." When asked whether those CNAs or other staff who worked with CNA #3 or Resident #11 on 4/8/17 were interviewed about the allegation, the Administrator stated, "Sometimes we have written documentation," and noted she could not recall whether any written statements were obtained from staff.</p> <p>On 8/9/17 at 8:00 am, CNA #4, who also provided cares for Resident #11 on 4/8/17, stated she did not recall being asked to provide a statement regarding the alleged abuse.</p> <p>On 8/9/17 at 8:40 am, CNA #3 stated, "It was the first time I worked with her [Resident #11]. I remember her call light was on and when I walked in her room she was wet. I wanted to put a brief on her, but instead got a large pad out of her closet. It was around breakfast and I was on the unit by myself answering call lights. I didn't know anything about her. I got report from the shift before and the other aides had told me they had been in her room already several times that morning because she was wet. When I walked in her room urine had been running off the pad and onto the floor so I had to do a complete bed change. She did not complain of pain that I recall. Then after I changed her sheets, I went back to</p>	F 225			

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F 225	<p>Continued From page 11 answering call lights."</p> <p>CNA#3 failed to provide care consistent with Resident #11's plan of care which indicated two staff were to assist the resident with bed mobility.</p> <p>On 8/10/17 at 9:30 am, the Director of Nursing (DON) stated, "I only started as a new employee the day before this incident. The nurse manager called me about a concern regarding [Resident #11]. I was only told general concerns that one staff member [CNA #3] was rough. As part of our investigation, initially she [the Administrator] would have obtained those [staff statements]. I, as the DON, asked her [the Administrator] to get statements and I don't recall if she got them or not. If they are not in [investigative documentation] then I would have to see if they were not attached. I don't recall if she got statements from the other staff or not at that point. As part of our investigation, we are to get statements from staff who knew about it or was around at that time. I was not aware of who needed to do the pieces of the investigation as far as statements."</p> <p>On 8/10/17 at 10:20 am the Administrator stated, "The DON started the investigation. I was not here at that time. I don't see any statements that we talked to the other CNAs that we talked to. I'm not finding the documentation. If there is an allegation of abuse, then we are to talk with the other staff that worked with the resident to see if there were any witnesses. If we can pinpoint anyone who worked with that resident at that time, then they would be interviewed. We would need to get information from the nurse and CNAs and anyone who had interactions with that</p>	F 225			

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F 225	Continued From page 12 person. But I did not go back to talk with the staff. I'm not sure the DON talked with the night shift staff or not. We did not know much about her [Resident #11]."	F 225			
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse	F 226		10/6/17	

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F 226	<p>Continued From page 13 prevention. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to implement abuse policies and procedures to thoroughly investigate an allegation of abuse involving a staff member for 1 of 2 residents (Resident #11) reviewed for abuse, neglect, and misappropriation of property. This failed practice had the potential for harm to all residents at the facility who allege mistreatment, neglect, abuse, and/or misappropriation of property by staff, another resident, and/or visitors. Findings include:</p> <p>The facility's Abuse Prohibition Policy, revised 7/1/13, documented, "The [abuse/neglect] investigation [and] report must include the following, at a minimum, interviews of all pertinent staff and witnesses ... have witnesses sign a written statement ... in cases of injury of unknown source, interviews of all staff having possible contact with the patient/resident over the 24 hours prior to injury ..."</p> <p>A Grievance/Concern Form involving Resident #11 and dated 4/8/17 documented, "... initially started off with a complaint of abuse against the bald man ask [sic] if he was rough but she stated that 'He turned me on my left side where it hurts,' he wanted to put a diaper on and resident said 'no,' staff 'Bald' man stated 'it make [sic] my job easier' ... clarified this statement later in the day the resident ... stated this a [sic] more of a mistreatment."</p> <p>A Summary of Investigation-Physical Abuse</p>	F 226	<p>F226</p> <p>Specific Residents Identified</p> <p>Resident # 11 discharged on 4/21/17 from the facility.</p> <p>Identification of Other Residents</p> <p>Abuse /neglect investigations for the last 60 days of other residents in the facility will be reviewed by the Center Executive Director or designee on or before 10/6/17 to ensure that written interviews of all pertinent staff and witnesses have been completed and signed per policy. Follow up will be completed including attempt to obtain missing statements as indicated.</p> <p>Systemic Changes</p> <p>Center Executive Director and Center Nurse Executive will be educated by Regional Staff on or before 10/6/17 regarding the requirement of investigations related to abuse/neglect including written and signed interviews of pertinent staff and witnesses.</p> <p>Beginning 10/7/17, the executive director or designee will review reportable investigations for completeness including ensuring that signed statements are in</p>		

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F 226	<p>Continued From page 14</p> <p>Allegation, dated 4/8/17, documented, "[Resident #11] reported to her husband that the bald CNA [Certified Nursing Assistant - CNA #3] turned her on her left side when it hurts when he was changing her." The Summary documented, "[Resident #11] reported that 'the bald guy was rude-he had an attitude. I had peed the bed and he wanted to put a diaper on me because it would make his job easier. He went too fast when he was pushing me side to side cleaning me up.'" The Summary documented no other staff members provided statements regarding Resident #11's allegation.</p> <p>Resident #11 was admitted to the facility with diagnoses that included neoplasm related pain, reduced mobility, difficulty walking, muscle wasting, and atrophy, malignant neoplasm of the thyroid gland, pathological fracture in left femur, and weakness.</p> <p>An Initial Nursing Assessment, dated 4/8/17, documented Resident #11's pain was "sharp, aching," and worsened by "movement, activity, and position[ing]."</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 4/14/17, documented Resident #1 was cognitively intact; required extensive assistance of at least two staff for bed mobility, transfers, dressing, toileting, and personal hygiene; and experienced bilateral range-of-motion impairment of the lower extremities.</p> <p>The facility's staffing schedule for 4/8/17 documented 3 CNAs, including CNA #3, worked the day shift, four CNAs worked evening shift,</p>	F 226	<p>place prior to closing/filing of the event.</p> <p>Monitoring</p> <p>Beginning the week of 10/7/17, reviews of each reportable investigation will be completed at the morning clinical meeting for 12 weeks by the facility interdisciplinary team to ensure completeness. Results of the audits will be reported to the QAPI Committee monthly for 3 months for review and remedial intervention. The Center Executive Director is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p> <p>Date of Compliance</p> <p>10/6/17</p>		

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F 226	<p>Continued From page 15 and two CNAs worked the night shift. The Investigation Summary did not include statements from any of these staff members regarding Resident #11's allegation.</p> <p>On 8/9/17 at 3:30 pm, the Administrator stated, "There were 3 CNAs on the hall at the time [of the alleged abuse]." When asked whether those CNAs or other staff who worked with CNA #3 or Resident #11 on 4/8/17 were interviewed about the allegation, the Administrator stated, "Sometimes we have written documentation," and noted she could not recall whether any written statements were obtained from staff.</p> <p>On 8/9/17 at 8:00 am, CNA #4, who also provided cares for Resident #11 on 4/8/17, stated she did not recall being asked to provide a statement regarding the alleged abuse.</p> <p>On 8/9/17 at 8:40 am, CNA #3 stated, "It was the first time I worked with her [Resident #11]. I remember her call light was on and when I walked in her room she was wet. I wanted to put a brief on her, but instead got a large pad out of her closet. It was around breakfast and I was on the unit by myself answering call lights. I didn't know anything about her. I got report from the shift before and the other aides had told me they had been in her room already several times that morning because she was wet. When I walked in her room urine had been running off the pad and onto the floor so I had to do a complete bed change. She did not complain of pain that I recall. Then after I changed her sheets, I went back to answering call lights."</p> <p>On 8/10/17 at 9:30 am, the Director of Nursing</p>	F 226			

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F 226	Continued From page 16 (DON) stated, "I only started as a new employee the day before this incident. The nurse manager called me about a concern regarding [Resident #11]. I was only told general concerns that one staff member [CNA #3] was rough. As part of our investigation, initially she [the Administrator] would have obtained those [staff statements]. I, as the DON, asked her [the Administrator] to get statements and I don't recall if she got them or not. If they are not in [investigative documentation] then I would have to see if they were not attached. I don't recall if she got statements from the other staff or not at that point. As part of our investigation, we are to get statements from staff who knew about it or was around at that time. I was not aware of who needed to do the pieces of the investigation as far as statements." On 8/10/17 at 10:20 am the Administrator stated, "The DON started the investigation. I was not here at that time. I don't see any statements that we talked to the other CNAs that we talked to. I'm not finding the documentation. If there is an allegation of abuse, then we are to talk with the other staff that worked with the resident to see if there were any witnesses. If we can pinpoint anyone who worked with that resident at that time, then they would be interviewed. We would need to get information from the nurse and CNAs and anyone who had interactions with that person. But I did not go back to talk with the staff. I'm not sure the DON talked with the night shift staff or not. We did not know much about her [Resident #11]."	F 226			
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246		10/6/17	

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F 246	<p>Continued From page 17</p> <p>483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p> <p>(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interviews, and record review, it was determined the facility failed to ensure call lights, water mugs, telephones, and personal items were accessible to residents. This was true for 1 of 13 sample residents (#3) and 1 random resident (#19) living in the facility at the time of the survey. The failure created the potential for harm if residents were unable to summon staff for assistance, access fluids to drink, make/receive telephone calls, and/or use personal items when desired. Findings include:</p> <p>1. A 7/10/17 admission Minimum Data Set assessment documented Resident #19 was understood by others and able to understand others; had severe cognitive impairment; required extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene; had occasional bowel and bladder incontinence; was at risk for pressure ulcers; and, had 1 fall with minor injury since admission to the facility.</p> <p>On 8/7/17 at 9:55 am, Resident #19 was observed in bed with the head of the bed raised to 40-45 degrees. A bedside table was on the</p>	F 246	<p>F246</p> <p>Specific Residents Identified</p> <p>The call light and over the bed table containing his water bottle and personal items for resident #3 will be placed within the resident's reach by the nursing assistant on or before 10/6/17. Resident #3 will be assessed for signs or symptoms of adverse effects post incident by the Center Nurse Executive or Designee on or before 10/6/17, follow up will be completed as indicated.</p> <p>Resident #19 discharged on 8/14/17 from the facility.</p> <p>Identification of Other Residents</p> <p>Resident rooms will be checked by the Center Executive Director or designee on or before 10/6/17 to ensure that call lights and personal items were placed within reach of the residents when they are in their rooms. Any findings will be corrected by the Center Executive</p>		

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F 246	<p>Continued From page 18</p> <p>resident's right side and behind the upraised head-of-bed. A call light cord was draped over the bedside table and the end of the cord (call button) hung over the far side of the table. When asked how he summoned assistance, the resident said he used a call light. The resident looked and felt around on the bed and said he did not know where the call light was.</p> <p>On 8/7/17 at 10:40 am, Resident #19 was observed in the doorway to his room in a wheelchair. The resident said he did not find his call light and added, "They never put it where I can get it."</p> <p>On 8/7/17 at 10:42 am, the Staff Development Coordinator (SDC) accompanied 2 surveyors to Resident #19's room, where the call light remained draped over the bedside table. The SDC said the call light should be within the resident's reach and that it was not accessible when the resident was in bed.</p> <p>2. Resident #3 was admitted to the facility on 4/11/17 with multiple diagnoses, including osteoporosis with pathological fractures, decreased mobility, and malaise.</p> <p>The resident's 7/12/17 quarterly MDS assessment documented intact cognition and extensive assistance required with bed mobility, transfers, dressing, and toileting.</p> <p>Resident #3's hearing impairment care plan included a 4/24/17 intervention for the call light to be within reach at all times.</p> <p>Resident #3's fall risk care plan included the</p>	F 246	<p>Director or designee on or before 10/6/17.</p> <p>Systemic Changes</p> <p>Facility staff will be re-educated on or before 10/6/17 by the Center Executive Director or designee that call lights and personal items including water bottles and telephones must be kept within reach of each resident.</p> <p>Beginning 10/7/17, the Center Nurse Executive will update the center's quality of life rounding tool (used for weekly nursing/therapy rounds) to reflect checks to ensure that resident personal items are within reach.</p> <p>Monitoring</p> <p>Beginning the week of 10/7/17, facility rounds will be completed by the Center Executive Director or designee weekly x 4 weeks and then monthly x 2 months to ensure that call lights and personal items including water bottles are within reach of the residents. Results of the audits will be submitted to the QAPI Committee monthly for 3 months for review and remedial intervention. The QAPI Committee will re-evaluate the need to further monitoring after 3 months. The Center Executive Director is responsible for monitoring and compliance.</p> <p>Date of Compliance</p>		

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F 246	<p>Continued From page 19 following interventions: * Ensure all necessary personal items within reach when in bed, dated 4/24/17; and, * Remind to use the call light when attempting to ambulate or transfer, dated 7/14/17.</p> <p>On 8/8/17 at 8:20 am, Resident #3 was observed awake in bed with the head of the bed raised to about 40 degrees. An over bed table was 2 feet from the bed. Two water mugs - 1 large and 1 small - 2 pairs of eyeglasses, 1 pair of sunglasses, and a small box of tissues were on the over bed table. The resident said he thought he could reach one of the water mugs but was unsuccessful when he tried. A small plastic glass and a portable telephone were on the bedside table next to the bed on the resident's right side. However, with the head of the bed raised, the bedside table was behind the resident and also inaccessible.</p> <p>On 8/8/17 at 9:10 am, a staff member exited Resident #3's room with a meal tray and the resident was observed still in bed with the head of the bed raised to about 40 degrees. The over bed table with the 2 water mugs, eyeglasses, and tissues on it was 3 feet from the bed, and the plastic glass and portable telephone were still on the bedside table to the right and behind the resident. At 9:12 am, CNA #1 entered the room and asked the resident if he needed anything. When asked if the resident could reach a water mug, eyeglasses or the telephone, the resident and CNA #1 both said "No." The CNA moved the overbed table next to the bed and placed the portable telephone on it. At that time, the resident's call light cord was clipped to the front of his t- shirt, but the end with the push button</p>	F 246	10/6/17		

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F 252	Continued From page 21 resident rooms clean and comfortable. These had the potential for harm if residents experienced a decline in their sense of self-worth and well-being from not living in a homelike environment. Findings include: 1. On 8/7/10/17 at 9:00 am, Room 306 and Room 422 were observed with dirty, sticky floors. Housekeeper #1 stated urine could be smelled in Room 422. 2. On 8/11/17 at 1:30 pm, Room 306 was observed with dried food on the floor by the bed. Housekeeper #1 stated resident rooms were cleaned daily.	F 252	Specific Residents Identified The floors in rooms 306 and 422 will be cleaned by the housekeeper on or before 10/6/17. Room 422 will be cleaned by the housekeeper on or before 10/6/17 so that the urine odor was no longer present. The floor in room 306 will be cleaned by the housekeeper on or before 10/6/17 and the food removed from the floor. The residents in rooms 306 and 422 will be assessed by nursing on or before 10/6/17 with follow up completed as indicated. Identification of Other Residents The floors in resident rooms in the facility will be reviewed by the Center Executive Director or designee on or before 10/6/17 to ensure that they are clean and homelike. Resident rooms will be reviewed by the Center Executive Director or designee on or before 10/6/17 to ensure that odors are not present. Any findings will be corrected by the Housekeeping Supervisor or designee on or before 10/6/17. An environmental round will be completed by the Center Executive Director and Director of Maintenance to identify any concerns with needed repairs, cleaning, or other needed environmental modifications on or before 10/6/17. Any identified areas will be immediately		

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F 252	Continued From page 22	F 252	<p>addressed or scheduled for repair/cleaning follow-up as indicated.</p> <p>Systemic Changes</p> <p>Facility staff will be educated by the Center Executive Director or designee on or before 10/6/17 regarding providing a comfortable, homelike environment for residents. Any issues found with dirty floors or odors will be addressed.</p> <p>A clipboard for staff to use to report Housekeeping concerns will be placed in the charting room on or before 10/6/17 to communicate concerns regarding floors and odors to housekeeping staff.</p> <p>Beginning 10/7/17 the housekeeping communication clipboard will be brought to morning stand-up and will be reviewed by the director of housekeeping or designee for any required follow-up.</p> <p>Monitoring</p> <p>Beginning the week of 10/7/17, facility rounds will be completed weekly x 4 weeks and then monthly x 2 months by the Center Executive Director or designee to ensure that resident rooms provide a</p>		

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F 252	Continued From page 23	F 252	homelike environment for the residents and that concerns with odors and dirty floors are corrected. Results of the audits will be reported to the QAPI Committee monthly for 3 months for review and remedial intervention. The QAPI Committee will re-evaluate the need for further monitoring after 3 months. The Center Executive Director is responsible for monitoring and compliance. Date of Compliance 10/6/17		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual	F 278		10/6/17	

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F 278	<p>Continued From page 24 who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review, hospice services agreement review, and interview, it was determined the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for 1 of 2 residents (#15) who elected the Hospice benefit and reviewed for assessment accuracy. This failed practice created the potential for harm for Resident #15, who the MDS assessment did not identify as having a life expectancy of less than 6 months, and any resident in the facility desiring hospice services. Findings include:</p> <p>A Hospice Services Agreement between the facility and hospice provider, dated 11/1/14, documented, "Hospice is a licensed patient and family-centered program that provides interdisciplinary services for the palliation and management of terminal illness."</p> <p>Resident #15 was admitted to the facility with diagnoses that included malignant neoplasm of</p>	F 278	<p>F 278</p> <p>Specific Residents Identified</p> <p>Resident # 15 was discharged from the facility on 8/17/17.</p> <p>Identification of Other Residents</p> <p>On or before 10/6/17, residents with hospice services will be reviewed by the Center Nurse Executive or designee to ensure that a certification of terminal illness is present in the medical record and that the MDS assessment accurately reflects the residents' current status. MDS Modifications will be completed as indicated on or before 10/6/17 by the MDS coordinator.</p> <p>Systemic Changes</p>		

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F 278	<p>Continued From page 25 the lung and palliative care.</p> <p>Physician Orders, dated 5/16/17, documented "Admit [Resident #15] under care of [name of hospice agency]."</p> <p>Resident #15's Comprehensive Care Plan, initiated 5/17/17, documented, "Hospice care due to end stage diagnosis of lung cancer."</p> <p>An Admission MDS assessment, dated 5/23/17, documented Resident #15 was cognitively intact, did not have a condition or chronic disease that may result in a life expectancy of less than 6 months, and received hospice services as a resident in the facility.</p> <p>Resident #15's clinical record did not contain a Certificate of Terminal Illness, however the hospice agency providing services to Resident #15 provided a statement from the resident's physician that documented, "I certify that ... [Resident #15] is terminally ill and has a life expectancy of six (6) months or less, if the illness runs its normal course." Three different Certifications of Terminal Illness, dated 11/29/16, 2/27/17, and 7/27/17, were also provided by the hospice agency.</p> <p>On 8/10/17 at 2:33 pm, MDS Coordinator #1 stated, "Sections J and Section O [of the MDS assessment] should match for someone receiving hospice services. I do see an order from the physician to admit her [Resident #15] under care of [hospice agency]." MDS Coordinator #2 stated, "On Section J of the MDS, there should be physician's documentation of a life expectancy of less than 6 months in order to</p>	F 278	<p>On or before 10/6/17, the Practice Development Specialist or designee will provide education to the MDS staff regarding accuracy of the MDS assessments and requirement for certification of terminal illness with relation to hospice services.</p> <p>On or before 10/6/17, the Center Nurse Executive or designee will review residents who have newly elected hospice services in the daily clinical meeting to ensure a certification of terminal illness is present in the medical record. MDS assessments will be reviewed to ensure accuracy. Modifications of the MDS will be completed by the MDS Coordinator or designee as indicated by the review on or before 10/6/17.</p> <p>Monitoring</p> <p>Beginning the week of 10/7/17, audits of 3 residents on hospice services will be completed by the Center Nurse Executive or designee to ensure that a certification of terminal illness is present in the medical record MDS accuracy.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The QAPI Committee will Re-evaluate the need for further monitoring after 3 months. The Center</p>		

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F 278	<p>Continued From page 26 code it 'yes' on the MDS."</p> <p>On 8/10/17 at 2:45 pm, RN #2 stated she completed the admission MDS for Resident #15 on 5/23/17. When asked about Section J and Section O regarding Resident #15 and the Certification of Terminal Illness, RN #2 stated, "I know [Resident #15] is receiving hospice services, but that doesn't mean she has a life expectancy of less than 6 months. I would have to look under the physician order and plan of care to see if a terminal prognosis was documented. If I marked 'No' on the MDS, then I wouldn't have found the documentation in the chart. I don't remember seeing it in the chart."</p> <p>On 8/10/17 at 4:00 pm, Hospice RN #1 stated, "There should be documentation of the terminal illness in the chart, but ... I'm not seeing it. They [facility staff] should have access though to our 'Read-only' hospice charts. [Resident #15] has been receiving hospice services since September 2016. We do have a Certification of Terminal Illness and her diagnosis is lung cancer." Hospice RN #1 then stated, "Every 3 months we do 2 sets of recertifications for hospice services and we look to see if the person still qualifies for hospice services which [Resident #15] does. [Facility staff] should be accessing our documents as well to see she has a Certification of Terminal Illness."</p> <p>On 8/10/17 at 5:28 pm, the Administrator stated, "There are only a few people here that have access to their [hospice provider] records." When asked about the Certification of Terminal Illness for Resident #15, the Administrator stated, "That is part of the hospice criteria. That is a criteria for</p>	F 278	<p>Nurse Executive is responsible for monitoring and compliance.</p> <p>Date of Compliance 10/6/17</p>		

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

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F 278	Continued From page 27 admission and we should have it in the medical record." On 8/11/17 at 8:30 am, the facility's Clinical Quality Specialist (CQS) stated, "I have not seen the Certification of Terminal Illness." The Director of Nursing (DON) stated, "We don't have it in the building this morning." On 8/11/17 at 9:10 am, the Care Transition Nurse stated, "I called the Medical Director [hospice agency] this morning and I went through their computer system to look for the Certification of Terminal Illness form and I did not find the form. Hospice should provide that to us and put that in her chart. There are only five of us here who have access to the hospice records. When I called the hospice doctor this morning and said I could not find the form, he had to call the hospice medical records person and he told me ... they [hospice] found out those specific forms (Certification of Terminal Illness) do not populate in their [hospice] computer system and the doctor's response this morning was 'Where they're going, I don't know.'" On 8/11/17 at 9:30 am, the CQS stated, "We should be communicating with the MDS people and they should have communicated with medical records or the Administrator or me if they saw someone was receiving hospices services and there's no Certificate of Terminal Illness documentation in the chart. I concur we have a problem we need to fix here."	F 278			
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10	F 280		10/6/17	

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F 280	<p>Continued From page 28</p> <p>(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 cultural preferences in developing goals of care.</p> <p>483.21</p>	F 280		

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F 280	<p>Continued From page 29</p> <p>(b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 280			

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F 280	<p>Continued From page 30</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' care plans were reviewed and/or revised to reflect their current needs. This was true for 3 of 17 (#2, #6, and #9) residents reviewed for care plan revision. Resident #2 had multiple care planned items that were not updated after her condition changed. Resident #6 and #9 sustained a fall, and the care plan was not revised or updated after the fall. The deficient practice had the potential to cause harm if residents did not receive appropriate care and interventions due to inaccurate information on the care plan. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 1/7/16 following surgical right hip replacement and was re-admitted on 4/24/17 with diagnoses that included fracture of the right tibia and fibula (lower leg), reduced mobility, muscle wasting, history of falls, brain cancer, mild cognitive impairment, and seizures.</p> <p>a. The resident's ADL (Activities of Daily Living) care plan, initiated on 4/22/17, documented staff was to provide a right arm trough to support the right upper extremity.</p> <p>The arm trough was not observed in place at any time during survey.</p> <p>On 8/11/17 at 12:05 pm, LPN #1 stated the arm trough was discontinued on 4/24/17.</p> <p>b. A risk for falls care plan, initiated on 4/20/17, documented Resident #2 was "weight bearing as tolerated."</p>	F 280	<p>F 280</p> <p>Specific Residents Identified</p> <p>On or before 10/6/17, residents # 2, 6, and 9 will be assessed by the Center Nurse Executive or designee for adverse effects related to care plans not reflecting the resident's current status. Follow up will be completed as indicated.</p> <p>On or before 10/6/17 the Center Nurse Executive or designee will revise resident # 2's care plan including removal of the arm trough, hip precautions, yes / no communication board, and restorative ambulation program. The weight bearing status was updated to reflect the resident's current status.</p> <p>On or before 10/6/17, resident # 6 & 9's fall care plans were updated by the Center Nurse Executive or designee to reflect the resident's current status, including interventions implemented after resident # 6's fall on 7/17/17 and resident # 9's fall on 7/18/17.</p> <p>Identification of Other Residents</p> <p>On or before 10/6/17, the Center Nurse Executive or designee will review resident care plans for accuracy. Resident care plans that have identified discrepancies will be revised to reflect the resident's current status and follow up completed by the nurse manager or designee to reflect resident current status and care and services provided.</p>		

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F 280	<p>Continued From page 31</p> <p>A Medication Review Report, dated 7/6/17, included a physician's order that documented, "Non-Bearing Status to Right Leg every shift."</p> <p>The August 2017 Medication Administration Record (MAR) documented Resident #2 was "non-weight bearing to right leg."</p> <p>The resident was was not observed walking at any time during survey.</p> <p>On 8/10/17 at 5:10 pm, LPN #7 said she did not know the resident's current weight bearing status.</p> <p>On 8/11/17 at 9:15 am, the Director of Nursing (DON) said the resident was non-weight bearing and the care plan had not been updated.</p> <p>On 8/11/17 at 12:05 pm, LPN #1 said the arm trough was discontinued on 4/24/17 and the hip precautions were discontinued in August of 2016, but the interventions were not removed from the care plan.</p> <p>c. The resident's alterations in functional mobility care plan documented that hip precautions were initiated on 1/7/16.</p> <p>On 8/11/17 at 12:05 pm, LPN #1 said the hip precautions were discontinued on 8/24/16.</p> <p>On 8/11/17 at 9:15 am, the DON said Resident #2's hip precautions were removed from the care plan on 8/10/17.</p> <p>d. The restorative ambulation program care plan, initiated on 6/10/16, documented Resident #2</p>	F 280	<p>Systemic Changes</p> <p>On or before 10/6/17, the Practice Development Specialist or designee will provide education to Licensed Nurses regarding the center's policy for timely and accurate care plan revisions.</p> <p>On or before 10/6/17, residents will be reviewed by the Center Nurse Executive or designee in daily clinical meeting to ensure resident changes of condition are reflected accurately on the care plan. Follow up will be completed as indicated.</p> <p>Beginning 10/7/17, a nurse manager or designee will review the comprehensive plan of care quarterly, prior to the resident's scheduled care plan conference. Any identified discrepancies will be corrected at that time.</p> <p>Monitoring</p> <p>Beginning the week of 10/7/17, audits of 5 resident's care plans will be reviewed by the Center Nurse Executive or designee to ensure that the residents care plan has been updated to accurately reflect the residents' current status. Follow up for identified residents will be completed as indicated.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to</p>		

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F 280	<p>Continued From page 32 was to walk with a platform front-wheel walker.</p> <p>The resident was not observed walking at any time during survey. In addition, the resident was ordered to be non-weight bearing after a fall with right leg fracture in April 2017.</p> <p>On 8/11/17 at 9:15 am, the DON said the restorative ambulation program was removed from Resident #2's care plan on 8/10/17.</p> <p>e. An impaired communication care plan, initiated 1/14/16, documented Resident #2 was to receive a "YES/NO" board to facilitate communication.</p> <p>The "YES/NO" communication board was ordered by Resident #2's physician on 4/24/17.</p> <p>The resident's July 2017 MAR documented the "YES/NO" board was used.</p> <p>On 8/9/17 at at 11:00 am, CNA #8 said staff no longer used Resident #2's "YES/NO" communication board and would instead rephrase a question when the resident's response to questions seemed inconsistent.</p> <p>The "YES/NO" board was not observed at any time during survey. The DON said Resident #2's "YES/NO" communication board was removed from the care plan on 8/10/17.</p> <p>2. The facility's Falls Management Policy, revised 3/15/16, documented, "Patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk</p>	F 280	<p>the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Center Nurse Executive is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p> <p>Date of Compliance 10/6/17</p>		

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135104	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2017
NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
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F 280	<p>Continued From page 33 and minimize injury. Review and revise care plan regularly ... update care plan to reflect new interventions."</p> <p>Resident #6 was admitted to the facility with diagnoses that included cerebral infarction, reduced mobility, hemiplegia, hemiparesis, abnormalities of gait and mobility, and unsteadiness on feet.</p> <p>An MDS assessment, dated 5/23/17, documented Resident #6 was cognitively intact; required extensive assistance of 2 staff for bed mobility, transfers, and toileting; and could stabilize only with staff assistance when moving from a seated- to standing position, moving on and off a toilet, and with surface-to-surface transfers.</p> <p>An Incident and Accident Report, dated 7/17/17, documented Resident #6 experienced a non-injury fall and reported, "Resident noticed by CNA [Certified Nursing Aide] lying down on the floor beside his bed, verbalized that he slid down from the bed ... no injury noted from the fall ... assisted by 2 person to get up to wheelchair ..."</p> <p>Resident #6's Comprehensive Care Plan, revised on 7/13/17, was not updated or revised with any new goals or interventions following the 7/17/17 fall.</p> <p>On 8/7/17 at 8:00 am, Resident #6 was observed sitting in an electric wheelchair waiting for breakfast to be served.</p> <p>On 8/7/17 at 9:15 am, CNA #7 stated, "[Resident #6] needs extensive assistance with most of his</p>	F 280			

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F 280	<p>Continued From page 34</p> <p>ADLs [Activities of Daily Living]. He does use a urinal and can take himself to the bathroom."</p> <p>On 8/8/17 at 10:15 am, Resident #6 stated, "I think I was getting out of bed by myself and I felt a little woozy. I was reaching for my chair and I turned myself over. They [staff] had to come and pick me up off the floor and put me in my chair. I had a stroke and I can't support myself."</p> <p>On 8/8/17 at 9:35 am, LPN #2 stated, "We assist [Resident #6] with his ADLs. He can be non-compliant at times with transfers."</p> <p>On 8/8/17 at 5:00 pm, the DON stated, "Usually when someone has a fall there will be an ongoing conversation between the nurse manager, floor nurse, and direct care nurse. We try to find a root cause and come up with interventions and we should be implementing this as soon as possible or at least within 24 hours on the care plan. The nurse responsible for the care at the time or the nurse manager would be the ones to follow up with the care plan." At 6:35 pm, the DON stated, "I've looked through the Incident Report for the fall [Resident #6] had on 7/17/17 and I cannot find where the care plan has been updated from the fall. I would expect follow up documentation and revision on the care plan regarding the fall he had."</p> <p>3. Resident #9 was readmitted to the facility on 12/12/16 with diagnoses that included osteoporosis, neuropathy, and obesity.</p> <p>Resident #9's Quarterly Minimum Data Set (MDS) assessment, dated 7/21/17, documented she was cognitively intact, required extensive</p>	F 280			

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F 280	<p>Continued From page 35</p> <p>assistance of 2 or more staff for transfers and had no falls.</p> <p>An SBAR (Situation, Background, Assessment, Recommendation) Communication form, dated 7/19/17, documented Resident #9 experienced a fall on 7/18/17.</p> <p>Resident #9's care plan was not updated to reflect interventions post fall to protect her from injury until 8/9/17. On 8/9/17 at 3:30 pm, the Director of Nursing (DON) stated Resident #9 did not currently have a care plan in place for falls.</p> <p>An 8/9/17 Fall Care Plan documented Resident #9 was to alert staff when going outside to pick fruit and she was to use a Reacher assistive device when she was outside picking fruit.</p> <p>On 8/10/17 at 8:40 am, Licensed Practical Nurse (LPN) #1 stated Resident #9 was to inform staff when she wanted to go outside and pick fruit and staff were to ensure she had a Reacher with her. LPN #1 stated she had related the goals and interventions to staff members.</p> <p>On 8/7/17 at 3:35 pm, Resident #9 was observed notifying a staff member she wanted to go outside to pick fruit. The resident exited the front door on an electric wheelchair and proceeded to a walnut tree where she reached up and hand picked a walnut. At 3:43 pm, Resident #9 drove the electric wheelchair across the grass towards fruit trees on the side of the building. Resident #9, who was unaccompanied by staff, did not have a Reacher assistive device during this observation.</p>	F 280			

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F 280	Continued From page 36 On 8/10/17 at 8:40 am, LPN #1, when informed of the observation, stated she did not realize Resident #9 did not have a Reacher assistive device. LPN #1 stated the care plan was how the facility directed cares provided by staff.	F 280			
F 281 SS=E	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure administration of medications, assessment of residents, and the provision of cares per care plan were performed according to accepted standards of practice for 5 of 17 sample residents (#s 2, 5, 9, 10 and 11). This was true when: a) Medication was given to a resident (Resident #2) without applesauce, and the speech therapist recommended pills should be given whole in applesauce due to the resident's swallowing difficulty. b) Blood pressure medication was given without appropriately monitoring Residents #5 and #9's blood pressures. c) Neurological checks were not performed for Resident #9. d) Bowel protocols were not followed for Resident #10 and Resident #2.	F 281	F281 Specific Residents Identified On or before 10/6/17, resident # 2 will be assessed by the Center Nurse Executive or designee, for adverse effect related to pills not being administered whole in applesauce. Resident will be assessed by Speech Therapist on or before 10/6/17 related to medication administration method. Follow up completed as indicated and care plan will be updated to reflect the resident's current status. Resident # 2 will be assessed by the Center Nurse Executive or designee for bowel care interventions on or before 10/6/17. The results of the assessment will be reviewed with the residents' attending physician and changes to	10/6/17	

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F 281	<p>Continued From page 37</p> <p>e) Care-planned level of staffing assistance was not provided to Resident #11 during pericare.</p> <p>These failures created the potential for harm if residents received medication in a manner that increased their risk for choking, receive medication that caused undesirable changes in blood pressure, experienced constipation, and/or experience changes in neurological status that were undetected. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 1/7/16 following a surgical right hip replacement and was re-admitted on 4/24/17 with diagnoses that included fracture of the right tibia and fibula (lower leg), reduced mobility, muscle wasting, brain cancer, mild cognitive impairment, and seizures.</p> <p>a. A 5/3/17 Speech Therapy Encounter Note documented, "pt. [Patient] would benefit from pills whole one at a time in applesauce."</p> <p>On 8/10/17 at 2:13 pm, LPN #4 was observed administering oral medication to Resident #2. The medication was given as a single pill by spoon with no applesauce. When asked about how pills should be given to Resident #2, LPN # 4 stated the resident took pills whole without applesauce and he was not aware of any speech therapy recommendations or orders to give pills with applesauce.</p> <p>Speech Therapist #1 stated on 8/10/17 at 11:55 am that her recommendation was to give Resident #2's pills whole in applesauce.</p> <p>b. Resident #2's current physician orders</p>	F 281	<p>residents <input type="checkbox"/> bowel care regimen will be implemented as indicated / per physician order on or before 10/6/17.</p> <p>Resident # 5 <input type="checkbox"/>s blood pressure and pulse were assessed by the Center Nurse Executive or designee on or before 10/6/17 and any adverse effects will be addressed. Blood pressure medications and vital signs will be reviewed with MD for adjustments as indicated, on or before 10/6/17. Follow up will be completed as indicated and care plan will be updated to reflect the resident <input type="checkbox"/>s current status.</p> <p>Resident # 9 <input type="checkbox"/>s blood pressure, pulse and Neurological status were assessed by the Center Nurse Executive or designee on or before 10/6/17 and any adverse effects addressed. Blood pressure medications and vital signs will be reviewed with MD for adjustments as indicated. Follow up will be completed as indicated and the care plan will be updated to reflect the resident <input type="checkbox"/>s current status.</p> <p>Resident # 10 discharged from the facility on 3/6/2017.</p> <p>Resident # 11 discharged from the facility on 4/21/2017.</p> <p>Identification of Other Residents</p> <p>On or before 10/6/17, the Center Nurse Executive or designee will review</p>		

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F 281	<p>Continued From page 38</p> <p>included the following medications: Miralax in 48 ounces of fluid daily as needed for constipation, Milk of Magnesia (MOM) at bedtime if no BM (bowel movement) in three days, Dulcolax suppository rectally as needed for constipation if no results from MOM by next shift, and Fleet enema 1 dose as needed for constipation if no results from Dulcolax in two hours. Each of these orders was dated 4/24/17.</p> <p>Resident #2's 7/17/17 Physician's Orders documented staff was to monitor the resident's bowel movements for 7 days and notify the physician if the resident experienced constipation for more than 3 days.</p> <p>The resident's Bowel Continence Record documented no bowel movement from 7/18/17 to 7/21/17 (4 days) and from 7/27/17 to 8/2/17 (7 days).</p> <p>There was no documentation in the resident's clinical record that the physician was notified of these periods during which the resident did not experience a bowel movement.</p> <p>The July 2017 Medication Administration Record for July documented Resident #2 received one dose of Miralax on 7/30/17. No other bowel interventions were documented for periods of time in July and August when the resident did not have a bowel movement for 3 or more days.</p> <p>2. Resident #9 was readmitted to the facility on 12/12/16 with diagnoses that included osteoporosis, neuropathy, hypertension (HTN), and obesity.</p>	F 281	<p>residents who required neurological assessments in the past 30 days, for timely and accurate completion. Residents identified to have incomplete or missing neurological assessments will be assessed for adverse effects.</p> <p>On or before 10/6/17, residents who require special medication instructions for administration (such as crushed, or in applesauce) will be reviewed by the center nurse executive or designee to ensure that resident instructions are updated on the resident MAR and plan of care. Follow-up will be completed as indicated.</p> <p>On or before 10/6/17, residents currently receiving antihypertensive medications will be reviewed by the Center Nurse Executive or designee, to identify residents that require monitoring & of blood pressure and/or pulse prior to antihypertensive medication administration. Follow-up will be completed as indicated for identified residents by a nurse manager or designee on or before 10/6/17 to include physician notification, order changes, and/or care plan updates as indicated.</p> <p>On or before 10/6/17, a review of current residents' bowel documentation for past 30 days will be completed by the Center Nurse Executive or designee, to identify those who did not receive PRN bowel medications according to MD parameters. Those identified to have missing</p>		

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F 281	<p>Continued From page 39</p> <p>The Quarterly MDS assessment, dated 7/21/17, documented Resident #9 was cognitively intact, required extensive assistance of 2 or more staff for transfers, and had no falls.</p> <p>a. A Situation, Background, Assessment, Recommendation (SBAR) Communication form, dated 7/19/17, documented Resident #9 experienced a fall on 7/18/17.</p> <p>On 8/9/17 at 3:30 pm, the DON stated Resident #9 was found outside by a visitor. The DON stated the resident had been trying to pick a plum and fell out of her chair, the fall was unwitnessed, and that neurological assessments should be completed for any unwitnessed fall.</p> <p>On 8/10/17 at 8:40 am, LPN #1 stated Resident #9 said she did not hit her head, however the facility's protocol directed staff to initiate neurological assessments on "all" unwitnessed falls.</p> <p>On 8/11/17 at 8:55 am, the DON and LPN #1 stated the facility could not locate documentation that neurological checks had been performed.</p> <p>b. Resident #9's August 2017 Physician Orders documented:</p> <p>* Norvasc 5 milligrams (mg) once daily for HTN (hypertension), ordered 12/21/16. * Hydralazine HCL 25 mg three times daily for HTN; staff were to withhold the medication if the resident's systolic blood pressure (BP) was less than 100 mmHg (millimeters pressure of mercury), ordered 6/7/17.</p>	F 281	<p>documentation of bowel interventions will be re-assessed by the Center Nurse Executive or designee on or before 10/6/17 with follow up including physician notification completed as indicated.</p> <p>On or before 10/6/17, five random care observations per shift will be reviewed by the Center Nurse Executive or designee, to ensure residents <input type="checkbox"/> level of assistance provided is consistent with residents <input type="checkbox"/> plan of care. Any identified concerns will be immediately addressed.</p> <p>Systemic Changes</p> <p>On or before 10/6/17, licensed staff will be re-educated by the Practice Development Specialist or designee on providing care per physicians orders and / or center policy to include completion of neurological assessment, bowel care, medication administration method, and blood pressure monitoring for hypertensive medications as indicated/ ordered. Licensed staff will complete / pass a post-test on or before 10/6/17 to validate competency.</p> <p>On or before 10/6/17, Certified Nursing Assistants will receive education from the Practice Development Specialist or designee regarding providing residents with appropriate level of care consistent with the residents care plan / Kardex level of assistance. Certified Nursing Assistants will complete / pass a</p>		

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F 281	<p>Continued From page 40</p> <p>Resident #9's July 2017 MAR documented staff was to administer Norvasc daily, BP was to be assessed three times daily, including prior to administration of the Hydralazine. The MAR documented the following:</p> <ul style="list-style-type: none"> * 7/9/17 - Hydralazine administered for BP of 96/65 mmHg. * 7/15/17 at 2:00 pm - BP not assessed, Hydralazine not administered. * 7/28/17 at 8:00 am and 2:00 pm - BP not assessed and Hydralazine not administered. Norvasc not administered at 8:00 am. * 7/29/17 at 8:00 am and 2:00 pm - BP not assessed and Hydralazine not administered. Norvasc not administered at 8:00 am. <p>Similar findings were documented on the June 2017 MAR.</p> <p>On 8/9/17 at 11:00 am, the SDC (Staff Development Coordinator) stated she thought staff preformed BP evaluations and administered the medications on 7/15/17, 7/28/17 and 7/29/17, however, just did not document BPs and medication administrations. She stated the 7/9/17 dose of Hydralazine that should have been withheld was documented as administered.</p> <p>3. Resident #5 was admitted to the facility on 5/24/16 with multiple diagnoses, including HTN.</p> <p>An Altered Cardiovascular Status Care Plan, revised 5/26/16, documented staff were to assess Resident #5's vital signs, administer medications as ordered, and to notify the physician of any "abnormalities."</p>	F 281	<p>post-test on or before 10/6/17 to validate competency</p> <p>On or before 10/6/17, the bowel monitoring system will be reviewed and revised by Center Nurse Executive or designee, to include daily monitoring by a nurse manager or designee.</p> <p>Beginning 10/7/17, residents with falls will be reviewed in morning clinical meeting by the Center Nurse Executive or designee to ensure Neurological assessment was initiated and completed / monitored as indicated.</p> <p>On or before 10/6/17, Certified Nursing Assistants will complete an ADL (transfers, toileting, bed mobility) competency that includes providing level of assistance consistent with the plan of care / kardex, administered by the Practice Development Specialist or designee.</p> <p>On or before 10/6/17, Licensed Nurses will complete a medication pass competency administered by the Practice Development Specialist or designee to ensure that medications are administered per physicians orders, including the method of administration of medication per order (crushed, applesauce) bowel care medication administration, blood pressure monitoring and following parameters for administration.</p>		

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F 281	<p>Continued From page 41</p> <p>Resident #5's August 2017 Physician Orders documented:</p> <ul style="list-style-type: none"> * Norvasc 2.5 mg once daily for HTN, ordered 2/9/17. * Lisinopril 40 mg in the morning for HTN, ordered 6/23/17. * Metoprolol 50 mg twice daily for HTN. The medication was to be withheld when systolic BP was less than 110 mmHg and heart rate (HR) less than 55 beats per minute (bpm), ordered 5/24/16. <p>The MAR from 8/1/17 through 8/7/17 documented Resident #5's BP was to be assessed twice daily prior to the administration of Metoprolol. Resident #5's HR was not assessed and her BP medication was not withheld as follows:</p> <ul style="list-style-type: none"> * 8/1/17 - HR not assessed; Metoprolol administered. * 8/4/17 - HR not assessed; Metoprolol administered. * 8/6/17 - BP assessed as 106/65 mmHg; Metoprolol administered. <p>Similar findings were documented on the June and July 2017 MAR.</p> <p>On 8/9/17 at 11:00 am, the SDC stated Resident #5's Metoprolol was documented as having been administered despite physician orders directing staff to withhold the medication per BP and HR parameters.</p> <p>4. Resident #10 was readmitted to the facility on</p>	F 281	<p>Monitoring</p> <p>Beginning the week of 10/7/17, the Center Nurse Executive or designee will audit 5 residents MARS and 5 medication administrations to ensure medication is administered according to MD order / parameters including bowel and hypertensive medications including method of administration (crushed, applesauce) per MD order / care plan.</p> <p>Beginning the week of 10/7/17, the Center Nurse Executive or designee will audit 3 CNAs weekly to ensure ADL assistance is provided according to resident plan of care.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Center Nurse Executive or designee is responsible for monitoring and follow-up. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p> <p>Date of Compliance</p> <p>10/6/17</p>		

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F 281	<p>Continued From page 42</p> <p>8/12/16 with multiple diagnoses, including chronic kidney disease, oxygen therapy dependence, congestive heart failure (CHF), diabetes mellitus, and history of urinary tract infections.</p> <p>Resident #10's 2/16/17 Significant Change MDS assessment documented extensive assistance of 1 to 2 staff was required for all ADLs, including bed mobility and toileting.</p> <p>An ADL Care Plan, dated 10/28/16, documented Resident #10 required was dependent on staff for all ADLs. The bowel incontinence care plan directed staff to check and change for incontinence in the morning, before meals, before bed, and during night rounds and PRN (as needed).</p> <p>Resident #10's physician orders for 3/1/17 through 3/6/17 documented:</p> <ul style="list-style-type: none"> * Milk of Magnesia 30 mL (milliliters) PRN at bedtime for constipation if no bowel movement (BM) for three days, ordered 1/4/17. * Dulcolax Suppository PRN for constipation if no results from the MOM by the next shift, ordered 1/4/17. * Fleet Enema 1 dose PRN for constipation and if no results from Dulcolax within 2 hours. The physician was to be notified if there were no results from the enema, ordered 1/4/17. <p>ADL Flowsheets from 2/1/17 through 3/6/17 documented Resident #10 had a BM on 2/23/17 and did not have another BM until 3/5/17, 10 days later.</p>	F 281			

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F 281	<p>Continued From page 43</p> <p>Resident #10's February 2017 MAR did not document Milk of Magnesia, Dulcolax Suppository, or a Fleet Enema was administered as ordered by the physician.</p> <p>Resident #10's MAR from 3/1/17 through 3/6/17 MAR documented a single dose of Milk of Magnesia was administered on 3/3/17. The MAR did not document the Dulcolax Suppository or Fleet Enema was administered following the Milk of Magnesia's failure to stimulate a BM. Resident #10's clinical record did not contain documentation the physician was notified about the lack of bowel movement for 10 days.</p> <p>On 8/10/17 at 2:56 pm, Resident #10's Interested Party stated the resident was not always offered an opportunity to toilet.</p> <p>On 8/10/17 at 4:30 pm, the SDC stated the facility's bowel protocol directed staff to notify the direct care nurse when residents failed to experience a BM for 3 days. The SDC stated she could not explain why the protocol had not been followed for Resident #10.</p> <p>5. Resident #11 was admitted to the facility on 4/7/17 with diagnoses that included neoplasm related pain, reduced mobility, difficulty walking, muscle wasting and atrophy, malignant neoplasm of the thyroid gland, malignant pleural effusion, weakness, and pathological fracture of the left femur.</p> <p>An Admission Nursing Assessment, dated 4/7/17, documented Resident #11 experienced sharp pain, aching, and soreness aggravated by movement, physical activity and positioning. The</p>	F 281			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 281	<p>Continued From page 44</p> <p>Assessment documented Resident #11 required staff assistance with repositioning.</p> <p>A 4/7/17 Care Plan documented Resident #11 required the assistance of two staff members for bed mobility, dressing, toileting, personal hygiene, bathing and transfers due to fatigue, activity intolerance, confusion, and limited mobility.</p> <p>An Admission MDS assessment, dated 4/14/17, documented Resident #11 was cognitively intact; required extensive assistance of at least 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene; and experienced range-of-motion impairment to both legs.</p> <p>On 8/9/17 at 3:30 pm, the Administrator stated Resident #11 experienced increased pain when a Certified Nursing Aide (CNA #3) rolled the resident side-to-side while providing pericare to the resident without staff assistance. The Administrator stated, "When we did our investigation we found that [CNA #3] had rolled her [Resident #11] side to side by himself when changing her. It was his [CNA #3] first day working with her on 4/8/17. She did not get here to the facility until around 6:30 pm on [4/7/17]. When a resident comes in, we do have a task list upon admission that will tell the CNAs if someone is a one person or two persons assist."</p> <p>On 8/9/17 at 6:00 pm, the Staff Development Coordinator (SDC) stated, "Upon admission to the facility the nurse who does the assessment will automatically update the care plan, then the care plan will auto populate the CNAs' Kardex [document to instruct how to provide care to a</p>	F 281			

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F 281	<p>Continued From page 45</p> <p>resident] and the Kardex will tell the CNAs if that resident is a 1 person/2 person transfer or if that person needs assistance of 2 for ADLs. The ADL care plan was initiated on 4/7/17, the day of admission, and the care plan stated staff assist of 2 with bed mobility, dressing, toileting, transfers, and hygiene."</p> <p>On 8/10/17 at 8:00 am, CNA #4 stated, "[Resident #11] was fairly new to us. I had not worked with her before. I got report from the night shift that she required extensive assistance of 2. Around breakfast time me and [CNA #10] went in her room and she was soaked. Her bed was soiled so we both changed her."</p> <p>On 8/10/17 at 8:40 am, CNA #3 stated, "I only worked with her [Resident #11] on the day shift of 4/8/17. I remember I was answering call lights; I was on the unit by myself around lunch. When I went in her [Resident #11] room, she said she had 'an accident.' She was wet. Urine had been running off the sheets so I had to do a whole bed change. I didn't know anything about her. I didn't get anything in report and only heard from the other aides that they had been in her room already several times that morning to change her." When asked whether she asked for staff assistance to provide Resident #11's pericare and bed change, CNA #3 stated, "No, I didn't. I wasn't sure I needed help. Nothing was communicated to me about her being a 2 person assist. I didn't know she was a 2 person assist when I came in."</p> <p>On 8/10/17 at 9:30 am, the DON stated, "The initial care plan was initiated on 4/7/17. The admitting nurse creates a care plan for ADLs</p>	F 281			

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F 281	Continued From page 46 after the initial assessment is completed, the nurse will add any additional information. The nursing assessment was completed on 4/7/17. It should be communicated from the nursing staff to the CNAs regarding ADLs. This should also be taking place in shift-to-shift report from the CNAs. It would have populated on the CNAs Kardex that she [Resident #11] was a 2 person assist." On 8/10/17 at 10:50 am, the SDC stated, "The CNAs would have had access on their ADL documentation sheet to show that she [Resident #11] was a 2 person assist for bed mobility. From looking at the ADL documentation that the CNAs use, I'm seeing the CNAs had access in their Kardex to show she [Resident #11] was a 2 person assist."	F 281			
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 309		10/6/17	

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F 309	<p>Continued From page 47 care plan, and the residents' choices, including but not limited to the following:</p> <p>(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure:</p> <p>*As needed (PRN) pain and other PRN medications were monitored for effectiveness. * Non-pharmacological interventions were attempted prior to the administration of PRN medications. * PRN medications had appropriate indications for use.</p> <p>This was true for 5 of 10 residents (#2, #3, #5, #9, and #15) reviewed for medication use and had the potential for harm should medications not have their desired effect, lead to adverse consequences, or if residents received excessive dosages over prolonged periods of time. Findings include:</p>	F 309	<p>F309</p> <p>Specific Residents Identified</p> <p>Residents # 2, 3, 5, and 9's pain will be re-assessed on or before 10/6/17, by the Center Nurse Executive or designee. Residents' pain management plans and care plans, including the use of pharmacologic and non-pharmacologic interventions will be reviewed for effectiveness and indications for use by the Center Nurse Executive or designee on or before 10/6/17. Follow-up will be completed by a Licensed Nurse on or before 10/6/17 including MD notification, and updates to orders, and resident care plans as indicated.</p>		

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F 309	<p>Continued From page 48</p> <p>1. Resident #5 was admitted to the facility on 5/24/16 with multiple diagnoses, including chronic pain, colitis, abdominal pain, chronic obstructive pulmonary disease, arthritis, restlessness, and agitation.</p> <p>The Pain Care Plan, initiated 5/26/16, documented staff was to assess Resident #5's pain, administer pain medications as ordered and monitor the effectiveness of the medication.</p> <p>Resident #5's August 2017 Physician Orders documented:</p> <ul style="list-style-type: none"> * 2 tablets of Acetaminophen 325 milligrams (mg) every 4 hours PRN for mild pain, ordered 5/24/16. * Acetaminophen Suppository 650 mg rectally every 4 hours PRN for pain, ordered 5/24/16. * Tramadol 50 mg by mouth every 6 hours PRN for pain, ordered 7/25/17. <p>Resident #5's July 2017 Medication Administration Record (MAR) documented 17 administrations of Tramadol and 3 doses of oral Acetaminophen. Nineteen of the 20 doses did not include an indication for use, or monitoring of effectiveness.</p> <p>Resident #5's MAR from 8/1/17 through 8/7/17 documented Resident #5 received Tramadol on 8/4/17 and 8/6/17, and an Acetaminophen Suppository on 8/1/17. Resident #5's PRN Pain Management Flowsheet from 8/1/17 through 8/7/17 was blank. Neither, the MAR or PRN pain</p>	F 309	<p>Resident # 15 discharged from the facility on 8/17/2017.</p> <p>Identification of Other Residents</p> <p>On or before 10/6/17, a review of PRN medication administration for the last 30 days will be completed by the Center Nurse Executive or designee to ensure that PRN medication is indicated, that non-pharmacologic interventions are implemented as indicated, and follow-up assessment for efficacy was completed. Resident□s with missing re-assessments will be assessed by the Center Nurse Executive or designee on or before 10/6/17. Any additional follow-up will be completed as indicated.</p> <p>A review of resident□s requiring pain intervention care plans will be completed on or before 10/6/17 by the Center Nurse Executive or designee to ensure that there is a plan that addresses residents pain management in place. Care plans will be updated as indicated by the Center Nurse Executive or designee on or before 10/6/17.</p> <p>Systemic Changes</p> <p>The Practice Development Specialist or designee will provide education to Licensed Nurses on or before 10/6/17 regarding pain management including</p>		

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F 309	<p>Continued From page 49</p> <p>management flowsheet documented the effectiveness or non-pharmacological interventions attempted prior to administration.</p> <p>On 8/9/17 at 9:37 am, the Director of Nursing (DON) stated a resident complaining of pain and with orders for PRN pain medication were to be assessed and non-pharmacological interventions attempted prior to medication administration. The DON said staff should follow-up with residents receiving pain medication to assess the medication's effectiveness.</p> <p>2. Resident #9 was readmitted to the facility on 12/12/16 with diagnoses that included osteoporosis, neuropathy, lower back pain, and obesity.</p> <p>Resident #9's Quarterly MDS assessment, dated 7/21/17, documented she was cognitively intact and required extensive assistance of 2 or more staff for most Activities of Daily Living (ADL).</p> <p>Resident #9 did not have a Pain Care Plan as of 8/11/17.</p> <p>Resident #9's August 2017 Physician Orders documented:</p> <ul style="list-style-type: none"> * 2 tablets of Acetaminophen 325 mg every 4 hours PRN for mild pain, ordered 12/21/16. * Tramadol 50 mg by mouth every 6 hours PRN for pain, ordered 7/25/17. <p>Resident #9's 8/1/17 through 8/7/17 MAR documented she was given Tramadol on 8/3/17 and 8/7/17, and Acetaminophen on 8/1/17 and</p>	F 309	<p>pain assessment, indications for pain medication use, pharmacologic and non-pharmacologic interventions, monitoring and documentation requirements. Post tests will be completed by Licensed Nurses on or before 10/6/17 to validate competency.</p> <p>Beginning the week of 10/7/17, the Center Nurse Executive or designee will review residents with new orders for pain medication/ intervention, and or new admissions to ensure that pain intervention and care plan is in place and updated at the morning clinical meeting.</p> <p>Monitoring</p> <p>Beginning the week of 10/7/17, audits of 5 residents will be completed by the Center Nurse Executive or designee to ensure that PRN pain medication is administered as indicated per MD orders and follow up documentation of efficacy is completed as per facility guidelines, and that there is a pain/ comfort plan of care in place.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Center Nurse Executive is responsible for monitoring and follow-up. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p>		

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F 309	<p>Continued From page 50</p> <p>8/3/17. Resident #9's PRN Pain Management Flowsheet from 8/1/17 through 8/7/17 was blank and did not include the effectiveness of the medication. Similar findings were found on the June and July 2017 MAR</p> <p>On 8/9/17 at 9:37 am, the DON stated staff were to assess and attempt non-pharmacological interventions for any resident with orders for PRN medication prior to medication administration, and that staff were to assess the efficacy of PRN medication administration.</p> <p>3. The facility's Pain Management Policy, revised 11/28/16, documented, "If PRN medications are given, document on the back of the MAR or on the PRN Pain Management Flow Sheet ... Patients receiving interventions for pain will be monitored for the effectiveness ... in providing pain relief. Document ... effectiveness of PRN medications."</p> <p>Resident #15 was admitted to the facility with diagnoses that included malignant neoplasm of the lung, and related acute and chronic pain.</p> <p>Physician Orders for Resident #15, dated 5/16/17, documented staff was to administer Morphine Sulfate (concentrate) solution 20 mg/ml (milligrams/milliliter) 0.5 ml every 2 hours as needed for pain.</p> <p>Resident #15's care plan, initiated 5/17/17, documented, "Resident exhibits or is at risk for alterations in comfort related to lung cancer, end of life care/hospice care ... Medicate resident as ordered for pain and monitor for effectiveness ..."</p>	F 309	<p>Date of Compliance</p> <p>10/6/17</p>		

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F 309	<p>Continued From page 51</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 5/23/17, documented Resident #15 was cognitively intact and received scheduled- and PRN pain medication.</p> <p>Physician Orders for Resident #15, dated 6/29/17, documented staff was to administer Hydromorphone HCL Tablet 2 mg every 4 hours as needed for pain.</p> <p>An undated PRN Management Flow Sheet documented that on 7/26/17 Resident #15 was experiencing severe pain ("10" on a 10-point severity scale) in the right arm at 6:00 am. Non-pharmacological interventions were attempted and Hydromorphone was administered without reassessment to gauge the medication's effectiveness.</p> <p>A PRN Management Flow Sheet documented Resident #15 was experiencing "general" pain at a level of "7" on the 10-point scale. Non-pharmacological interventions were attempted and sublingual Morphine SL was administered to Resident 15, however there was no documentation as to whether the medication was effective. On 8/8/17 and 8/9/17, Hydromorphone 2mg was administered to Resident #15 for level "8" pain. Non-pharmacological interventions were attempted, however the Flow Sheet did not contain documentation the Hydromorphone was monitored for effectiveness.</p> <p>The MAR for 8/1/17 through 8/11/17 documented Morphine Sulfate was administered to Resident #15 on 8/2/17, but did not document any administration that day of Hydromorphone. The</p>	F 309			

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F 309	<p>Continued From page 52</p> <p>facility's Narcotic Log Book, however, documented Resident #15 was provided Hydromorphone, 2 mg, on 8/8/17 and 8/9/17.</p> <p>Resident #15's clinical record did not contain documentation regarding Resident #15's pain or effectiveness of treatment (Morphine Sulfate and Hydromorphone) on 8/2/17, 8/8/17 or on 8/9/17.</p> <p>On 8/10/17 at 3:30 pm, Licensed Practical Nurse (LPN) #3 stated, "What I would do is document the pain, then what I did as a non-pharmacological intervention before giving the medication, then go back and rate the effectiveness to see if the medication was effective or not. From what I can see here [PRN pain management flowsheet] it [effectiveness] wasn't documented on 8/2, 8/8 or on 8/9. They [staff] should have documented here or on the Nurse's Notes."</p> <p>On 8/10/17 at 3:33 pm, the DON stated, staff should be documenting the effectiveness of medications [Morphine and Hydromorphone]. On this [PRN Pain Management Flow Sheet], they are not documenting the effectiveness that I can tell. The DON then stated, "On 8/8 the Hydromorphone, I don't see it was signed out on 8/8 or 8/9 and they [staff] didn't sign it out on the MAR. That was just this week too. I don't see any documentation of the effectiveness. Our process is that if giving a PRN pain medication, they are supposed to rate the pain level, then attempt any non-pharmacological interventions, then after administering the medication, go back and document the effectiveness of the medication."</p> <p>On 8/10/17 at 3:45 pm, the Clinical Quality</p>	F 309			

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F 309	<p>Continued From page 53</p> <p>Specialist (CQI) stated, "I did not see any notes of the monitoring of her [Resident #15] pain in the computer charting notes. I don't see any other pain documentation addressing the pain on those days [8/2/17, 8/8/17, and 8/9/17] and the staff should be documenting the efficacy of pain level.</p> <p>LPN #4, who administered Morphine to Resident #15 on 8/2/17 and 8/10/17 at 4:15 pm, stated, "It looks like I forgot to document the effectiveness on 8/2. On 8/2 I gave Morphine to her [Resident #15]. I forgot to document it on the PRN flowsheet. I do recall when I gave the Morphine she [Resident 15] was at a pain level of 7 out of 10. I just forgot to document it."</p> <p>4. Resident #2 was admitted to the facility on 1/7/16 following surgical replacement of the right hip, and was re-admitted on 4/24/17, with diagnoses that included fracture of the right tibia and fibula, reduced mobility, muscle wasting and atrophy, and history of falls.</p> <p>The resident's 6/27/17 quarterly MDS assessment documented severe cognitive impairment and pain.</p> <p>Resident #2's alterations in comfort care plan, dated 1/7/16, documented staff were to medicate for pain as ordered and monitor the medication for for effectiveness and side effects.</p> <p>Physician Orders directed staff to provide oxycodone every 6 hours as needed for pain. Subsequent orders increased the oxycodone to every 4 hours as needed on 7/13/2017 and every 3 hours as needed on 8/8/17.</p>	F 309			

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F 309	<p>Continued From page 54</p> <p>The resident's clinical record documented that the efficacy of oxycodone was not consistently monitored. July and August 2017 PRN Pain Management Flow Sheets were blank 18 of 37 times before pain medication and 20 of 37 times after pain medication.</p> <p>Progress Notes from 7/1/17 through 8/8/17 did not provide additional documentation regarding the resident's pain level before and/or after pain medication on the following dates: 7/16/17 through 7/25/17, 7/28/17, 8/3/17, and 8/7/17.</p> <p>5. Resident #3 was admitted to the facility on 4/11/17 with multiple diagnoses, including osteoporosis, thoracic vertebra fracture and rheumatoid arthritis.</p> <p>The resident's Physician's Orders for 7/1/17 - 8/31/17 included Tylenol with Codeine #3 (T3) 1 tablet every 6 hours PRN for pain.</p> <p>The indication for T3 and the efficacy after the administration of the T3 was not consistently monitored as follows:</p> <p>* July 2017 MAR - T3 was administered 12 times. None of the 12 administrations of T3 were recorded on the PRN Pain Management Flow Sheet for July 2017; the pain evaluation and efficacy of 9 of the 12 (75%) T3 administrations was not noted in any Progress Note from 7/1/17 to 8/9/17.</p> <p>* August 2017 MAR - T3 was administered 7 times. None of the 7 administrations of T3 were recorded on the PRN Pain Management Flow Sheet for August 2017; the pain evaluation and</p>	F 309			

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F 309	Continued From page 55 efficacy of 5 of the 7 (71%) T3 administrations was not noted in any Progress Note from 8/1/17 to 8/9/17.	F 309			
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to ensure dependent residents were provided assistance with toileting consistent with their needs. This was true for 1 of 8 residents (#9) reviewed for incontinence. The lack of assistance with toileting created the potential for harm if residents were to experience embarrassment, decreased sense of self-worth, skin breakdown, or otherwise compromised physical and/or psychosocial well-being. Findings include: Resident #9 was readmitted to the facility on 12/12/16 with diagnoses that included osteoporosis, neuropathy, lower back pain, and obesity. A Quarterly MDS (Minimum Data Set) assessment, dated 7/21/17, documented Resident #9 was cognitively intact and required extensive assistance of 2 or more staff for transfers and toileting. The Activities of Daily Living (ADL) Care Plan, dated 12/22/16, documented Resident #9 required the assistance of 2 staff for dressing,	F 312	F 312 Specific Residents Identified On or before 10/6/17, resident # 9 will be assessed by the Center Nurse Executive or designee for adverse effects related to the use of bed pan / toileting and interviewed regarding toileting preferences. Resident #9 will be reviewed by the Center Nurse Executive or designee, on or before 10/6/17 for current assistive needs with toileting, the care plan will be updated to residents current status. Identification of Other Residents On or before 10/6/17, the Center Nurse Executive or designee will review current residents to identify those who require assistance with toileting. Residents who require assistance will be observed to ensure the level of assistance provided is consistent with the plan of care. Follow up will be completed by a licensed nurse	10/6/17	

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F 312	<p>Continued From page 56 bathing, transfers, toileting, and bed mobility.</p> <p>The Behavior Care Plan, dated 1/25/17, documented Resident #9 was resistive to cares and liked to remain on a bed pan for "extended periods of time." The care plan did not specify the "extended" length of time the resident preferred to remain on a bed pan.</p> <p>A Nurse's Note, dated 1/25/17, documented Resident #9 desired to remain on a bed pan for longer than 10 minutes. The facility documented the risks verses benefits of this practice were discussed with Resident #9 and noted Resident #9 would be assisted off the bedpan if she experienced pain. The Note documented staff would limit the resident's time on a bed pan to "less than 20 minutes."</p> <p>On 8/8/17 at 3:50 pm, Resident #9 stated she was left on a bed pan for more than 1 hour about a week prior and that this was not the first such occurrence. She stated she had been left on the bed pan for as long as 2 hours and that she felt ignored each time she was left on a bed pan for an extended period of time. Resident #9 stated she liked having enough time to use the bed pan, however 1 hour was "ridiculous." Resident #9 stated 2 staff were supposed to assist her with toileting, but on multiple occasions "only" one Certified Nursing Assistant (CNA) would assist. Resident #9 stated that a "couple weeks" prior, 1 CNA was assisting her to toilet, but the CNA struggled to lift her enough to remove her clothes and place the bed pan under her as she became incontinent of stool. Resident #9 said the CNA had to summon assistance from another staff member to assist cleaning her up. Resident #9</p>	F 312	<p>on or before 10/6/17 as indicated to include care plan / Kardex updates to reflect residents current status, and any education as needed.</p> <p>Systemic Changes</p> <p>On or before 10/6/17, the Practice Development Specialist or designee will provide education to nursing staff in regards to providing care to residents consistent with the residents' plan of care. CNAs will complete/pass a post test to validate competency on or before 10/6/17.</p> <p>On or before 10/6/17, Certified Nursing Assistants will complete an ADL (transfers, toileting, bed mobility) competency that includes providing level of assistance consistent with the plan of care / kardex, administered by the Practice Development Specialist or designee.</p> <p>Monitoring</p> <p>Beginning the week of 10/7/17, observations of 5 residents requiring assistance with toileting needs will be completed by the Center Nurse Executive or designee to ensure that assistance is provided according to the resident's plan of care.</p> <p>Beginning the week of 10/7/17, interviews will be completed of 5 residents by the</p>		

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F 312	Continued From page 57 stated she did not like "going" in her pants. Resident #9's July 2017 ADL Flowsheet documented she was assisted with toileting by one staff member on 7/3/17, 7/4/17, 7/5/17, 7/11/17, 7/12/17, 7/14/17, 7/17/17, 7/18/17, 7/19/17, 7/20/17, 7/23/17, 7/24/17, and 7/30/17. On 8/9/17 at 9:37 am, the Director of Nursing (DON), Clinical Quality Specialist (CQS), and Licensed Practical Nurse (LPN) #7 were informed of Resident #9's concerns with toileting. The DON stated 1-2 hours was too long to leave the resident on a bed pan. LPN #7 stated an "extended period of time" with Resident #9 was about 20 minutes. She stated no one should be left on a bed pan for 1 hour to 2 hours. On 8/9/17 at 12:10 pm, the CQS stated she expected 2 staff to assist Resident #9 with toileting, as care planned and per the MDS.	F 312	Center Nurse Executive or designee to ensure that assistance is being provided according to the resident's plan of care. Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remediation. The Center Nurse Executive is responsible for monitoring and follow-up. The QAPI Committee will re-evaluate the need for further monitoring after 3 months. Date of Compliance 10/6/17		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 314		10/6/17	

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F 314	<p>Continued From page 58</p> <p>with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, staff interviews, and policy review, it was determined the facility failed to ensure residents admitted to the facility did not develop multiple pressure ulcers, or that pressure ulcers that did develop did not worsen under the facility's care. This was true for 2 of 4 (#2 and #10) residents reviewed for pressure ulcers and resulted in harm to Resident #10, who developed multiple pressure ulcers to the right heel, buttocks, and coccyx. Findings include:</p> <p>1. Resident # 10 was readmitted to the facility on 8/12/16 with multiple diagnoses, including chronic kidney disease and history of urinary tract infections. Resident #10 did not have a diagnosis of an unstageable pressure ulcer upon readmission to the facility on 8/12/16.</p> <p>Resident #10's 8/19/16 readmission MDS assessment documented the presence of 1 Stage I pressure ulcer.</p> <p>a. Resident #10 developed multiple wounds during his stay at the facility:</p> <p>Resident #10's initial Skin Integrity Report, dated 8/12/16, documented the presence of a MASD (moisture associated skin damage) wound to his right buttocks with flaking blanchable skin measuring 2 cm (centimeter) by 0.8 cm and less than 0.1 cm deep.</p>	F 314	<p>F314</p> <p>Specific Residents Identified</p> <p>Resident # 2's skin will be assessed on or before 10/6/17 by the Center Nurse Executive or designee, for skin breakdown. Any findings will be addressed. The resident's treatments and skin care plan will be reviewed by the Center Nurse Executive or designee on or before 10/6/17 with updates completed as indicated.</p> <p>Resident # 10 discharged from the facility on 3/6/2017.</p> <p>Identification of Other Residents</p> <p>On or before 10/6/17, current residents' skin will be assessed by the Center Nurse Executive or designee to identify any previously unidentified skin impairments. Current residents with identified skin impairments will be reviewed by Center Nurse Executive or designee to ensure that any previously unidentified skin impairment is investigated on or before 10/6/17.</p> <p>A review of current residents with skin impairments medical record and treatment records will be completed by</p>		

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F 314	<p>Continued From page 59</p> <p>On 8/10/17 at 4:30 pm, the SDC (Staff Development Coordinator) stated the wound was MASD due to fecal incontinence, refusals to reposition, and refusal of cares.</p> <p>A Nurse's Note, dated 10/13/16 at 11:00 pm, documented the presence of a MASD to the buttocks and a Stage I pressure ulcer to the right heel. Resident #10's clinical record did not include a Skin Integrity Report for the pressure ulcer to the right heel until 10/31/16.</p> <p>A Nurse's Note, dated 10/20/16 at 11:00 pm, documented the presence of a MASD to the middle of the buttock and right buttock. The clinical record did not document the wound sizes or an assessment of the wounds until 10/22/16.</p> <p>Resident #10's initial Skin Integrity Report, dated 10/22/16, documented the presence of a "new" wound to the right buttocks with epithelial tissue measuring 8 cm by 5.6 cm and 0 cm deep.</p> <p>Resident #10's initial Skin Integrity Report, dated 10/22/16, documented the presence of a "new" open area to his coccyx with epithelial tissue which was intact and deep purple measuring 3.3 cm by 3 cm and no depth documented.</p> <p>A Nurse's Note, dated 10/24/16 at 2:52 pm, documented the nurse assessed Resident #10's buttock and coccyx region and observed a 10 cm x 7 cm reddened open area to the coccyx and right buttock. The Note documented a low Air Loss (LAL) Mattress was initiated, incontinence was reevaluated, repositioning every two hours was continued, and a Turn and Position (TAP) device were initiated. The LAL mattress was</p>	F 314	<p>the center nurse executive or designee on or before 10/6/17 to ensure that assessment including the skin integrity report, treatments, and care plan interventions are in place and meet resident needs. Follow-up including physician notification, change in treatment, or care planned intervention will be completed by the Center Nurse Executive or designee on or before 10/6/17.</p> <p>Systemic Changes</p> <p>Nursing Staff will be re-educated by the Practice Development Specialist or designee on or before 10/6/17 regarding the Genesis Skin Care Delivery process that includes but is not limited to pressure ulcer prevention measures, skin checks, wound assessment, and documentation requirements. Licensed Nurses will complete/ pass a post-test to validate competency related to skin care on or before 10/6/17.</p> <p>On or before 10/6/17 the Center Nurse Executive or designee will identify a Center Skin Coordinator to oversee the center Genesis Skin Care Delivery process including the Implementation of regular wound rounding and other components of the Genesis Skin Care Delivery process.</p>		

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F 314	<p>Continued From page 60 initiated after the facility had identified multiple pressure ulcers.</p> <p>Resident #10's Skin Integrity Report, dated 10/28/16, documented the presence of an "unstageable PU" wound to the left buttock and coccyx.</p> <p>Resident #10's initial Skin Integrity Report, dated 10/31/16, 18 days after the right heel injury was discovered, documented the presence of a SDTI (Suspected Deep Tissue Injury) pressure ulcer to the right heel measuring 4.2 cm x 2.4 cm with an unknown depth.</p> <p>Resident #10's Skin Integrity Report, dated 12/16/16, documented the right heel wound as healed.</p> <p>Resident #10's Skin Integrity Report, dated 1/5/17, documented the presence of the right heel SDTI pressure ulcer again. The report documented the wound was intact and deep purple and measured 3.8 cm x 2.6 cm and less than 0.1 cm deep.</p> <p>The Skin Integrity Records identified the same wounds on multiple sheets and it was unclear to as to what was measured, assessed, and treated.</p> <p>b. An "At Risk" for Skin Breakdown Care Plan, dated 10/17/15, documented Resident #10 was a risk of skin breakdown related to impaired sensation, a history of pressure ulcers, limited mobility, incontinence and moisture excessive perspiration. Interventions included floating Resident #10's heels while in bed, staff were to</p>	F 314	<p>Monitoring</p> <p>Beginning the week of 10/7/17, an audit of 5 residents will be completed by the Center Nurse Executive or designee to ensure that there are no unidentified skin impairment, skin checks are completed per policy, and that skin integrity care plans are in place, and interventions are implemented per the plan of care.</p> <p>Beginning the week of 10/7/17, an audit of 5 residents with skin impairments will be completed by the Center Nurse Executive or designee to ensure that treatments are in place and being completed per MD order.</p> <p>These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the QAPI Committee for review monthly for 3 months for review and remedial intervention. The Center Nurse Executive is responsible for monitoring and follow-up. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p> <p>Date of Compliance 10/6/17</p>		

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F 314	<p>Continued From page 61</p> <p>monitor his skin for breakdown, and pressure redistribution surfaces were to be applied to his bed and wheelchair. The "at risk" care plan revised interventions on 2/23/16 to include staff was to ensure the right heel was elevated at all times, Resident #10 could reposition himself, and Resident #10 was to have sage boots on his feet while in a wheelchair.</p> <p>A Skin Breakdown Care Plan, dated 10/17/15, documented Resident #10 had a wound to his right heel. The "right heel" Skin Breakdown Care Plan documented the wound as resolved on 2/23/16.</p> <p>A Skin Breakdown Care Plan, dated 9/20/16, documented Resident #10 had an "abrasion" on his "medial back." Interventions included weekly skin and wound assessments with measurements and description of the wound.</p> <p>Resident #10's clinical records did not include documentation of the "abrasion" to his "medial back" as identified on the care plan.</p> <p>After the discovery of the heel, coccyx, right and left buttock pressure ulcers, the Skin Breakdown Care Plan of his "medial back" was revised on 10/28/16 to include interventions of a low air loss mattress to protect his skin, staff were directed to turn and reposition the resident at least every two hours and as needed (PRN), and staff were to monitor Resident #10 for placement and use of Prevalon positioning system every shift and PRN. The revisions to the care plan did not include the unstageable pressure ulcers to his coccyx, right and left buttocks and reopening of his right heel. The facility did not provide evidence the care</p>	F 314			

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F 314	<p>Continued From page 62 plan was updated to include these wounds.</p> <p>c. Resident #10's February 2017 Physician Orders documented:</p> <ul style="list-style-type: none"> * Staff was to apply skin prep each shift and every night shift PRN for the SDTI to the right heel, ordered 10/31/16. * Staff were to cleanse the unstageable right buttock and coccyx wounds with normal saline, pad dry and cover with Duoderm/hydrocolloid every night shift every two days and PRN, ordered 1/6/17. * Skin Checks were to be completed on Monday and Friday nights and staff were to document whether there was no skin injury/wound; a new skin injury/wound; and/or a previously noted skin injury/wound, ordered 1/4/17. * Staff were to apply Z-guard to Resident #10's buttocks each day shift, ordered 1/4/17. <p>Resident #10's February 2017 MAR and TAR documented weekly skin assessments were to be completed twice a week. The February 2017 MAR and TAR did not include documentation of a weekly skin assessment on 2/23/17 and 2/27/17.</p> <p>Resident #10's February 2017 MAR and TAR documented staff was to apply skin prep every shift to the right heel. The February 2017 MAR and TAR did not include documentation this was completed 2/13/17, 2/14/17, 2/15/17, 2/17/17, 2/26/17, 2/27/17, and 2/28/17.</p> <p>Resident #10's February 2017 MAR and TAR</p>	F 314			

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F 314	<p>Continued From page 63</p> <p>documented staff were to cleanse the unstageable right buttock and coccyx wounds with normal saline, pat dry and cover with Duoderm/hydrocolloid each night shift every two days. Resident #10's February 2017 MAR and TAR did not include documentation this was completed on 2/15/17.</p> <p>Resident #10's 2/17/17 Physician Order documented staff were to cleanse the buttocks with saline, pat dry, apply alginate to the wound base, cover with Mepilex, and change the dressing every three days. Resident #10's February 2017 MAR and TAR did not include documentation this was completed on 2/17/17 and 2/23/17.</p> <p>Resident #10's 2/24/17 Physician Orders documented staff were to cleanse the buttocks with saline, pat dry, apply alginate to the wound base, cover with a foam dressing, secure with Mepilex, and change the dressing every three days. Resident #10's February 2017 MAR and TAR did not include documentation this was completed on 2/24/17. Resident #10 went 8 days without a dressing change.</p> <p>Resident #10's February 2017 MAR and TAR documented staff was to apply Z-guard to the buttocks each day shift. Resident #10's February 2017 MAR and TAR did not include documentation this was completed 2/13/17, 2/14/17, 2/15/17, 2/26/17, 2/27/17, and 2/28/17.</p> <p>Similar findings related to MARs and TARs were found for October 2016 through January 2017, as well as for 3/1/17 through 3/6/17.</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER TWIN FALLS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 674 EASTLAND DRIVE TWIN FALLS, ID 83301		
(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 314	<p>Continued From page 64</p> <p>On 8/10/17 at 4:30 pm, the SDC stated Resident #10 was resistive to cares, floating of the heels, and repositioning. She could not find consistent documentation of the refusals. The SDC also stated she was unable to locate documentation of wound measurements.</p> <p>On 8/11/17 at 9:20 am, the SDC stated she could not find evidence that treatments had been completed other than those documented as completed on Resident #10's MAR and TAR.</p> <p>On 8/11/17 at 1:37 pm, the SDC stated the facility could not locate an I&A after the discovery of the medial abrasion to the back was identified. She stated she did not know why an I&A was not completed, but one should have been completed.</p> <p>The facility was inconsistent with identification and measurements of wounds in the Nurses Notes and on the Skin Integrity Records related to whether there were 1 or 4 wounds present on Resident #10's coccyx and buttock region.</p> <p>The facility failed to update and maintain the plan of care related to pressure related wounds.</p> <p>The facility failed to ensure the care and treatment of the pressure wounds was provided and documented.</p> <p>The facility did not ensure that wound identification was consistent, or that assessments, interventions, treatments, and care plan updates of multiple recurrent pressure ulcer wounds was performed and documented.</p>	F 314			

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F 314	<p>Continued From page 65</p> <p>2. Resident #2 was admitted to the facility on 1/7/16 following surgical replacement of the right hip, and was re-admitted on 4/24/17, with diagnoses that included fracture of the right tibia and fibula, reduced mobility, muscle wasting and atrophy, and history of falls.</p> <p>The resident's 12/27/16 annual MDS assessment, 5/1/17 significant change MDS assessment, and 6/27/17 quarterly MDS assessment each documented Resident #2 was at risk to develop pressure ulcers, but had no healed or unhealed pressure ulcers.</p> <p>Resident #2's care plan, initiated 1/7/16, documented the skin was to be monitored for signs and symptoms of breakdown and a pressure reducing surface was to be applied to the bed. Additional care plan interventions, initiated on 5/2/17, directed staff to assist the resident turn every 2 hours as tolerated, evaluate for any localized skin issues, observe the skin daily with ADL care, report abnormalities, and float the heels while in bed as tolerated. On 7/12/17, the care plan directed staff to "float [Resident #2's] heels while in bed."</p> <p>The clinical record documented Resident #2 sustained fractures to the right tibia and fibula from a fall at the facility on 4/19/17. The resident was subsequently hospitalized on 4/21/17 for pain and fracture management, and a long leg cast was applied on 5/2/17.</p> <p>Resident #2's physician orders, dated 6/1/17 and the July 2017 TAR documented a non-removable cast was in place to the resident's right lower leg.</p>	F 314			

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F 314	<p>Continued From page 66</p> <p>An Orthopedic Office Visit Progress Note, dated 7/11/17, documented the cast was removed from Resident #2's right leg "without complications," and recorded non-pitting edema in the right lower leg.</p> <p>Progress Notes (PNs) documented the following:</p> <ul style="list-style-type: none"> * 7/11/2017 at 1:53 pm - The resident's cast was removed and noted physician orders to reduce edema to the right lower leg. No documented abnormalities or concerns regarding the skin after the long leg cast was removed from the right lower leg. * 7/12/2017 at 9:49 am - "...without cast on leg". * 7/12/2017 at 1:14 pm - A change in condition was noted related to a skin wound "in the morning." The physician was notified at 11:30 am and family was notified at 1:00 pm. * 7/12/17 at 1:41 pm - A Braden Scale documented the resident was at moderate risk for the development of pressure ulcers. * 7/12/17 at 5:36 pm - "This am [morning] RN [Registered Nurse] assessed RLE [right lower extremity] skin ... area of 4 cm X 3.5 cm X UN [unstageable], stable dry black eschar [dead tissue] to R [right] heel. Reviewed wound and risk factors with MD [physician] and is agreeable ... wound is unavoidable due to occurring under a hard cast ... and not able to be assessed until cast removal." <p>A Skin Integrity Report, dated 7/12/17, recorded a 4 cm by 3.5 cm unstageable pressure ulcer to</p>	F 314			

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F 314	<p>Continued From page 67 the right heel.</p> <p>The resident was observed multiple times daily during the survey with Sage boots in place to both feet and lower legs.</p> <p>On 8/8/17 at 5:35 pm, the right heel pressure ulcer, covered by black eschar, was observed as RN #3 measured it at 2.4 by 2.9 cm.</p> <p>On 8/10/17 at 5:10 pm, LPN (Licensed Practical Nurse) #7 said skin should be assessed within 24 hours after cast removal.</p> <p>On 8/11/17 at 9:10 am, the DON (Director of Nursing) said residents' skin should be assessed as soon as possible after a cast was removed, but "we have 24 hours." When asked to provide a policy/procedure regarding skin assessment after cast removal, the DON provided a copy of the "Skin Integrity Report" that documented, "...to accurately stage [determine the size and nature of the ulcer] within 24 hours of admission and/or after discovery of a new in-house acquired pressure ulcer."</p> <p>On 8/11//17 at 10:45 am, the DON provided two hand-written statements, both dated 8/10/17. One statement, written by LPN #4, documented he did not remember what time the resident returned to the facility on 7/11/17, but he assessed the resident's skin and "identified a [sic] area on [right] her heel appears black and was dry." He further stated the DON was notified and that he was informed the wound would be assessed for staging. The DON's 8/10/17 statement documented she was notified of a black spot on Resident #2's right heel, and she</p>	F 314			

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F 314	Continued From page 68 advised LPN #4 that the area would be assessed by herself or another RN "first thing in the morning." The facility failed to promptly assess a "black" area on Resident #2's right heel after removal of a long leg cast that had been in place for more than two months. The resident returned to the facility after cast removal in the early afternoon on 7/11/17, and the heel pressure ulcer was not assessed until the next day.	F 314			
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are	F 323		10/6/17	

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F 323	<p>Continued From page 69</p> <p>appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and review of clinical records and incident/accident (I&A) reports, it was determined the facility failed to ensure residents were adequately supervised and assisted as care planned. This was true for 2 of 6 (#2 and #9) residents reviewed for falls. Resident #2 was harmed when she sustained two fractures to her right lower leg as one staff, rather than two, assisted her with a transfer. Two days after the injury, the resident experienced significant pain and required hospitalization. Resident #9 sustained a skin tear related to a fall on facility grounds. The facility failed to care plan for falls and supervision which placed the resident at risk for harm. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 1/7/16 following right hip replacement, and was readmitted on 4/24/17 with diagnoses that included fracture of the right tibia and fibula, reduced mobility, muscle wasting and atrophy, seizures, and history of falls.</p> <p>The resident's 12/27/16 annual Minimum Data Set (MDS) assessment and 3/27/17 quarterly MDS assessment both documented moderately impaired cognition, extensive assistance required from two or more staff for transfers, occasional pain, and no falls.</p> <p>The resident's 5/1/17 significant change MDS assessment differed from the previous two assessments in the following areas: severely impaired cognition, frequent pain, and one fall.</p>	F 323	<p>F323</p> <p>Specific Residents Identified</p> <p>On or before 10/6/17 resident #2 will be assessed by the Center Nurse Executive or designee related to fall risk, and level of assistance required for transfers. The results of these assessments will be reviewed by the centers IDT, and reviewed with the resident's attending physician. The Center Nurse Executive or designee will complete follow-up as indicated by the assessment and review including updates to resident #2's care plan on or before 10/6/17.</p> <p>Resident #9's fall risk and fall care plan will be reviewed by the center nurse executive or designee on or before 10/6/17. Follow-up will be completed as indicated by the review on or before 10/6/17 to include updates to the Plan of Care and Kardex as needed, validation of interventions at the bedside, and communication with the resident/responsible party related to residents plan of care.</p> <p>Identification of Other Residents</p> <p>On or before 10/6/17 an audit will be completed of current residents by the</p>		

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F 323	<p>Continued From page 70</p> <p>The Activities of Daily Living (ADL) care plan, dated 1/7/16, recorded "2 person Hoyer lift for all transfers".</p> <p>An SBAR (Situation, Background, Assessment, Recommendation) Communication Form, dated 4/19/17, documented, "CNA (Certified Nursing Assistant) was transferring resident, alone, back to bed and resident's knee and foot gave way, resident was lowered to the ground, then assisted back to bed." The SBAR documented the only change was new pain in the right hip and thigh. The pain was rated as "7" (on a scale of 1-10 with 10 being the most severe). Movement aggravated the pain, and lying still and pain medication alleviated the pain.</p> <p>A 5/2/17 Event Summary Report documented the resident was lowered to the floor on 4/19/17 at 3:30 pm. The report also documented a CNA transferred the resident "using a one person assist and asked the resident to put her arms around her neck. During the transfer the CNA stated that she had to lower the resident to the floor because the resident's legs buckled. The CNA reported that she assisted the resident to the floor softly and she did not think that the resident was injured. Upon interview, this CNA confirmed that she did not use a gait belt for this transfer, and she did not consult the Kardex (guidance to CNAs) for the transfer status". The CNA summoned another CNA to assist with placing the resident in bed.</p> <p>Progress Notes (PN) dated 1/19/17 through 8/8/17 documented:</p> <p>* 4/19/17 at 6:40 pm - The resident fell in the</p>	F 323	<p>Center Nurse Executive or designee, to identify residents at risk for falls. Residents at risk for falls will be reviewed at bedside to ensure that interventions are in place and that care plans/Kardex are updated to reflect the current resident status and follow up corrections completed as indicated.</p> <p>On or before 10/6/17 residents will be reviewed for level of assistance required with transfers by the Center Nurse Executive or designee. The Center Nurse Executive or designee will update the residents care plan and Kardex to reflect resident's required level of assistance on or before 10/6/17.</p> <p>Systemic Changes</p> <p>On or before 10/6/17, he Practice Development Specialist or designee will provide education to Licensed Nursing Staff regarding resident fall risk, assisting with transfers per resident care plan/Kardex, implementation of preventative interventions and post fall assessments. Competency will be validated by a post test administered on or before 10/6/17 by the Practice Development Specialist or designee.</p> <p>On or before 10/6/17, the Practice Development Specialist or designee will provide education to CNA staff related to reviewing the KARDEX prior to starting shift assignment for care instructions</p>		

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F 323	<p>Continued From page 71 afternoon.</p> <p>* 4/20/17 at 2:32 pm - The resident reported she had a seizure, was unable to say how long it lasted, and nursing assessment documented no significant changes.</p> <p>Progress Notes after the fall documented the resident had no significant pain and no significant changes.</p> <p>*4/21/17 at 12:00 am - Physician Assessment: "Right leg pain, worsening pain after a fall ... structural abnormality to the right leg ... will xray the lumbar spine, pelvis and entire leg. Given the pain with simply touching her leg, I recommended we do the xrays in house." The physician also ordered Valium as a muscle relaxer at that time.</p> <p>* 4/21/17 at 6:15 pm - "Light purplish blue discoloration to [right] shin approx[imately] 15 X 7 cm [15 by 7 centimeters]." Xray results showed acute fracture of the tibia and fibula, however the physician ordered further evaluation at the hospital due to difficulty reading the in-house xray report.</p> <p>* 4/21/17 at 7:57 pm - Planned transfer out of the facility.</p> <p>*4/21/17 at 8:13 pm - Notified by physician the resident would be a direct admit to the hospital surgical floor.</p> <p>A hospital admission assessment, dated 4/21/17 at 9:08 pm, documented an orthopedic surgeon was consulted and the resident was allowed no</p>	F 323	<p>including level of assistance and interventions for safe transfers, and fall prevention.</p> <p>Beginning 10/7/17, CNA staff will review the KARDEX with the oncoming shift during the shift to shift report, the unit nurse will be responsible for monitoring compliance with this process.</p> <p>On or before 10/6/17, the Center Nurse Executive or designee will complete a center round to validate that care planned fall interventions are implemented at the bedside, and follow up will be completed as indicated for any identified concerns.</p> <p>On or before 10/6/17, the Center Nurse Executive or designee will review residents with falls in daily clinical meeting for root cause and to ensure the care plan has been updated with appropriate interventions. Follow up will be completed as indicated.</p> <p>Beginning 10/7/17 residents who have a fall will be reviewed by the IDT in the weekly Customer at Risk meeting to evaluate effectiveness of interventions implemented post fall.</p> <p>Monitoring</p>		

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F 323	<p>Continued From page 72</p> <p>oral intake except for anti-seizure medication with a sip of water in anticipation of surgery. A hinged brace was applied to the right lower extremity.</p> <p>A 4/21/17 hospital x-ray report confirmed fractures of the tibia and fibula without significant displacement.</p> <p>Orthopedic and Internal Medicine Notes documented Resident #2 was equipped with a hinged long leg splint and placed on non-weightbearing status on the right lower extremity. The Notes documented, "Try for reasonable pain control" for the resident who was "just moaning and in obvious pain..."</p> <p>The 4/25/17 Event Investigation Interview Record documented the CNA transferred Resident #2 to her bed and the resident's legs started to "give out." The resident's legs were positioned between the CNA's legs, and the CNA "sort of walked her backward to sitting then onto her back in laying position." The resident was then lifted by her arms and pants into bed, which had been lowered. The 4/25/17 Investigation Interview Record also documented the CNA was not aware the resident required two-staff for transfers.</p> <p>On 8/10/17 at 5:20 pm, LPN (Licensed Practical Nurse) #7 said the information regarding how to transfer the resident was accessible to each CNA on a tablet device, and training was provided to the CNA during orientation regarding how to access this information.</p> <p>Resident #2 fell on 4/19/17 when she was transferred by one CNA. Two days after the fall,</p>	F 323	<p>Beginning the week of 10/7/17, audits of 5 residents with falls will be completed by the Center Nurse Executive or designee, to ensure that resident fall risk has been reviewed and care plans have been updated to reflect the resident's current status with interventions implemented at the bedside as indicated.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial interventions. The Center Nurse Executive is responsible for monitoring and follow-up. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p> <p>Date of Compliance 10/6/17</p>		

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F 323	<p>Continued From page 73</p> <p>the physician identified worsening pain in the right leg. The resident was transferred to a hospital and was diagnosed with fractures of the right tibia and fibula. She required inpatient hospitalization for pain control and was placed on NPO status (nothing by mouth) in anticipation of surgical intervention. On day two of the hospitalization, the physicians determined that non-operative care was the "best option" and a splint was applied to stabilize the right leg.</p> <p>2. Resident #9 was readmitted to the facility on 12/12/16 with diagnoses that included osteoporosis, neuropathy, and obesity.</p> <p>Resident #9's Quarterly MDS assessment, dated 7/21/17, documented she was cognitively intact, required extensive assistance of 2 or more staff members for transfers and had no falls.</p> <p>Resident #9's clinical record did not contain a Fall Care Plan prior to 8/9/17. On 8/9/17 at 3:30 pm, the DON stated Resident #9 did not currently have a care plan in place for falls.</p> <p>Resident #9's Fall Care Plan, dated 8/9/17, documented she was to alert staff when going outside to pick fruit and she was to use a Reacher assistive device when outside picking fruit.</p> <p>Resident #9's Situation, Background, Assessment, Recommendation (SBAR) Communication form, dated 7/19/17, documented she experienced a fall on 7/18/17. The SBAR did not identify how Resident #9 fell.</p>	F 323			

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F 323	<p>Continued From page 74</p> <p>On 8/9/17 at 3:30 pm, the Director of Nursing (DON) stated the facility had not completed an investigation into Resident #9's 7/18/17 fall. She stated the nurse who was on duty the day of the fall did not report the fall. The DON stated Resident #9 was found outside by a visitor and the nurse left a note in the chart without notification to other staff, the physician, or the resident's family. The DON stated she learned Resident #9 fell the next day during a skin assessment in which a 2.8 centimeter (cm) by 2.1 cm skin tear was discovered on Resident #9's left hand. The DON stated she asked the resident how the injury occurred and Resident #9 stated it was from a fall the previous day. The DON stated Resident #9 had been trying to pick a plum and fell out of her chair. The DON stated the fall was unwitnessed.</p> <p>On 8/10/17 at 8:40 am, LPN #1 stated Resident #9 was now asked to inform staff when she wanted to go outside and pick fruit and staff were to ensure she had a Reacher assistive device when picking fruit. LPN #1 said she informed staff of the goals and new interventions.</p> <p>On 8/7/17 at 3:35 pm, Resident #9 was observed notifying a staff member she wanted to go outside to pick fruit. Resident #9 left through the front door, propelled her wheelchair to a walnut tree, reached up with her hand, and picked a walnut. On 8/7/17 at 3:43 pm, Resident #9 propelled her wheelchair across the grass near a gazebo with a walnut in hand towards other fruit trees on the side of the building. The resident did not have any tools or the Reacher assistive device, nor was Resident #9 accompanied by staff while she was outside.</p>	F 323			

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F 323	Continued From page 75 On 8/10/17 at 8:40 am, LPN #1, when informed of the observation, stated she did not realize Resident #9 was without the Reacher assistive device. On 8/11/17 at 12:20 pm, Resident #9 stated the facility had given her a Reacher to pick fruit that week.	F 323			
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		10/6/17	

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F 431	<p>Continued From page 76</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure medications provided to residents were not expired. This was true for medications observed in one of one medication storage room and had the potential for harm if residents received medications that were expired and potentially ineffective. Findings include: On 8/10/17 at 10:15 am, the medication room was observed with two expired medications: Vitamin C, 500 milligrams (mg), expired July</p>	F 431	<p>F 431</p> <p>Specific Residents Identified</p> <p>On or before 10/6/17, the Vitamin C 500mg which expired July 2017 and the tetanus diphtheria vaccination which expired March 2017 will be destroyed according to facility guidelines.</p> <p>Identification of Other Residents</p>		

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F 431	Continued From page 77 2017, and a tetanus/diphtheria vaccination, which expired in March 2017. On 8/10/17 at 11:00 am, Administration Staff #1 stated, "They [medications] are expired and should be discarded."	F 431	On or before 10/6/17, the Center Nurse Executive or designee will review the center's stored drugs and biologicals for expiration. Drugs and biologicals identified to be expired will be destroyed on or before 10/6/17 by the Center Nurse Executive or designee according to facility guidelines. Systemic Changes On or before 10/6/17, the Practice Development Specialist or designee will provide education to Licensed Nurses regarding the disposal/ destruction of expired drugs and biologicals. On or before 10/6/17 the Center Nurse Executive or designee will implement monthly checks of the drug and biological storage areas. Corrective action will be taken for expired drugs or biologicals. Monitoring Beginning the week of 10/7/17 an audit of drug and biological storage area(s)/ (med room, carts, refrigerators) will be completed by the Center Nurse Executive or designee to ensure that expired drugs and biologicals are not being used. Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee meeting monthly for 3 months for review and remedial		

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F 431	Continued From page 78	F 431	interventions. The Center Nurse Executive is responsible for monitoring and follow-up. The QAPI Committee will re-evaluate the need for further monitoring after 3 months. Date of Compliance 10/6/17		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 441		10/6/17	

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F 441	<p>Continued From page 79</p> <p>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> <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.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 441			

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F 441	<p>Continued From page 80</p> <p>by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 2 of 4 residents (#3 and #17) reviewed for indwelling urinary catheter use and 1 random resident (#39) observed during a meal service in the dining room. The failure created the potential for cross contamination which could result in infections when: a) Resident #3's and #17's urinary drainage bags were on the floor; b) sterility was not maintained when Resident #17's indwelling urinary catheter was changed; c) hand hygiene was inadequate or not performed after direct contact with Residents #3, #17 and #39; and d) a staff member picked up ice from the dining room floor and resumed pouring beverages. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 4/11/17 with multiple diagnoses, including benign prostatic hypertrophy with lower urinary tract symptoms, urinary incontinence, malaise and decreased mobility.</p> <p>On 8/8/17 at 8:20 am, Resident #3 was observed laying in bed and his uncovered urinary drainage bag was on the floor at the left side of the bed. At 9:10 am, the urine bag was still on the floor.</p> <p>a. On 8/8/17 at 9:12 am, Certified Nursing Assistant (CNA) #1 entered Resident #3's room and asked if he needed assistance. The resident said "No." As the CNA began to leave, she was asked about the urinary drainage bag. CNA #1 said the drainage bag should not be on the floor and that she would get a privacy cover. CNA #1 returned to the room at 9:20 am. As the CNA</p>	F 441	<p>F441</p> <p>Specific Residents Identified</p> <p>On or before 10/6/17, the Center Nurse Executive or designee will assess resident # 3, 17 and 39 for signs and symptoms of infection / negative outcomes. Negative findings will be addressed by the Center Nurse Executive or designee as indicated.</p> <p>Resident #3 and Resident #17's urinary drainage bags were replaced by the unit nurse on or before 10/6/17.</p> <p>Identification of Other Residents</p> <p>On or before 10/6/17, the Center Nurse Executive or designee will conduct an audit of residents for signs and symptoms of infection. Residents identified to have signs or symptoms of infection will be reported to the MD and findings will be addressed as indicated.</p> <p>A center wide infection control round will be completed by the center infection preventionist to identify any infection control concerns on or before 10/6/17. Corrective actions will be implemented at the time of identified concern.</p> <p>Direct care staff will be observed completing hand hygiene by the Center</p>		

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F 441	<p>Continued From page 81</p> <p>began placing the drainage bag into the privacy bag she was asked if the drainage bag was contaminated. The CNA said that it was contaminated and that she would get bleach wipes to clean it. CNA #1 returned to the room at 9:24 am and cleansed the drainage bag, including the drain spout, with bleach wipes. The CNA said bleach wipes were "just like alcohol." She then placed the drainage bag into the privacy bag and suspended it on the bed frame.</p> <p>b. On 8/8/17 at 9:30 am, after cleaning Resident #3's urinary drainage bag with bleach wipes, CNA #1 removed her gloves. Without performing any type of hand hygiene, the CNA picked up the resident's water mug and said she would go and put ice in it. CNA #1 passed the sink as she left the room.</p> <p>Immediately afterward, CNA #1 was asked about the lack of hand hygiene. She said she was going to wash her hands and, "I don't like sanitizer." CNA #1 then went directly to the ice chest in the hallway and without performing hand hygiene of any kind scooped ice into Resident #1's water mug. When asked again about hand hygiene, CNA #1 said she used hand sanitizer before she removed the lid on the water mug and scooped ice.</p> <p>2. Resident #17 was admitted to the facility on 2/3/17, and readmitted on 7/24/17, with multiple diagnoses, including urinary retention.</p> <p>Resident #17's care plan documented the presence an indwelling urinary catheter related to neurogenic bladder. Interventions included keeping the catheter off the floor.</p>	F 441	<p>Infection Preventionist or designee on or before 10/6/17 to ensure that hand hygiene was completed per policy/ guidelines. Any discrepancies will be immediately addressed.</p> <p>Licensed Nurses will be observed completing a simulated sterile catheter insertion by the Infection Preventionist or designee on or before 10/6/17. Any concerns related to sterile technique will be addressed at that time.</p> <p>Systemic Changes</p> <p>On or before 10/6/17, the Practice Development Specialist or designee will provide education to staff regarding infection prevention measures including hand hygiene and indwelling urinary catheter care.</p> <p>On or before 10/6/17 licensed nurses will be re-educated by the Practice Development Specialist or designee on infection prevention measures and sterile technique.</p> <p>On or before 10/6/17, the Practice Development Specialist or designee will complete a hand-washing competency for staff who provide cares.</p> <p>On or before 10/6/17, the Practice Development Specialist or designee will complete a indwelling urinary catheter care competency for staff who provide indwelling urinary catheter care.</p>		

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F 441	<p>Continued From page 82</p> <p>On 8/9/17 at 3:30 pm, Resident #17 was observed laying in bed with his covered urinary drainage bag suspended under the bed frame. Licensed Practical Nurse (LPN) #8 and CNA #11 were present but the LPN left the room almost immediately. Between 3:30 pm and 4:30 pm, the following was observed:</p> <p>a. On 8/9/17 at 3:30 pm, CNA #11 informed the resident that all of his clothes needed to be changed. The CNA assisted the resident to undress and when his pants were removed, the urinary drainage bag in a privacy bag fell to the floor. As CNA #11 continued to undress the resident, the urinary drainage bag partially came out of the privacy bag and was in contact with the floor. CNA #12 entered the room to assist CNA #11. CNA #12 did not mention the urinary drainage bag on the floor or attempt to pick it up. The urinary drainage bag remained on the floor for over 5 minutes until 3:40 pm when LPN #8 returned to the room. The LPN instructed CNA #11 to pick up the urinary drainage bag. The LPN also informed the resident that the Foley catheter needed to be changed.</p> <p>b. On 8/9/17 at 4:20 pm, LPN #8 and LPN #9 were observed preparing to replace Resident #17's existing indwelling urinary catheter. At 4:22 pm, LPN #8 opened the sterile catheter insertion kit and applied sterile gloves to both of her hands. At that point, LPN #9 asked LPN #8 to hand her a pair of sterile gloves. LPN #8 contaminated her left glove when she picked up an unopened package of sterile gloves and handed it to LPN #9. LPN #9 applied the sterile gloves, deflated the balloon at the end of the</p>	F 441	<p>Licensed nurses will complete an indwelling urinary catheter insertion competency administered by the Practice Development Specialist or designee on or before 10/6/17.</p> <p>Monitoring</p> <p>Beginning the week of 10/7/17, the Center Nurse Executive or designee will conduct a weekly audit of 5 staff members for hand hygiene per policy/guidelines.</p> <p>Beginning the week of 10/7/17, the Center Nurse Executive or designee will conduct an audit of 5 residents, for peri-care completed per policy/guidelines. Beginning the week of 10/7/17 an audit of 2 licensed staff completing real or simulated procedures involving sterile technique will be completed by the center nurse executive or designee to ensure that sterile technique is maintained.</p> <p>Audits will be completed weekly X 4 then Monthly X 2. Results will be reported to the QAPI Committee monthly for 3 months for review and remedial interventions. The Center Nurse Executive is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p>		

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F 441	<p>Continued From page 83</p> <p>existing catheter, and then LPN #8 removed the existing catheter. LPN #8 did not remove the contaminated gloves, perform hand hygiene and don a new pair of sterile gloves before inserting the new indwelling urinary catheter.</p> <p>Immediately afterward, LPN #8 said she wasn't sterile, that she would notify the physician and the resident would need to be observed for signs and symptoms of infection.</p> <p>3. On 8/10/17 at 8:15 am, Registered Nurse (RN) #2 was observed administering several medications, including 2 topical medications and 2 transdermal fentanyl patches, to Resident #39 before touching the resident's shoes and wheelchair footrests with her gloved hands. RN #2 confirmed correct foot placement with the resident then removed her gloves and left the room. The RN passed the sink as she left the room.</p> <p>Immediately afterward, when asked about the lack of hand hygiene, RN #2 said she should have "at least changed my gloves."</p> <p>4. The facility's Hand Hygiene Policy, revised 3/16/15, documented, "Hand washing is performed frequently and using correct hand washing technique. Hand washing is performed after: Handling any food ... Before touching any clean utensils, plates, cups, or pans ... when moving from one task to another."</p> <p>On 8/7/17 at 12:21 pm, CNA #5 was observed preparing and passing out beverages to residents. CNA #5 scooped ice from an ice chest beverage cart and filled a cup with juice and ice.</p>	F 441	<p>Date of Compliance</p> <p>10/7/17</p>		

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F 441	Continued From page 84 At this time several small pieces of ice dropped to the floor, which CNA #5 picked up the ice with her bare hands. CNA #5 then walked back to the beverage cart and threw the small pieces of ice into the trash. CNA #5 continued touching the resident's cup and pitcher with her bare hands, and pouring the juice into the cup with her bare hands. CNA #5 then gave the cup of juice to a resident without washing or sanitizing her hands. After putting the cup of juice on the resident's table, CNA #5 was observed walking to the front of the dining room and washing her hands. On 8/11/17 at 12:25 pm, the Clinical Nurse Consultant (CNC) stated, "After [CNA #5] touched the floor, she should have sanitized her hands. That would be our expectation." On 8/11/17 at 12:30 pm, the Staff Development Coordinator stated "We do cover hand hygiene at general orientation then we do regular in-services. There is obviously a need ... that we need to do an in-service with [CNA #5] regarding proper hand hygiene."	F 441			
F 465 SS=D	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account	F 465		10/6/17	

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F 465	<p>Continued From page 85 non-smoking residents. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to ensure 1 of 61 resident rooms and 2 of 3 bathroom toilets used by visitors and staff were in good repair. This failure had the potential for harm if residents experienced negative feelings or a decreased sense of well-being from the condition of their living environment. Findings include:</p> <p>1. On 8/10/17 at 9:15 am, a small hole was observed in the bathroom door of Room 25. At 9:16 am, Maintenance Staff #1 stated, "I see that [hole] and will have it repaired."</p> <p>2. On 8/7/17 at 10:15 am, the toilets in the two public West Wing restrooms were observed in need of repair: The toilet in Restroom #1 did not properly refill with clean water when flushed and the toilet seat was loose in Restroom #2.</p> <p>On 8/10/17 at 9:00 am, the Maintenance Supervisor stated the concerns would be addressed.</p>	F 465	<p>F-465</p> <p>Specific Residents Identified</p> <p>The hole in the back of the bathroom door in room 205 was repaired by the Maintenance Supervisor on 8/15/17. The toilet in public restroom #1 was repaired so that it flushes properly and the toilet seat in public restroom #2 was tightened by the Maintenance Supervisor on or before 10/6/17.</p> <p>Identification of Other Residents</p> <p>Doors in the facility were inspected by the Maintenance Supervisor on or before 10/6/17 to ensure that there were not any holes in the doors. Any issues that were found were repaired by the Maintenance Supervisor by 10/6/17. The toilets in the facility will be inspected by the Maintenance Supervisor or designee on or before 10/6/17 to ensure that they are working properly and that the toilet seat were not loose. Any concerns that were found will be addressed by the Maintenance Supervisor or designee on or before 10/6/17.</p> <p>An environmental round will be completed by the Center Executive Director and Director of Maintenance to identify any concerns with needed repairs, cleaning,</p>		

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F 465	Continued From page 86	F 465	<p>or other needed environmental modifications on or before 10/6/17. Any identified areas will be addressed as indicated.</p> <p>Systemic Changes</p> <p>Facility Staff will be educated by the Center Executive Director or designee on or before 10/6/17 regarding the requirement that the resident rooms and toilets in the facility be in good repair, and the facility system for notification of maintenance staff of items that need repair.</p> <p>Beginning 10/7/17, instructions for reporting maintenance/ housekeeping concerns will be posted in the employee break, and charting areas.</p> <p>Monitoring</p> <p>Beginning the week of 10/7/17, audits of the environment including resident rooms and facility bathrooms will be completed weekly x 4 weeks and then monthly for 2 months by the Center Executive Director or designee to ensure that rooms and toilets are in good repair. Results of the audits will be reported to the QAPI Committee monthly for three months for review and remedial interventions. The Center Executive Director is responsible for monitoring and compliance. The QAPI</p>		

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F 465	Continued From page 87	F 465	Committee will re-evaluate the need for further monitoring after 3 months. Date of Compliance 10/6/17		
F 469 SS=E	<p>483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of maintenance records as well as facility policies, it was determined the facility failed to provide an environment that was free from pests. This failed practice affected 2 of 7 residents (#9 and #20) taking part in a resident group interview and had the potential to adversely affect all residents in the facility. Findings include: On 8/8/17, 2 of 7 residents participating in a group meeting stated they informed the facility they had seen insects in their rooms, included flying and crawling ants. The facility's Infection Control Practices policy, effective 11/28/16, and Pest Control policy, effective 6/15/05, both addressed pests within the facility. The Infection Control policy documented, "The facility will provide a pest free environment by contracting with a pest vendor for appropriate services on a periodic basis whether weekly, monthly, or as needed. As well, all staff are educated in maintaining the proper cleanliness of the facility and storing food products in appropriate containers." The Pest Control policy</p>	F 469	<p>F469</p> <p>Specific Residents Identified</p> <p>The rooms for Residents #9 and #20 were treated for ants and re inspected for pests by the Maintenance Supervisor on or before 10/6/17. Any finding were corrected. Residents # 9 and #20 will be assessed by nursing for adverse affects on or before 10/6/17 and follow-up will be completed as indicated.</p> <p>Identification of Other Residents</p> <p>Resident rooms and rooms in the facility at increased risk for pests will be inspected for pests by the Maintenance Supervisor or designee on or before 10/6/17. Any findings will be corrected by the Maintenance Supervisor or designee on or before 10/6/17. A pest log book will be created on or before 10/6/17 for staff to notify Maintenance staff of pest</p>	10/6/17	

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F 469	<p>Continued From page 88 documented, "To maintain the department and facility in a pest-free condition ... Pest sightings are recorded in a log book."</p> <p>An invoice/inspection report from the pest control provider for the last visit at the facility, dated 6/20/17, documented a colony of ants was found in the mechanical room.</p> <p>On 8/9/17 at 5:55 pm, Maintenance Staff #1 stated, "We don't keep a log book that I am aware of. When the [exterminator] company comes they document it if they see any pests."</p> <p>On 8/09/17 at 6:25 pm, the pest control company arrived at the facility for another inspection at the request of Maintenance Staff #1. A tour was conducted of resident rooms that included those residents who eat at least one meal in their room to determine whether there was an infestation of ants. The pest control officer discovered ants in 2 of the 61 rooms, 304B and 206B. Room 304B was observed with dead ants near a bait station in the corner of the room. Room 206B was observed with live ants in a corner where the resident kept empty soda bottles.</p> <p>On 8/9/17 at 6:45 pm, Housekeeper #1 stated, "I will deep clean the room [206B] when the resident is not in his room."</p>	F 469	<p>sightings.</p> <p>Systemic Changes</p> <p>The Maintenance Supervisor, Maintenance Assistant and facility staff will be educated by the Center Executive Director or designee on or before 10/6/17 regarding the facility pest control policy including the pest log book.</p> <p>Beginning 10/1/17 pest control will be increased to twice a month service until November and then monthly during the winter months.</p> <p>Monitoring</p> <p>Starting the week of 10/7/17, ten resident rooms or rooms at risks for increased pests will be inspected by the Maintenance Supervisor or designee weekly x 4 weeks and monthly x 2 months to ensure that pests are not present in the rooms. Results of the audits will be reported to the QAPI Committee monthly for 3 months for review and remedial intervention. The Center Executive Director is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months.</p> <p>Date of Compliance</p>		

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

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F 469	Continued From page 89	F 469			
F 526 SS=D	<p>483.70(o)(1)-(4) Hospice</p> <p>(o) Hospice services.</p> <p>(1) A long-term care (LTC) facility may do either of the following:</p> <p>(i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.</p> <p>(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.</p> <p>(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:</p> <p>(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.</p> <p>(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to</p>	F 526	10/6/17	10/6/17	

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F 526	<p>Continued From page 90 any resident. The written agreement must set out at least the following:</p> <p>(A) The services the hospice will provide.</p> <p>(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.</p> <p>(C) The services the LTC facility will continue to provide based on each resident's plan of care.</p> <p>(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.</p> <p>(E) A provision that the LTC facility immediately notifies the hospice about the following:</p> <p>(1) A significant change in the resident's physical, mental, social, or emotional status.</p> <p>(2) Clinical complications that suggest a need to alter the plan of care.</p> <p>(3) A need to transfer the resident from the facility for any condition.</p> <p>(4) The resident's death.</p> <p>(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.</p>	F 526			

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F 526	<p>Continued From page 91</p> <p>(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.</p> <p>(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p>	F 526			

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F 526	<p>Continued From page 92</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.</p> <p>The designated interdisciplinary team member is responsible for the following:</p> <p>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.</p> <p>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.</p> <p>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with</p>	F 526			

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F 526	<p>Continued From page 93 the medical care provided by other physicians.</p> <p>(iv) Obtaining the following information from the hospice:</p> <p>(A) The most recent hospice plan of care specific to each patient.</p> <p>(B) Hospice election form.</p> <p>(C) Physician certification and recertification of the terminal illness specific to each patient.</p> <p>(D) Names and contact information for hospice personnel involved in hospice care of each patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest</p>	F 526			

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F 526	<p>Continued From page 94</p> <p>practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and interview, it was determined the facility failed to delineate duties between a hospice agency and the facility for residents receiving hospice services. This was true for 1 of 2 residents (#15) reviewed for hospice care and created the potential for harm if care, medications, and/or services were not provided to terminally ill residents receiving end-of-life care. Findings Include:</p> <p>The facility's Hospice Services Agreement, dated 11/1/14, documented, "When a center resident is authorized by Hospice for admission to the Hospice Program, or when the center admits a Hospice patient to the Center, Hospice and Center shall jointly develop and agree upon the patients [sic] POC [plan of care] ... Hospice and Center each shall maintain a copy of each patient's POC in the clinical records maintained by each party."</p> <p>Resident #15 was admitted to the facility with diagnoses that included malignant neoplasm of the lung and palliative care.</p> <p>Physician Orders for Resident #15, dated 5/16/17, documented, "Admit under care of [hospice agency]."</p> <p>Resident #15's care plan, initiated 5/17/17, documented, "Hospice care due to end stage diagnosis of lung cancer."</p>	F 526	<p>F-526</p> <p>Specific Residents</p> <p>Resident # 15 discharged from the facility on 08/17/2017.</p> <p>Identification of Other Residents</p> <p>A review of residents on hospice services will be completed by the Center Nurse Executive or designee to ensure that required hospice documentation is available in the medical record including delineations of duties on or before 10/6/17. Follow-up will be completed to ensure the medical record will be updated by the Center Nurse Executive or designee on or before 10/6/17.</p> <p>A care plan meeting including staff from the hospice agencies will be held on or before 10/6/17 for current residents who are receiving hospice services to ensure that all duties are delineated in the plan of care for each resident. Copies of the Delineation of Services Plan will be placed in the resident record by the Center Executive Director or designee on or before 10/6/17.</p>		

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F 526	<p>Continued From page 95</p> <p>Resident #15's Admission Minimum Data Set (MDS) assessment, dated 5/23/17, documented the provision of hospice services.</p> <p>Resident #15's clinical record did not contain a delineation of duties between the facility and the hospice agency providing services to the resident.</p> <p>On 8/10/17 at 2:00 pm, Resident #15 was observed sleeping in her room.</p> <p>On 8/10/17 at 4:00 pm, Hospice Registered Nurse (RN) #1 stated, "[Resident #15] has been on hospice services since September 2016." When asked for a delineation of duties between the facility and hospice agency, Hospice RN #1 stated, "There should be documentation in the chart, but I'm not seeing it. [Facility staff] have access to our 'read only' hospice charts."</p> <p>On 8/10/17 at 5:28 pm, the Administrator stated, "There are only a few people here that have access to their [hospice] records." When asked for a delineation of duties for Resident #15, the Administrator stated, "That is part of the hospice criteria [and] criteria for admission [to the facility] ... we should have it in the medical record."</p> <p>On 8/11/17 at 8:30 am, when asked for a delineation of duties between the facility and hospice agency, the Director of Nursing (DON) stated, "I don't know what that is."</p> <p>On 8/11/17 at 9:15 am, the Administrator stated, "They (hospice) should be providing us that documentation. I know they fax us weekly updated reports and they report to the nurses</p>	F 526	<p>Systemic Changes</p> <p>The Interdisciplinary Team will be educated by the Center Executive Director on or before 10/6/17 regarding the need for a care plan meeting and delineation of duties agreement for each patient who elects hospice.</p> <p>Beginning 10/7/17 residents who elect the hospice benefit will be reviewed by the Center Nurse Executive or designee at morning clinical meeting to ensure that required hospice documentation is available in the medical record including certification of terminal illness and plan of care with delineation of duties.</p> <p>Beginning 10/7/17 a care conference will be scheduled for residents, family/ responsible party, hospice staff, as soon as possible after hospice is elected to review the integrated plan of care with delineation of duties, and residents goals and interventions for end of life care.</p> <p>Monitoring</p> <p>Starting the week of 10/7/17, the medical record for 3 residents on hospice services will be reviewed by the Center Executive Director or designee weekly x 4 weeks and monthly x 2 months to ensure that the delineation of duties agreement is present for each patient. A report will be</p>		

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F 526	Continued From page 96 here." On 8/11/17 at 9:30 am, the Clinical Quality Specialist (CQS) stated, "Once someone goes onto hospice services there is a meeting that takes place and we discuss the delineation of duties as far as who is doing what, medications, goals for comfort upon admission, responsibilities and who we should be contacting at hospice and who hospice should be contacting."	F 526	submitted to the QAPI Committee monthly for 3 months for review and remedial intervention. The Center Executive Director is responsible for monitoring and compliance. The QAPI Committee will re-evaluate the need for further monitoring after 3 months. Date of Compliance 10/6/17		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RUSSELL S. BARRON – Director

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December 18, 2017

Lori Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

Dear Ms. Bentzler:

On **August 11, 2017**, an unannounced on-site complaint survey was conducted at Twin Falls Center.

The Complaint was investigated during a Complaint and Federal Recertification Survey conducted August 7, 2017 to August 11, 2017.

Immediately upon entering the facility, the survey team conducted a general tour of resident rooms and common areas. Throughout survey, seventeen individual residents and all residents in general were observed for quality of care, signs of distress, physical environment concerns, infection control, and quality of life issues. Facility staff was observed providing care, interacting with residents and responding to residents' needs and requests.

The clinical records of the identified resident and four other residents were reviewed for quality of life and quality of care concerns, including pressure ulcer and wound management, incontinence care, medication administration, weight concerns, missing items, and infection control practices. The facility's grievance files and Incident and Accident reports were reviewed.

Interviews were conducted with multiple residents; direct care staff, including nurses and nursing aides; the Director of Nursing Services, Social Worker, laundry director, human resources, and

Wound Nurse. All interviews included questions about quality of life and quality of care issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007494

ALLEGATION #1:

The identified resident was in contact isolation where the facility did not require an interested party to use personal protective equipment.

FINDINGS:

Based on interviews with residents, their family members, and record review, there were no concerns discovered concerning the use of personal protective equipment with residents on isolation precautions.

The identified resident's record was reviewed regarding necrotizing fasciitis to the knee. The resident was removed from strict isolation precautions and placed on contact isolation. Staff were instructed to use personal protective equipment when coming into contact with the wound site, however both staff and visitors were allowed to touch the resident without the use of personal protective equipment if they did not come into contact with the wound site.

Based on interviews and record reviews the allegation was not substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Staff did not assist the identified resident with eating and the resident lost more than 100 pounds in the last year at the facility.

FINDINGS #2:

Based on observations and interviews with staff and residents, there were no concerns with residents who required eating assistance at meals. Three meal observations took place throughout the survey and dining assistance was provided to all residents in the assisted room by 3 to 4 staff; staff assistance was also provided to those residents eating in their rooms.

Residents interviewed did not complain about meal times or not receiving required staff assistance with eating.

The identified resident's weight fluctuated while at the facility due to diuretic therapy ordered to address a medical condition related to fluid retention.

Based on observation and interviews, the allegation could not be substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The identified resident lost multiple clothing items and the resident's laundry was not provided to the family in a timely manner for cleaning.

FINDINGS #3:

Numerous observations, interviews, and a review of residents' clinical records did not reveal any concerns with missing items, including clothing. Residents interviewed at the facility stated staff attempts to locate any missing items and the facility replaces those items if they are not found. The facility's Grievance file did not contain concerns related to missing items from November 2016 through March 2017.

No issues were identified with staff knowledge regarding misappropriation of property, abuse, and/or neglect.

The identified resident's clinical record did not contain information regarding a missing Disneyland jacket, and the facility provided documentation that glasses reported missing in early 2016 had been located. A second grievance filed later in 2016 alleging a second set of eyeglasses were missing was not substantiated as the facility did not have a record of the resident going to an eye doctor or evidence he received glasses. The facility provided evidence that the eye doctor did not order a second set of eyeglasses for the identified resident.

Based on observation, interviews, and record review, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility did not assist the resident to the bathroom or manage his bowel care.

FINDINGS #4:

Eight residents were reviewed for incontinence care.

The identified resident's record documented he was not provided adequate bowel care and became severely constipated.

Based on observations, interviews and record reviews, the allegation was substantiated and cited at F312. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

The identified resident developed multiple pressure ulcers which worsened at the facility.

FINDINGS #5:

Based on record review and interviews with residents and family members, it was determined the facility did not provide necessary cares and services for specialized wound care needs.

The identified resident's record documented multiple pressure ulcers re-opened and worsened on multiple occasions during his stay at the facility.

Based on interviews and record reviews, the allegation was substantiated and cited at F314. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

The facility did not provide medications in a timely manner.

Lori Bentzler, Administrator
December 18, 2017
Page 5

FINDINGS #6:

Eight residents were observed throughout survey receiving scheduled and as-needed medications as ordered by the physician. Three nurses were observed on day shift providing twenty-five different medications, which were delivered per physician orders and at their scheduled times.

Several residents interviewed did not voice concerns about medications.

The identified resident's clinical record contained documentation that the resident received intravenous medications as scheduled.

Based on observations, interviews, and record reviews, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

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

Sincerely,

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

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

DS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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December 19, 2017

Lori Bentzler, Administrator
Twin Falls Center
674 Eastland Drive
Twin Falls, ID 83301-6846

Provider #: 135104

Dear Ms. Bentzler:

On **August 11, 2017**, an unannounced on-site complaint survey was conducted at Twin Falls Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007504

ALLEGATION #1:

The facility failed to ensure resident cares were provided as needed.

FINDINGS #1:

Based on observation, interview, and clinical record review, it was determined the facility failed to thoroughly investigate allegations of abuse and/or neglect.

Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Lori Bentzler, Administrator
December 19, 2017
Page 2 of 2

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

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

Sincerely,

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

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

DS/lj