



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
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3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

September 18, 2017

Bradley Hruza, Administrator  
Valley Vista Care Center of St. Maries  
820 Elm Street  
St Maries, ID 83861-2119

Provider #: 135075

Dear Mr. Hruza:

On **August 25, 2017**, a survey was conducted at Valley Vista Care Center of St. Maries by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 28, 2017**. Failure to submit an acceptable PoC by **September 28, 2017**, may result in the imposition of civil monetary

penalties by **October 21, 2017**.

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

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

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

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

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

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

- **Civil money penalty**
- **Denial of payment for new admissions effective November 25, 2017**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 25, 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.

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

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **September 28, 2017**. If your request for informal dispute resolution is received after **September 28, 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,



Nina Sanderson, LSW, Supervisor  
Long Term Care

Bradley Hruza, Administrator  
September 18, 2017  
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NS/lj

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

PRINTED: 11/09/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135075</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/25/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>VALLEY VISTA CARE CENTER OF ST MARIES</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 ELM STREET ST MARIES, ID 83861</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification survey conducted August 21, 2017 to August 25, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Linda Kelly, RN Cecilia Stockdill, RN Haley Young, LSW</p> <p>This report reflects changes resulting from the Informal Dispute Resolution (IDR) process completed on October 19, 2017.</p> <p><b>ABBREVIATIONS:</b></p> <p>ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CBC = Complete Blood Count cc = cubic centimeter(s) cm = centimeter CNA = Certified Nursing Assistant CPR = Cardiopulmonary Resuscitation CVA = Cerebrovascular Accident DNS = Director of Nursing Fax = Facsimile ICPM = Interdisciplinary Care Plan Meeting IDT = Interdisciplinary Team Lab = laboratory LPN = Licensed Practical Nurse malodorous = foul smelling MAR = Medication Administration Record mcg = microgram(s) MD = physician MDS = Minimum Data Set</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

09/26/2017

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 mg = milligrams NA = Nursing Assistant PO Q 8 HRS = By mouth every 8 hours POST = Physician Orders for Scope of Treatment PRN = as needed RA = Restorative Aide RAR = Resident at Risk RN = Registered Nurse SOB = Shortness of breath ST = Speech Therapist sTSH/TSH = Thyroid Stimulating Hormone-sensitive, a blood test TAR = Treatment Administration Record UTI = Urinary Tract Infection	F 000			
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES  483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).  (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 155		10/18/17	

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F 155	<p>Continued From page 2</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure a resident's code status was clearly communicated to staff. This was true for 1 of 15 (Resident #9)</p>	F 155	<p>This Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the</p>		

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F 155	<p>Continued From page 3</p> <p>sampled residents. The deficient practice created the potential for harm if staff failed to provide cardiopulmonary resuscitation (CPR) to a resident who had elected that option. Findings include:</p> <p>Resident #9 was admitted to the facility on 10/1/13 with multiple diagnoses including anxiety disorder, major depressive disorder, and type II diabetes.</p> <p>Resident #9's quarterly Minimum Data Set (MDS - a standardized screening and assessment tool used for long term care residents), dated 5/19/17, documented the resident was cognitively intact.</p> <p>Resident #9's current face sheet (demographic and quick emergency information reference) documented the resident had chosen a "Do Not Resuscitate" status, and had a legal guardian in place.</p> <p>Resident #9's "Idaho Physician Orders for Scope of Treatment (POST)" form dated 9/30/13 documented Resident #9 was a "full code (resuscitate in the event of a cardiac or respiratory arrest)."</p> <p>Review of Resident #9's medical chart and room number indicated a green circular sticker was in place in both locations.</p> <p>On 8/24/17 at 8:50 am, Licensed Practical Nurse (LPN) #2 who was a travel nurse working in the facility for the first time said if a resident had no pulse or was not breathing and she was unsure of their code status, she would refer to the POST form in their chart to determine whether they</p>	F 155	<p>Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of the federal and state law require it. This provider maintains that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of long term care facilities, and this Plan of Correction, in its entirety, constitutes this providers alleged compliance. Completion dates are provided for the procedural procession purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with requirements of participation or that corrective action was necessary.</p> <p>Resident Specific: Resident #9's face sheet was corrected to indicate that he was, per his POST form, a full code on 08/25/2017. His door tag and chart were also updated at this time with green stickers to serve as indicators to staff that he was a full code.</p> <p>Other residents: All residents have the potential to be</p>		

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F 155	<p>Continued From page 4 should be resuscitated.</p> <p>On 8/25/17 at 2:50 p.m. Certified Nursing Assistant (CNA) #6 said to determine a resident's code status she would look for a green or red sticker on the outside of their chart and room, as a green sticker meant the resident was a "full code" and the red sticker meant the resident was a "do not resuscitate." She said if the sticker was not in place, she would refer to the resident's face sheet. When CNA #6 checked the face sheet for Resident #9 and saw it was incorrect, she said it would be "very bad" to confuse a resident's code status.</p> <p>On 8/25/17 at 3:00 pm RN #1, the acting Director of Nursing Services (DNS), said the code status on the face sheet and the POST form should always match. She said the staff could refer to the green or red stickers on the chart or the resident's door, but if the stickers were gone they should look at the resident's POST form. She verified Resident #9 was a "full code" and should be resuscitated in the event of a cardiac or respiratory emergency.</p>	F 155	<p>affected by this deficient practice. An audit of all residents' face sheets was conducted between 09/20/2017 and 09/22/2017 by the Medical Records Director and Resident Services Coordinator to verify that all face sheets correctly identified each resident's code status based on their current POST forms. Door tag and chart stickers (indicators of code status preference) were also audited these dates to verify that each resident's code status was accurately represented.</p> <p>Facility Systems: Beginning the week of 09/25/2017, for all new admissions and readmissions, Medical Records staff will input information from each new resident's POST form onto the face sheet. This face sheet will then be reviewed by the Resident Services Coordinator to verify that the information indeed matches the resident's POST form. Once verified, the face sheet will be placed in the chart and the corresponding sticker will be placed on the resident's door and chart. When, at the request of a resident or their responsible party, changes are made to a resident's POST form, the Resident Services Coordinator will inform Medical Records staff. From there, the process for updating the face sheet will mimic that of the admission/readmission process.</p> <p>Monitoring: Beginning the week of 10/01/2017, a weekly audit will be conducted by the</p>	

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F 155	Continued From page 5	F 155	Corporate Compliance Nurse (or designee) verifying that residents with recent changes and all newly admitted/readmitted residents <input type="checkbox"/> face sheets, door tag and chart stickers, and POST forms match. This audit will continue weekly for one month, bi-weekly for two additional months and then monthly for two months. Results of these audits will be shared monthly at this facility's QAPI meeting. At the conclusion of the auditing process, based on the results of the audits, the QAPI committee will determine the need for and frequency of ongoing audits to maintain compliance with this regulation.		
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 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.	F 225		10/18/17	

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F 225	Continued From page 6  (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.  (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  (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.  (2) Have evidence that all alleged violations are thoroughly investigated.  (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  (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	F 225			

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F 225	<p>Continued From page 7</p> <p>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 resident and staff interview, and review of clinical records and Incident and Accident Reports, it was determined the facility failed to thoroughly investigate injuries of unknown origin. This was true for 1 of 15 (#4) sample residents reviewed. The facility failed to thoroughly investigate the incidents, which placed Resident #4 at risk for harm and further injuries. Findings include:</p> <p>Resident #4 was readmitted to the facility on 3/9/17 with diagnoses including chronic pain syndrome, right leg below the knee amputation, anemia (low red blood cell count), congestive heart failure, and Type II diabetes.</p> <p>The resident's urinary and bowel incontinence care plan, dated 3/9/17, documented an intervention for a bedpan when requested.</p> <p>The resident's fall prevention care plan, dated 3/9/17, documented an intervention for Hoyer (brand name for a machine used to lift residents) for transfers.</p> <p>a. A 3/9/17 Admission/Re-Admit/Discharge Full Body Assessment documented an open area/skin split between Resident #4's buttocks, and that there were no other open areas.</p> <p>A 4/12/17 at 8:00 pm Resident Incident Report documented a 0.5 cm (centimeter) by 4 cm abrasion to the resident's right posterior/buttock,</p>	F 225	<p>Resident Specific: Prior to survey, resident number four's care plan was updated to alert staff that she was not to use the bed pan any longer. The injury has not recurred. The redness that was concluded to have been caused by the mechanical lift resolved within hours and has not recurred. She has had no other injuries of unknown origin and/or injuries received during provision of care. There is no other action to take for this resident.</p> <p>Other residents: All residents with injuries of origin and/or injuries received during provision of care are at risk of this deficient practice. All Accident and Incident reports from 08/01/2017 through 09/26/2017 were reviewed for complete investigations by the NHA and Corporate Compliance Nurse on 09/27/2017.</p> <p>Facility Systems: A Handbook for Managers was implemented and placed at all Nurse's stations to guide staff in policy and procedure and regulatory requirements for investigations. Licensed Nursing staff were educated on the use of this reference source for accurate and complete Accident and Incident reporting and investigating on 09/05/2017.</p>		

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F 225	<p>Continued From page 8</p> <p>close to where the Hoyer lift strap goes between the legs. A Staff Statement documented two CNAs "notice [sic] sore on right side between leg &amp; butt cheek" while providing care to the resident.</p> <p>An Interdisciplinary Progress Note, dated 4/13/17 at 1:00 am documented the abrasion to Resident #4's right buttock area "corresponds to where [H]oyer lift strap comes up between legs..."</p> <p>A 4/13/17 Interdisciplinary Progress Note documented Resident #4 had a "sheer [sic] to the right buttock/thigh area and ... bedpan injury likely occurred during placement."</p> <p>A 4/13/17 Incident Report Investigation Summary, documented the sheared area was "likely" caused by the bedpan being pushed under the resident.</p> <p>On 8/24/17 at 4:50 pm, the wound nurse said she was responsible for investigating this incident. The wound nurse stated she spoke to "all the CNAs" while investigating the cause of the injury, but she did not document the interviews.</p> <p>b. A Resident Incident Report, dated 5/12/17 at 8:30 am, documented the resident reported being struck in the face by the "machine" when being assisted to get up for breakfast. A small reddened area was noted to the left cheek with "slight discoloration" under the left eye and some tenderness. A Staff Statement documented Resident #4 stated she was hit in the left eye by the Hoyer lift. The statement documented the left eye appeared "puffy."</p> <p>An Interdisciplinary Progress Note, dated 5/12/17</p>	F 225	<p>Beginning 09/27/2017, all Accident and Incident skin reports will be reviewed by the IDT during the daily stand up meeting and by the Nurse Manager on the weekends. Any follow-up investigation determined to be necessary and timeframe for completion will be assigned by the NHA. A log book of Accident and Incident report investigation status will be maintained by the Corporate Compliance Director or designee for assurance of prompt and thorough investigations.</p> <p>Monitoring: Beginning the week of 10/01/2017, a weekly audit for thorough completion of all Accident and Incident investigations will be completed by the Corporate Compliance Director and/or the Corporate Compliance Nurse. These weekly audits will continue for five months. Results of the audits will be shared at the monthly QAPI committee meetings. At the conclusion of five months of weekly auditing, the QAPI committee will determine, based on compliance, the need for and frequency of ongoing auditing.</p>		

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F 225	<p>Continued From page 9</p> <p>day shift, documented Resident #4 reported that she was hit in the face by the mechanical lift "machine" when getting up for breakfast. A small, slightly reddened area was present on the left cheek under the eye with "possible discoloration" under the eye and slight tenderness. The Progress Note documented that the staff who assisted the resident that morning said they did not see the incident occur.</p> <p>The Incident Report Investigation Summary, completed on 5/15/17, documented the resident was struck in the face by the Hoyer lift during a transfer. The nurse documented there was no obvious sign of injury except for a "minor spot of red skin which resolved quickly."</p> <p>On 8/23/17 at 3:12 pm, Resident #4 said she did not recall being struck in the face by the "machine," but said that she had been "bumped a couple times, nothing serious."</p> <p>On 8/24/17 at 4:40 pm, RN #2 said she did not know who was assisting the resident when she was struck in the face with the Hoyer lift. When asked if she obtained statements from staff members who worked that shift and the preceding shifts, RN #2 said, "I think I did ask others but didn't write it down."</p> <p>c. An Incident Report, dated 8/8/17 at 8:30 am, documented a CNA notified the licensed nurse of a new abrasion to Resident #4's lower right buttock. The Incident Report documented the area was related to being a "pinch [sic] from [the] bedpan." An attached Accident Report by a CNA documented the CNAs "noticed fresh bruising/tearing around lower right buttocks"</p>	F 225			

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F 225	Continued From page 10 when putting the resident on the bedpan. Attached Staff Statements and an Occurrence Report, also dated 8/8/17, contained written statements that documented the bruise and tear on Resident #4's right buttock were not present the day before.  An Interdisciplinary Progress Note, dated 8/8/17 at 8:30 am, documented a "new abraded [sic] area" to Resident #4's lower right buttock "...from her skin being pinch [sic] from [the]bedpan..."  On 8/23/17 at 5:00 pm, two CNAs were observed providing care to the resident. There was mild redness in between the buttocks on the right side. CNA #1 said that bedpan was no longer being used for the resident.  On 8/24/17 at 4:50 pm, RN #2 said she talked to staff from the previous shift about the resident's injury on 8/8/17, but she did not document the interviews. RN #2 stated the appearance of the resident's skin was consistent with being pinched by the bedpan as it was placed under her buttocks.  The facility failed to investigate injuries of unkown origin, and/or injuries which occurred during the provision of care.	F 225			
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:  (i) The right to participate in the planning process,	F 280		10/18/17	

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F 280	<p>Continued From page 11 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 (b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of</p>	F 280		

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F 280	<p>Continued From page 12 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents and/or surrogate decision makers were invited to attend care planning meetings. This was true for 7 of 15 residents (#s</p>	F 280	<p>Resident Specific: Resident numbers #1, #5, #6, #7, #9, and #13 were contacted in-person by the Resident Services Coordinator on 09/21/2017 and invited to participate in a</p>		

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F 280	<p>Continued From page 13</p> <p>1, 4, 5, 6 7, 9 and 13) sampled for care plan participation. The deficient practice created the potential for harm if care was provided in a way inconsistent with resident needs and preferences. Findings include:</p> <p>The facility's "Care Planning - Interdisciplinary Team" policy, dated September 2013, documented, "The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development and revisions to the resident's care plan. The resident will be informed of his or her right to participate in treatment and an explanation will be included in a resident's medical record if the participation of the resident and his/her representative for developing the resident's care plan is determined not to be practicable. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals will be documented in the resident's clinical record in accordance with established policies."</p> <p>1. Resident #9 was admitted to the facility on 10/1/13 with multiple diagnoses including anxiety disorder, major depressive disorder, and Type II diabetes.</p> <p>Resident #9's quarterly Minimum Data Set (MDS), dated 5/19/17, documented the resident was cognitively intact. Resident #9's face sheet documented the resident had a legal guardian.</p> <p>On 2/20/17, an "Interdisciplinary Care Planning Meeting" (ICPM) form for Resident #9 documented the resident's legal guardian</p>	F 280	<p>care planning conference. Representatives of each of these residents were contacted by telephone also on 09/21/2017 with an invitation to do the same. Care conferences were coordinated and scheduled to be held per each resident and representative's availability. Resident and representative input regarding care preference will be obtained and documented at the time of their conference. Resident #4 and her family attended a care planning conference 09/13/2017. Input from the resident and her family regarding care preference and goals was obtained and included in her plan of care at that time.</p> <p>Other residents: All residents have the potential to be affected by this deficient practice. A resident meeting was held on 09/22/2017 to inform residents of their right to participate in their own plans of care. Each was given a letter outlining the Care Conference process. This letter also listed a number of staff members that a resident can contact anytime they wish to make changes in their plan of care. Residents that were unable to attend the resident meeting were met with individually as appropriate. Each resident was given the opportunity to ask questions and to offer any input they wished to include in their current plans of care. Letters outlining the Care Conference process and the rights of residents and their representative to be involved in the care were mailed out to all resident representatives on 09/27/2017.</p>		

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F 280	<p>Continued From page 14</p> <p>attended a care planning meeting. Resident #9 did not attend. There was no documentation that Resident #9 was informed of the meeting, or offered the opportunity to have input on her care plan. The ICPM documented Resident #9's advanced directives were reviewed and discussed as part of the meeting.</p> <p>Resident #9's ICPM form for 5/24/17 was blank in the areas to document when and how the resident and guardian were notified, and the resident/family input section of that form was also blank. The facility had no documentation that either Resident #9 or the legal guardian were invited to participate in the meeting.</p> <p>Resident #9's ICPM form for 8/23/17 did not document when or how the resident and guardian were notified of the date and time of the conference.</p> <p>On 8/23/17, Resident #9 stated she did not recall being invited to or attending any care plan conference meetings.</p> <p>2. Resident #13 was admitted to the facility on 11/30/15 with multiple diagnoses including peripheral vascular disease, atrial fibrillation, and major depressive disorder.</p> <p>Resident #13's 7/21/17 MDS documented the resident was cognitively intact.</p> <p>Resident #13's ICPM form for 4/25/17 documented the resident's family was provided with mailed notification of the meeting. There was no documentation Resident #13 was informed of the meeting, or invited to attend. The form did not</p>	F 280	<p>This letter also included the name and phone number of staff to reach out to should the representative wish to offer input at any time.</p> <p>Facility systems: On 09/26/2017, the IDT responsible for the care planning process were in-serviced on the expectations related to care conferences and the importance of obtaining resident and representative input in creation of resident-centered and resident-driven care plans. Beginning the week of 09/26/2017 all residents scheduled for an upcoming MDS will be invited in-person and in writing to a care planning meeting by the Resident Services Coordinator. For residents who desire to have their representatives involved in their plans of care, an invitation will be mailed to their representative of choice followed by an invitation by phone. Responses will be documented in the resident's record. When residents and/or their representatives are unable or decline to attend the meeting, the Resident Services Coordinator will request their input and report information to the care planning team during the care planning meeting.</p> <p>Monitoring: Beginning the week of 10/01/2017, the Corporate Compliance Nurse or designee will audit all Care Planning Meetings scheduled the prior week to ensure that resident and family input was sought,</p>		

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F 280	<p>Continued From page 15</p> <p>document whether Resident #13 and/or the resident's family attended the care planning meeting.</p> <p>On 8/24/17, the Medical Records Coordinator stated a resident who had a responsible party or legal guardian should still be invited to attend their care plan meeting. She stated there was no documentation to show residents had been invited to attend their meetings, but staff should document when they spoke to resident about attending a care plan meeting.</p> <p>On 8/25/17, Resident #13 stated she had never been invited to, or attended, a care planning meeting. Resident #13 stated she would like to participate in such meetings.</p> <p>3. Resident #6 was admitted on 10/15/16 with multiple diagnoses including an injury at C-1 (first cervical vertebra), cerebral infarction (stroke), difficulty walking, and muscle weakness.</p> <p>The resident's ICPM record, dated 1/23/17, documented a letter was sent on 12/23/17 [not legible]. Four staff members signed agreement with the plan of care; however, there was no documentation the resident had input regarding their plan of care.</p> <p>On 7/11/17, Resident #6's clinical record documented a quarterly MDS assessment was completed. The assessment documented cognitively intact functioning, extensive assistance with dressing and toileting, and used a wheelchair or walker. There was no documentation the resident's care plan was reviewed with the resident following the 7/11/17 MDS.</p>	F 280	<p>documented, and implemented appropriately. This audit will continue weekly for one month, bi-weekly for two additional months and then monthly for two months. Results of these audits will be shared monthly at this facility's QAPI meeting. At the conclusion of the auditing process, based on the results of the audits, the QAPI committee will determine the need for and frequency of ongoing audits to maintain compliance with this regulation.</p>		

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F 280	<p>Continued From page 16</p> <p>On 8/22/17 at 12:30 p.m. Resident #6 said she did not remember ever attending a care plan meeting.</p> <p>4. Resident #1 was admitted to the facility on 4/6/16 with multiple diagnoses, including Parkinson's disease, dementia with behaviors, and depression.</p> <p>A quarterly MDS assessment, dated 6/2/17, documented Resident #1 had moderately impaired cognition and required extensive assistance with ADL's [Activity of Daily Living].</p> <p>A quarterly ICPM record, dated 3/6/17, documented a resident and family invitation letter was mailed to Resident #1's family on 2/21/17 with no response received. Six staff members signed in agreement with the plan of care for Resident #1; however, there was no documentation the resident or family were involved in the care planning process.</p> <p>A quarterly ICPM record, dated 6/7/17, was blank for the resident and family invitation to be invited to the care planning meeting. Five staff members signed in agreement with the plan of care; however there was no documentation the resident or family were involved in the care planning process.</p> <p>On 8/24/17 at 10:45 am, the MDS coordinator said each discipline will fill out their section on the ICPM record before the care conference meeting with the resident and/or family. The MDS coordinator was unable to provide documentation that Resident #1 and/or her family participated in the care planning process for either the 3/6/17 or</p>	F 280			

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F 280	Continued From page 17 6/7/17 review.	F 280			
F 281 SS=E	<p>5. Similar findings were identified for Resident #s 4, 5, and 7.</p> <p>483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>(b)(3) Comprehensive Care Plans</p> <p>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure that medications were administered as ordered, interventions were implemented as care planned, and neurological assessments were completed per facility policy. This was true for 4 of 15 sample residents (#s 4, 5, 8, and 10.) This was true when:</p> <p>a) Resident #4's scheduled pain medication was not consistently administered, and medications were not administered one to two at a time in pudding as ordered, and laboratory (lab) tests were not completed as ordered.</p> <p>b) Neurological assessments were incomplete for Resident #s 8 and 10.</p> <p>c) Labs were not completed as ordered for Resident #5.</p> <p>These failures created the potential for harm if</p>	F 281	<p>Resident Specific:</p> <p>1. One on one counseling was provided between 09/26/2017 and 09/29/2017 to the nurses identified as responsible for the documentation omission for administration resident #4's scheduled analgesic medications. Identified nurses were also counseled regarding the expectation of medication administration and the importance of policy and procedure adherence. The order for resident #4 to receive medications two at a time in pudding was reviewed by licensed staff and found to no longer be appropriate for this resident. This order was discontinued on 09/14/2017 and her care plan updated accordingly. LPN #3 was counseled on 09/26/2017 regarding the importance of verifying that medications are able to be crushed prior to administration. Lab results from resident #4's lab draw on 03/23/2017</p>	10/18/17	

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F 281	<p>Continued From page 18</p> <p>residents did not receive pain medication as ordered and medications in the prescribed manner, cueing while eating in order to decrease the risk for choking, and monitoring for changes in neurological status. Findings include:</p> <p>1. a. Resident #4 was admitted on 11/27/07 and readmitted on 3/9/17 with diagnoses including chronic pain syndrome, anemia (low red blood cell count), congestive heart failure, and Type II diabetes.</p> <p>Resident #4's Physician Orders for August 2017, documented hydrocodone/APAP (pain medication) 7.5 mg/325 mg (milligrams) one by mouth every eight hours for pain. The orders documented to give medications one to two at a time in pudding and medications may be crushed unless contraindicated.</p> <p>Resident #4's medication administration record (MAR), for August 2017, documented the hydrocodone/APAP was to be given at 8:00 am, 4:00 pm and midnight daily. The MAR did not document the hydrocodone/APAP was given at midnight on 8/1, 8/2, 8/6, 8/7 and 8/22/17.</p> <p>On 8/25/17 at 11:57 am, RN (Registered Nurse) #1 was unable to state with certainty that the Resident received or been offered the medication when the MAR was blank.</p> <p>b. On 8/23/17 at 4:05 pm, LPN #3 (Licensed Practical Nurse) was observed administering medications to Resident #4. She crushed multiple medications (glipizide, gabapentin, Mucinex, hydrocodone, and Floramax lactobacillus) and mixed all of the medications in</p>	F 281	<p>were obtained from the lab on 09/25/2017. The lab test processed by the laboratory was a Comprehensive Metabolic Panel and not the Complete Blood Count as ordered by the physician. The Physician was notified of this error on 09/25/2017.</p> <p>2. Resident #8's fall occurred on 08/08/2017. His neurological status has remained at baseline since that time. There is no further action to take for this resident. Licensed nursing staff were in-serviced regarding post-fall neuro check interval and duration on 09/05/2017.</p> <p>3. Resident number #10's fall occurred on 07/05/2017. Her neurological status has remained at baseline since that time. There is no further action to take for this resident. Licensed nursing staff were in-service regarding post-fall neuro check interval and duration on 09/05/2017.</p> <p>4. Resident number #5's TSH lab originally due 06/2017 was drawn on 08/23/2017. Results were communicated to the MD on the same date.</p> <p>Other residents: All residents with care planned interventions specific to medication administration techniques prescribed to minimize choking risk are at risk for this deficient practice. An audit was conducted of all resident's care planned medication administration interventions on 09/25/2017 All interventions were reviewed for appropriateness and care plans updated as needed on this date.</p>		

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F 281	<p>Continued From page 19</p> <p>the same cup with pudding. The nurse then administered the medications to the resident.</p> <p>When asked how the resident should take her pills, LPN #3 said they should be crushed in pudding. She said she was not aware of the order to give one to two pills at a time. The nurse reviewed the Physician Order Flow Sheet, acknowledged the order to give medications one to two at a time, and crushed four medications (Floramax, Glipizide, gabapentin, and Mucinex) that are not to be crushed.</p> <p>c. A Physician's Telephone Order for Resident #4, dated 3/22/17, documented a CBC was to be drawn on 3/23/17. No results were located in Resident #4's clinical record.</p> <p>On 8/24/17 at 10:40 am, RN #1 said she would call the lab and ask for the 3/23/17 CBC results to be faxed to the facility.</p> <p>On 8/24/17 at 10:50 am, RN #1 provided a copy of Resident #4's medication administration record that documented the CBC was drawn on 3/23/17.</p> <p>On 8/25/17 at 11:55 am, RN #1 stated the lab was not able to produce results from a CBC drawn on 3/23/17. She said she was not aware of the reason for this and the facility was not notified of any problems with the blood sample.</p> <p>The facility did not ensure that Resident #4's CBC was completed in order to monitor the status of the resident's anemia, which created the potential for a delay in treatment.</p>	F 281	<p>Licensed nursing staff received reeducation on the importance adherence to policy and procedure for proper medication administration and documentation during the Licensed Nurse's Meeting on 09/05/2017.</p> <p>All residents with scheduled analgesic medications are at risk for this deficient practice. An audit of all such resident's current MARs was conducted between 09/25-26/2017. Identified omissions will be addressed with the responsible nurses.</p> <p>All residents under the care of LPN #3 were at risk for the identified deficient practice of crushing medications that are recommended by the manufacturer to be given intact. Education was provided to this LPN on 09/26/2017.</p> <p>Residents requiring neurological assessments per the facility's Fall Protocol are at risk for this deficient practice. Accident and Incident reports for the months of August and September through 09/26/2017 were audited to identify residents that were subject to the need for these assessments. The corresponding Neurological Assessment Flowsheets were reviewed for completeness. Any identified omissions will be addressed with staff responsible by 09/29/2017. Reeducation on the policy and procedure for neurological assessment initiation was completed with licensed nurse staff during the Monthly Licensed Nurse's meeting on 09/05/2017.</p>		

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F 281	<p>Continued From page 20</p> <p>2. Resident #8 was admitted to the facility on 6/1/13 with multiple diagnoses, including a CVA [Cerebrovascular accident] with left sided hemiplegia.</p> <p>Resident #8's quarterly MDS assessment, dated 7/7/17, documented Resident #8 was cognitively intact, required one person assist with ADL's [Activity of Daily Living], and had left sided limitations.</p> <p>An Accident/Incident Report documented Resident #8 was found laying on the floor in the middle of his room next to his wheelchair on 8/8/17 at 1:50 pm. Neurological checks were initiated at 8/8/17 at 2:00 pm and ended on 8/9/17 at 3:00 pm.</p> <p>From 8/21/17 through 8/25/17, there was a posting at two of three nurse's stations and in the medication room for licensed nurses to conduct neurological assessments on residents who had fallen every 15-minutes for an hour; every hour for four hours; every four hours for twenty-four hours, and then every shift for forty-eight hours.</p> <p>On 8/23/17 at 10:25 am, the DNS reviewed Resident #8's neurological assessments following his 8/8/17 fall and stated she thought the checks only needed to be done for 24 hours.</p> <p>On 8/23/17 at 11:00 am, the DNS was shown the postings available at the nurse's station and said, "Oh, that's what they must use here."</p> <p>On 8/23/17 at 11:30 am, LPN #3 said the nurses should follow the posted neurological checks and pointed at the sign at the nurse's station.</p>	F 281	<p>All resident with physician ordered labs are at risk for this deficient practice. An audit was completed on 09/26/2017 of all currently ordered labs to ensure that all had been drawn and results communicated to the appropriate physicians.</p> <p>Facility systems: As the facility systems for proper medication administration and documentation are in place and appropriate. The failure of the nurse to follow this system was addressed with her on 09/26/2017. Additionally, Licensed Nurses were provided reeducation regarding the expectation of adherence to policy and procedure regarding medication administration and documentation on 09/05/2017. The facility's Handbook for Managers, which nurses are instructed to reference for Accident and Incident reporting procedures, was updated to include copies the Facility's fall protocol with neurological assessment parameters on 08/24/2017. Licensed nursing staff were educated on the appropriate use of this handbook during the Licensed Nurse's Meeting on 09/05/2017. Beginning 09/27/2017, A copy of the parameters will also be attached to all Fall A&amp;I packets filled out by nurses when an Incident occurs. Beginning the week of October 1, 2017, all labs ordered for the month will be scheduled to be drawn no later than the seventh day of the month. A licensed nurse will be scheduled to come into the</p>		

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F 281	<p>Continued From page 21</p> <p>3. Resident #10 was admitted to the facility with hospice care on 6/30/17 with multiple diagnoses, including failure to thrive, dementia, arthritis, and pain.</p> <p>An Accident/Incident Report documented Resident #10 was found on the floor between her wheelchair and bed on 7/5/17 at 10:30 am. Neurological checks were completed on 7/5/17 at 10:30 am, 7/5/17 at 7:15 pm, and 7/6/17 at 7:15 am. No other neurological checks were documented.</p> <p>On 8/24/17 at 10:05 am, the DNS said the Neurological Assessment Flow Sheet for Resident #10 was incomplete.</p> <p>4. Resident #5 was admitted to the facility in 2013 and readmitted on 6/30/15 with multiple diagnoses including hypothyroidism.</p> <p>On 6/30/15, Resident #5's physician's orders documented a TSH (thyroid-stimulating hormone-sensitive, lab test to monitor thyroid replacement therapy effectiveness) level "yearly draw in February."</p> <p>A 2/17/17 TSH lab report documented the resident's level was 7.54 (almost double the reference range of 0.4-4.0).</p> <p>A 2/23/17 Physician's Telephone Order documented an increase in levothyroxine (thyroid hormone medication) to 100 micrograms (mcg) daily and to recheck the TSH in June 2017.</p> <p>Resident #5's 6/23/17 pharmacist Medication</p>	F 281	<p>facility with the sole responsibility of drawing all scheduled labs. Any labs not able to be obtained on the scheduled date will be assigned to the nurse on the cart the following day. If the lab is unable to be obtained on that date, the DNS will be notified and will be responsible for obtaining the lab. After the third failed attempt to obtain the lab, the MD will be notified for further orders. Labs ordered during the month will be scheduled as ordered. The floor nurse will be responsible for drawing the lab at the scheduled time. If that lab is unable to be obtained, the DNS will be notified and will be responsible for obtaining the lab. The MD will be notified of failure to obtain date-specific lab orders as appropriate. A lab log book will be initiated and maintained by Medical Records department staff. All labs ordered will be logged in the book as well as verification of completion date, results receipt, and MD notification.</p> <p>Monitoring: Beginning the week of 10/01/2017, the Corporate Compliance Nurse or designee will audit the floor nurses during medication pass to ensure that proper administration and documentation techniques are being performed. The DNS or designee will audit all labs to ensure compliance. In addition, the NHA or designee will audit fall A&amp;I's to ensure neurological assessments are taking place per facility protocol. These audit will</p>		

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F 281	Continued From page 22 Regimen Review documented a recheck TSH level was due and a physician visit note on 6/24/17 documented, "Due for an updated TSH." No TSH or lab results were found in the resident's clinical record.  On 8/24/17 at 3:20 pm, RN #1 said she did not know if the TSH lab test was done in June or not and "they're looking."  On 8/24/17 at 4:55 pm, RN #1 provided a TSH lab report, dated 8/24/17 at 1:45 pm, which documented the lab test was collected on 8/23/17 and that Resident #5's level was 16.31 (more than 4 times the reference range of 0.4-4.0). On the lab report was an unsigned and undated handwritten note to increase the levothyroxine to 0.125 mcg and to recheck the level in 90 days.  The TSH lab test was completed 2 months after it was ordered to be done which caused a 2 month delay in a change in Resident #5's thyroid hormone replacement therapy.	F 281	continue weekly for one month, bi-weekly for two additional months and then monthly for two months. Results of these audits will be shared monthly at this facility's QAPI meeting. At the conclusion of the auditing process, based on the results of the audits, the QAPI committee will determine the need for and frequency of ongoing audits to maintain compliance with this regulation.		
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 observation, interview, and record review, it was determined the facility failed to provide residents necessary assistance with activities of daily living. This was true for 1 of 15 sampled residents (#4). The deficient practice	F 312	Resident Specific: A speech therapy screen was completed for resident #4 on 09/25/2017. It was determined that due to improvement in her swallowing ability, she no longer	10/18/17	

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F 312	<p>Continued From page 23</p> <p>created the potential for harm if a resident experienced hunger or weight loss when not assisted to eat. Findings include:</p> <p>Resident #4's 6/16/17 quarterly MDS (Minimum Data Set) assessment documented moderate cognitive impairment and extensive assistance required with eating. Nutritional and Fluid Intake Care Plan initiated 3/9/17 documented the Resident was to take a drink after 2 bites of food per speech therapy.</p> <p>On 8/24/17 at 12:45 pm, Resident #4 was observed feeding herself as a staff member sat next to her in the main dining room. The resident was sitting in the dining room with the meal and drinks in front of her. The Resident took nine bites of food without taking a drink. Staff members were intermittently present at the table with the resident but did not cue or assist her to take a drink. CNA #9, who was an attendant in the dining room that meal, said she would cue the resident, ask her if the food was cut small enough and provide drinks such as cocoa, milk, juice and water. CNA #9 said she was aware of the care planned interventions that the resident should take a drink after two bites. She then asked the resident if she wanted more water. The resident said "no" and took another bite of food.</p> <p>On 8/23/17 at 3:00 pm, Resident #4 was observed eating an orange while sitting in her wheelchair near the nurses' station. There were no drinks available to the resident and no staff were observed cueing or monitoring the resident. CNA (Certified Nursing Assistant) #1 said the resident was "pretty independent" and they make sure she drinks the proper amount. The CNA</p>	F 312	<p>required the intervention of taking a drink after two bites of food. Her care plan was updated accordingly.</p> <p>Other residents: All other residents with care planned instruction to staff to offer drinks after bites of food are at risk for this alleged deficient practice. An audit was completed by the facility CDM of all dietary care plans on 09/26/2017. On the same date, identified residents were reviewed by the IDT to determine the appropriateness of these care planned interventions. Interventions found to be inappropriate were discontinued. CNA staff were in-serviced on the importance of knowing and following resident specific care planned interventions during the CNA Meetings held 09/26 and 09/28/2017.</p> <p>Facility Systems: Beginning the week of 09/25/2017 on weekdays, a member of the senior management team and, on weekends, a charge nurse will be assigned to monitor all meals and will keep in his/her possession a master list of residents with care planned need for staff assistance for drinks of liquids between bites. This person will be responsible for monitoring that staff are assisting as directed. The master list of residents will be maintained by the CDM or designee and updated as needed.</p>		

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F 312	Continued From page 24 said she was not aware of the care plan intervention for the resident to take a drink after two bites.	F 312	Monitoring: Beginning the week of 10/01/2017 a weekly audit of care plan adherence in dining will be conducted by the Restorative Nurse or designee. The weekly audit will be conducted for four weeks then bimonthly times two months, then monthly times two months. The findings of these audits will be presented to the QAPI committee. At the conclusion of the scheduled auditing process, the QAPI committee will, based on compliance, determine the need for and frequency of ongoing monitoring.		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  (b) Skin Integrity -  (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-  (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and  (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to	F 314	Resident specific: Upon admission, resident #10 was care	10/18/17	

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F 314	<p>Continued From page 25</p> <p>prevent the development of avoidable pressure ulcers. This was true for 1 of 2 sample residents (#10) reviewed for pressure ulcers. Resident #10 was harmed when she developed pressure ulcers to the coccyx/sacrum area and the right heel. Findings include:</p> <p>Resident #10 was admitted to the facility with hospice care on 6/30/17 with multiple diagnoses, including failure to thrive, dementia, arthritis, and history of pressure ulcers to the buttocks.</p> <p>The admission MDS [Minimum Data Set] assessment, dated 7/7/17, documented Resident #10 had severely impaired cognition, required extensive assistance with ADL's [Activity of Daily Living], and at risk for pressure ulcers.</p> <p>An Admission Nursing Evaluation/Data Collection sheet, dated 6/30/17, documented Resident #10 had a history of pressure ulcers with scars on the buttocks. The full body assessment, dated 6/30/17, documented on a body diagram, Resident #10 had 3 old pressure ulcer scars to left buttocks and 1 old pressure ulcer scar to right buttocks. Resident #10's bilateral heels were documented intact with 1-2 plus edema in her feet.</p> <p>Resident #10's Admission Care Plan, undated, documented interventions for staff to implement as follows:</p> <ul style="list-style-type: none"> <li>* Follow facility skin care protocol.</li> <li>* Turn every 2 hours and as needed.</li> <li>* Preventative measures per protocol.</li> <li>* Report to charge nurse any redness or skin breakdown immediately.</li> </ul>	F 314	<p>planned for an every two hour side to side turning schedule and placed on a pressure redistributing mattress. She received skin checks weekly on 06/30/2017, 07/07/2017, and 07/14/2017 and was found to be free of pressure related skin compromise. She was placed on an airbed on 07/17/2017. She was assessed on 08/24/2017 by the facility's contracted ARNP CWCNP, a nationally recognized expert in the diagnosis and treatment of wounds. Per her dictated note, resident #10 was suffering End-stage skin failure/Kennedy ulcer due to ischemic heart disease. According to her assessment, this medical condition made resident #10's skin impairment likely to occur in spite of the numerous interventions placed by the facility to prevent impairment. Treatment to skin impairment continues per the recommendation of the expert and in coordination with Hospice services.</p> <p>Other residents:</p> <p>Other residents with end-stage disease processes and assessed as high risk for skin breakdown are at risk for this alleged deficient practice. An audit was conducted 09/21-25/2017 of all current residents' Braden scales and diagnoses. Those found to be at risk had their care plans reviewed to ensure that interventions to prevent pressure ulcers were appropriately initiated.</p> <p>Facility systems:</p>		

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F 314	<p>Continued From page 26</p> <p>The facility's Pressure Ulcers/Skin Breakdown - Clinical Protocol, revised March 2014, did not include any "preventative measures."</p> <p>The MAR [Medication Assessment Record] or TAR [Treatment Assessment Record], dated July 2017, did not include weekly skin assessments to be completed by a licensed nurse.</p> <p>A Physician Progress noted, dated 7/12/17, documented Resident #10 had a history of failure to thrive, chronic pain, and was essentially bedridden in the facility. The Physician Progress Note, documented Resident #10 was doing "quite well" in the facility and the nursing staff had no concerns. The physical examination documented Resident #10's skin was free of rashes and extremities had no edema.</p> <p>a. An Accident/Incident Report, dated 7/15/17, documented a licensed nurse removed an optifoam dressing from Resident #10's sacrum and found an area that was dark purple in color to the coccyx/sacrum and faded to red at the edges. The measurements were 12 cm x 4 cm denuded area.</p> <p>An Interdisciplinary Progress Note by the Wound Nurse, dated 7/17/17, documented Resident #10 skin presented with a "butterfly wound consistent with a Kennedy Ulcer." The pressure ulcer to the coccyx/sacrum area measured 12 cm x 4 cm with 40% of the wound was unstageable due to eschar. The foam dressing was saturated with dark brown malodorous [foul smelling] drainage. The Wound Nurse contacted the hospice nurse for treatment orders for the coccyx wound.</p>	F 314	<p>Beginning 09/26/2017, any resident anticipated to be admitted under his/her Medicare Hospice benefit will be thoroughly reviewed by a facility nurse representative. Medical and social history will be assessed and current needs identified. Coordination between facility and Hospice staff will occur prior to admit and agreement made for a plan of care meeting clinical standards initiated. The initial plan will be reviewed and approved by the DNS or designee. Staff education for the prevention and treatment of pressure ulcers was completed 09/26/2017-09/28/2017, and will be ongoing.</p> <p>Monitoring: Beginning the week of 10/01/2017, a weekly audit of the Risk for Skin Impairment care plans of residents identified as high risk for skin impairment and end-stage disease processes resident's will be conducted by the corporate compliance nurse. These audits will continue weekly for four weeks, bimonthly for two months, then monthly for two months. Results from these audits will be shared monthly during the QAPI committee. Upon completion of the scheduled auditing process and based on compliance, the QAPI committed will determine the need for and frequency of ongoing auditing.</p>		

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	<p>Continued From page 27</p> <p>When asked for their policy regarding a "Kennedy Ulcer," the facility provided printouts of 2 pages of a PowerPoint presentation from 2008, and 3 pages from a blog in 2013. The facility's "Pressure Ulcer/Skin Breakdown - Clinical Protocol," revised March 2014 and identified by the facility as their pressure ulcer policy, did not recognize or define a Kennedy Ulcer. The facility was unable to provide evidence-based research from a nationally recognized source that such an ulcer was recognized by any authoritative entity, or why such an ulcer would be completely unavoidable.</p> <p>A Hospice Interim Order, dated 7/17/17, documented Resident #10 had a "Kennedy Terminal Stasis Ulcer" to the coccyx/sacrum and the facility staff were to perform wound care dressing changes daily and as needed as follows:</p> <ul style="list-style-type: none"> <li>* Cleanse coccyx/sacrum wound with wound cleanser or normal saline, apply skin prep to peri wound area, apply calcium alginate AG and cover with a foam dressing to coccyx/sacrum wound daily and as needed.</li> <li>* Apply an alternating pressure air mattress with side bolsters.</li> <li>* Staff to reposition Resident #10 side to side every 2 hours with pillows for support.</li> </ul> <p>A Wound Care Flow Sheet, dated 7/17/17 through 8/22/17, documented Resident #10's coccyx/sacrum wound was assessed weekly by the Wound Nurse as follows:</p>			

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F 314	<p>Continued From page 28</p> <p>* 7/17/17 - Measurements (Length, Width, Depth): 12 cm x 4 cm, no undermining or tunneling, moderate amount of malodorous brown drainage, wound bed - redness in color with 40% eschar tissue, and had pain.</p> <p>* 7/24/17 - Measurements: 4.5 cm x 7 cm x 2.5 with 2 cm of undermining from 6 o'clock to 12 o'clock, large amount of brown malodorous drainage, wound bed - 35% redness and 65% eschar in color with necrotic tissue [dead], and had pain.</p> <p>* 8/1/17 - Measurements: 4.5 cm x 8.5 cm x 3 cm with 3 cm of undermining from 6 o'clock to 12 o'clock and tunneling between 1 and 2 o'clock with 0.5 cm, large amount of brown malodorous drainage, wound bed - 30% redness and 70% eschar in color with necrotic tissue, and had pain.</p> <p>* 8/8/17 - Measurements: 5 cm x 9.2 cm x 3 cm with 3 cm of undermining from 6 o'clock to 12 o'clock and tunneling had increased to 1 cm, large amount of brown drainage with a slight odor, wound bed - 20% redness and 80% yellow in color with necrotic tissue, and pain with turning.</p> <p>* 8/15/17 - Measurements: 5 cm x 9.2 cm x 3 cm with increased undermining to 3.1 cm and tunneling to 1.1 cm, moderate amount of brown drainage with no odor, wound bed - 100% yellow slough in color with necrotic tissue, and no pain to the wound.</p> <p>* 8/22/17 - Measurements: 4.3 cm x 9 cm x 3.5 cm with undermining of 3.5 and tunneling 1.0 cm,</p>	F 314			

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F 314	<p>Continued From page 29</p> <p>moderate brown drainage, wound bed - 10% redness and 90% yellow slough in color with necrotic tissue, and no pain to the wound.</p> <p>On 8/23/17 at 3:15 pm, the Wound Nurse was observed changing the dressing to Resident #10's coccyx/sacrum wound. The Wound Nurse said the pressure ulcer was measured on 8/22/17 with the hospice nurse. The wound was shaped like a "butterfly." The wound bed was observed with granulating tissue approximately 9 cm in length, 5 cm width with gray and black tissue, and 4 cm depth with undermining between 6 o'clock to 12 o'clock and tunneling at 1-2 o'clock. A moderate amount of brown drainage was on the old dressing with no odor noted. The Wound Nurse said the pressure ulcer was increasing in size weekly, because it's a "Kennedy Ulcer," the wound wouldn't heal because Resident #10 was on hospice and her life expectancy was less than six months.</p> <p>On 8/24/17 at 9:45 am, the DNS said Resident #10's Admission Care Plan documented staff was turning Resident #10 side to side every 2 hours and as needed. The DNS was unable to find documentation for additional preventative measures to prevent the development of Resident #10's coccyx/sacrum pressure ulcer. The DNS said the pressure ulcer was unavoidable because Resident #10 was on hospice and the hospice agency diagnosed the pressure ulcer as a Kennedy Ulcer.</p> <p>On 8/24/17 at 12:15 am, the Wound Nurse said the hospice agency didn't think Resident #10 needed an air mattress when she was admitted to the facility on 6/30/17. The Wound Nurse said</p>	F 314			

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F 314	<p>Continued From page 30</p> <p>she was educated by the Administrator on 7/17/17, when the pressure ulcer developed, that the facility was responsible for Resident #10's plan of care not the hospice agency.</p> <p>b. A Physician Order, dated 7/20/17, documented heel lift boots and skin prep to bilateral heels twice a day for Resident #10. Resident #10's treatment administration record (TAR) included an area to document the provision of those treatments each morning and evening. The TAR was blank in the area for the morning administration of those interventions between 7/20/17 and 7/23/17.</p> <p>An Interdisciplinary Progress Note by the Wound Nurse, dated 7/24/17, documented Resident #10 had a fluid filled blister to her right heel. The measurements were 3.5 cm x 3.0 cm.</p> <p>An Interdisciplinary Progress Note by the Wound Nurse, dated 8/1/17, documented Resident #10's blister to right heel was black eschar and intact. No measurements were documented.</p> <p>An Interdisciplinary Progress Note by the Wound Nurse, dated 8/8/17, documented Resident #10's blister to right heel measured 1.0 cm x 1.1 cm intact with black eschar and resolving.</p> <p>An Interdisciplinary Progress Note by the Wound Nurse, dated 8/15/17, documented Resident #10's blister to right heel was a stable, flat, and a dry scab. No measurements were documented.</p> <p>An Interdisciplinary Progress Note by the Wound Nurse, dated 8/22/17, documented Resident #10's blister to right heel remains flat and a dry</p>	F 314			

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F 314	<p>Continued From page 31</p> <p>scab. No measurements were documented.</p> <p>On 8/23/17 at 3:15 pm, Resident #10 was observed in bed with heel lift boots to bilateral feet.</p> <p>On 8/24/17 at 12:15 pm, the Wound Care Nurse said Resident #10's right heel blister was found on 7/24/17, but the staff had been offloading her heels with pillows when she was admitted on 6/30/17. The Wound Nurse was unable to find documentation in the clinical record for staff to offload Resident #10's heels. The Wound Nurse said after the right heel blister was found, the facility received orders for Resident #10 to wear heel lift boots and apply skin prep to bilateral heels twice a day. The Wound Nurse said the right heel blister was healing when the heel lift boots were initiated.</p> <p>On 8/24/17 at 4:00 pm, LPN #4 was observed removing Resident #10's heel lift boots bilaterally. The right outer aspects of Resident #10's right heel had an approximately 1.0 cm x 1.0 cm black scab. The edges of the wound bed were intact without drainage. LPN #4 re-applied the heel lift boots to bilateral feet and placed a pillow under Resident #10's legs to offload her heels. LPN #4 said since Resident #10 wears the bilateral heel lift boots that the staff doesn't always need to offload her heels.</p> <p>Resident #10 was admitted to the facility with a history of pressure ulcers to her buttocks. Resident #10 was harmed when the facility failed to identify and implement effective preventative measures, such as an air mattress and to offload her heels. Resident #10 developed two pressure</p>	F 314			

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F 323 SS=G	to her coccyx/sacrum area and to her right heel. 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  (d) Accidents. The facility must ensure that -  (1) The resident environment remains as free from accident hazards as is possible; and  (2) Each resident receives adequate supervision and assistance devices to prevent accidents.  (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.  (1) Assess the resident for risk of entrapment from bed rails prior to installation.  (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.  (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined the facility failed to provide appropriate supervision to prevent accidents for 1 of 15 residents (#2). Resident #2 was harmed when she left the facility into an outdoor courtyard without adequate supervision, fell, and sustained an arm and hip fracture. Findings	F 323		10/18/17	
			Resident Specific: Resident #2 discharged from the facility on 05/23/2017.  Other Residents: All cognitively impaired ambulatory residents with a Fall Risk Evaluation of		

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F 323	<p>Continued From page 33 include:</p> <p>Resident #2 was admitted to the facility on 1/12/16 with diagnoses including Alzheimer's disease and dementia with behavioral disturbances.</p> <p>Resident #2's annual "Minimum Data Set" (MDS) assessment, dated 2/24/17, documented she was severely cognitively impaired, required set-up and assistance with ambulation, and extensive assistance of two persons for transfers. The MDS documented Resident #2 was not steady, but could stabilize without staff assistance for walking and turning around. The Care Area Assessment (CAA) for Resident #2's Activities of daily living documented the resident "exhibited balance problems" and, "staggers at times will tip forward if she bends over to pick up an item off the floor."</p> <p>On 1/26/16, Resident #2's care plan documented she was at risk of elopement. Interventions included keeping Resident #2 "in line of sight when out of the room."</p> <p>On 1/30/16, Resident #2's fall risk care plan documented she was at risk for falls related to wandering and the use of anti-seizure and antianxiety medications. The interventions included placing the resident on the facility's Falling Star Program, to increase staff awareness that she was at risk for falls.</p> <p>On 2/24/17, a "Fall Risk Evaluation" for Resident #2 documented she was at high risk for falls.</p> <p>On 5/5/17, a "Resident Incident Report" for</p>	F 323	<p>high fall risk for falls have the potential to be affected by this deficient practice. These residents were identified and their care plans were updated to require direct supervision when outside in the court yard. Their care plans were further reviewed to ensure that all current care planned interventions were appropriate for the resident's condition and relevant for fall and accident prevention. Care plans were updated as indicated. In addition, these residents care plans were updated to include 1:1 staffing when adverse side effects of PRN medications are identified until the side effects subside.</p> <p>Facility Systems: Moving forward all ambulatory residents with cognitive impairment and a baseline Fall Risk Evaluation score of high will be supervised with ambulation at all times. LP staff will be in-serviced on 09/27/17 regarding the change in resident supervision, regulatory compliance for F323 and the cited deficient practice. Starting the week of 10/01/2017 this change will be added to the weekly care plan audit checklist.</p> <p>Monitoring: Beginning the week of 10/01/2017 the DNS or designee will conduct weekly audits of resident care plans and Fall Risk Evaluations as well as staff observation audits to ensure that care planned interventions are being performed by staff as directed in the resident care plan.</p>		

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F 323	<p>Continued From page 34</p> <p>Resident #2 documented the resident sustained a 2-centimeter abrasion to her nose when she walked into a window. The report documented a CNA was walking with the resident at the time, but was unable to direct or guide her to prevent the resident from walking into the window.</p> <p>On 5/17/17, Resident #2's elopement care plan was updated to document she required line of sight supervision when up throughout the unit, instead of out of her room.</p> <p>Resident #2's physician's orders for August 2017 documented an order for the antianxiety medication Klonopin 0.25 mg to be given as needed for anxiety. Resident #2's Medication Administration Record (MAR) for May 2017 documented the resident received a dose of Klonopin on 5/23/17 at 12:45 pm. Medication literature for Klonopin (<a href="https://www.drugs.com/klonopin.html">https://www.drugs.com/klonopin.html</a>) documented, "The sedative effects of Klonopin may last longer in older adults. Accidents are common in elderly patients who take benzodiazepines. Use caution to avoid falling or accidental injury while you are taking Klonopin.</p> <p>On 5/23/17 at 5:25 pm, a "Resident Incident Report" documented Resident #2 was discovered to have fallen in the courtyard. The fall was documented as unwitnessed, but CNA #8 saw the resident face down on the cement ramp outside leading to the courtyard through the window, and alerted the LN on duty. CNA #8's statement on the report stated the resident was on "visual precautions" at the time the fall occurred, which meant the resident should always be visible to staff.</p>	F 323	<p>These audit will continue weekly for one month, bi-monthly for two additional months and then monthly for two months. Results of these audits will be shared monthly at this facility's QAPI meeting. At the conclusion of the auditing process, based on the results of the audits, the QAPI committee will determine the need for and frequency of ongoing audits to maintain compliance with this regulation.</p>		

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F 323	<p>Continued From page 35</p> <p>On 5/23/17 a "Fall Scene Investigation Report" for Resident #2 documented she was confused at the time of the fall, and had received antianxiety medication within 8 hours prior to the fall.</p> <p>A 5/23/17 hospital progress note for Resident #2 documented the resident had sustained a stable, comminuted humeral head (upper arm) fracture. A 5/26/17 hospital progress note documented Resident #2 had also sustained a left femoral neck (hip) fracture as a result of the 5/23/17 fall, which required surgical repair.</p> <p>On 5/29/17, the facility completed an Incident and Accident Report for Resident #2's 5/23/17 fall. The report documented the facility Administrator had determined the fall to be "unavoidable."</p> <p>The facility's "Safety and Supervision of Residents" policy, dated 12/2007, documented, "implementing interventions to reduce accident risks and hazards shall include the following ...d. ensuring interventions are implemented ...monitoring the effectiveness of the interventions shall include the following ...c. modifying or replacing interventions as needed."</p> <p>On 8/21/17 at 10:55 am, LPN #1 stated Resident #2 had a fall "a few months ago," and sustained an arm and hip fracture. LPN #1 stated the resident was in the courtyard outside the secured unit where she lived, and had an unwitnessed fall. LPN #1 stated although Resident #2 should have been in the staff's line of sight at the time of the fall, she was not.</p>	F 323			

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F 323	Continued From page 36  On 8/24/17 at 11:20 am, the Administrator said the "line of sight" intervention on Resident #2's care plan no longer applied to her after she was moved from the "behavioral hall" to the "secured unit." The Administrator stated Resident #2 was not at risk for falls and was able to ambulate independently. The Administrator was unable to explain how it had been determined the resident was not at risk for falls, when her fall risk assessment documented her fall risk as "high."  On 8/25/17 at 12:25 pm, the Behavioral Unit Care Manager (BUCM) stated Resident #2 was moved to the secured unit on 5/17/17 (6 days prior to the fall) because the resident had exit seeking and elopement behaviors. The BUCM stated the staff and family decided moving Resident #2 to the secured unit would give her the freedom to move in and out of the courtyard without needing to be redirected. The BUCM stated the elopement care plan was left in place until staff became familiar with Resident #2, and staff knew to have her in line of sight when she went off of the secured unit for activities. The BUCM said all the residents on the secured unit had 15 minute safety checks. The BUCM stated Resident #2 could ambulate independently and did not require assistance.  On 8/25/17 at 4:45 pm, the MDS nurse stated Resident #2 was coded to require "supervision" during ambulation on the most recent MDS. The MDS nurse stated the resident could ambulate on her own, but needed staff to supervise her because the resident had a tendency to stumble. Both the MDS nurse and the assistant MDS nurse stated Resident #2 should not have been	F 323			

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F 323	Continued From page 37 unsupervised when ambulating outside on 5/23/17, especially after receiving Klonpin earlier that day.  Resident #2 was harmed when the facility failed to adequately supervise a confused resident with a recent environmental change, assessed at baseline to be at high risk for falls, with an unsteady gait, and required supervision with ambulation. The resident suffered an unwitnessed fall outside the facility within 6 hours of receiving an antianxiety medication. The resident sustained a fractured arm and hip, with the hip fracture requiring surgical intervention.	F 323			
F 325 SS=G	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;  (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record	F 325	Resident Specific:	10/18/17	

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F 325	<p>Continued From page 38</p> <p>review, it was determined the facility failed to ensure residents received nutritional interventions to prevent unplanned weight loss. This was true for 1 of 4 residents (#5) reviewed for weight loss. Resident #5 was harmed when she experienced a 7.5% weight loss in one month, a 5.8 % weight loss a week later and another 3.7% weight loss a week after that. Findings include:</p> <p>Resident #5 was admitted to the facility in 2013 and readmitted on 6/30/15 with multiple diagnoses including severe osteoporoses, chronic iron deficient anemia, hypothyroidism, chronic pain and mild dementia.</p> <p>The most recent quarterly Minimum Data Set (MDS) assessment, dated 7/28/17, documented Resident #5 was understood by others, usually understood others, had moderate cognitive impairment, required extensive assistance with eating, and had unplanned weight loss.</p> <p>Interventions in Resident #5's alteration in nutritional/fluid intake/potential dehydration care plan, originated 6/30/15, included: * "If resident does not initiate self eating staff to assist with meals;" * Dining program breakfast and lunch; * Tires easily, staff to start meal with supplement first; * Small plates for individual food items, due to gets overwhelmed easily; * High calorie ice cream lunch and dinner; and * Boost pudding with breakfast and lunch.</p> <p>The resident's 8/4/17 ADL (Activities of Daily Living) Care Plan instructions to Certified Nursing</p>	F 325	<p>Resident #5's care plan was updated on 09/13/2017 to include full assistance with every meal.</p> <p>Other Residents: All residents experiencing an unplanned weight loss are at risk. A facility wide audit was conducted on 09/26/2017 on all residents experiencing an unplanned weight loss. Residents were identified and an observation was performed to ensure that the residents were receiving their care planned items and that they received the appropriate level of assistance with meals.</p> <p>Facility Systems: CNA and nursing staff will be in-serviced on F325 regulatory requirements and the facilities deficient practices by 09/28/2017. The facility has appointed a new Restorative Nurse and the Restorative Nurse will track all residents with unplanned weight loss. The Restorative Nurse will also observe and audit resident meals in the RA dining program as well as the dining halls to ensure residents are receiving the appropriate level of assistance and their care planned dietary needs are being followed. Restorative Nursing Aides will be in-serviced and educated regarding RA dining care plan's, dining assistance, new processes and timeliness of assistance by 09/28/2017. In addition, the RA dining care plan binder will now include the residents dietary care plan so</p>		

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F 325	<p>Continued From page 39</p> <p>Assistants and Restorative Aides (RA) documented:</p> <ul style="list-style-type: none"> <li>* Nosey cups with meals;</li> <li>* Start meal with supplement first then small plates for individual food items;</li> <li>* Restorative dining program set up; and,</li> <li>* "If does not initiate self eating staff to assist with meal."</li> </ul> <p>Resident #5's August 2017 Physician's orders included regular diet, small plate and thin liquids in nose cups, ordered 6/30/15.</p> <p>A 7/20/17 fax (facsimile) to the physician documented, "Resident is down another 7# [pounds] in 1 month" and asked if an appetite stimulant would be appropriate.</p> <p>On 8/3/17, the physician ordered Megace every day to "help appetite" and Boost supplement 1 can with each meal as tolerated.</p> <p>On 8/22/17 at 12:05 pm, Resident #5 and 3 other residents were observed at a table in the restorative area of the dining room. CNA #5 was seated across the table from Resident #5 and another CNA set-up Resident #5's meal then left the area. The resident's meal consisted of 6 small bite size pieces of ham, a teaspoon size portion of green peas and a tablespoon size portion of mashed potatoes with gravy on a saucer. This saucer was directly in front of the resident and it was surrounded by 4 nose cups of liquids, a dinner roll in a bowl, 1 unopened Boost pudding cup, 1 unopened box of liquid Boost and a piece of cake on a saucer wrapped in clear plastic. There was no ice cream on the table for Resident #5.</p>	F 325	<p>that the Restorative Nursing Aides can ensure that residents receive all care planned food items and supplements. The CDM will ensure that all residents receive their care planned supplements and special food items by separating supplements and special food items on the supplement list by individual dining hall.</p> <p>Monitoring: Beginning the week of 10/01/2017 the Restorative Nurse will conduct weekly audits of resident care plans and dining room observations to ensure compliance. This audit will continue weekly for one month, bi-monthly for two additional months and then monthly for two months. Results of these audits will be shared monthly at this facility's QAPI meeting. At the conclusion of the auditing process, based on the results of the audits, the QAPI committee will determine the need for and frequency of ongoing audits to maintain compliance with this regulation.</p>		

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F 325	<p>Continued From page 40</p> <p>On 8/22/17, from 12:06 pm to 12:20 pm, CNA #5 verbally cued Resident #5 several times about the food items on the saucer and the drinks on the table. The resident took 2 tiny bites of mashed potatoes and gravy but did not eat or drink anything else. At 12:20 pm, the Speech Therapist (ST) talked with the resident about the cake, which he unwrapped and placed in front of her. The ST verbally cued the resident to eat the cake, then he left the area. CNA #5 verbally cued the resident again but the resident did not eat or drink anything. At 12:32 pm, the resident still had not eaten or drunk anything and the Director of Therapy offered to take her to her room. The resident declined. By 12:44 pm, all of the other residents had left the area and CNA #5 moved next to Resident #5. The CNA asked the resident if she would like help, then opened the liquid Boost, offered it to the resident and the resident took several sips. At 12:47 pm, the CNA fed the resident 2 bites of ham then opened the pudding and put a spoon in it. The resident did not attempt to eat the pudding. At 12:49 pm, the CNA fed her 2 bites of the pudding to the resident, after which the resident said she was finished.</p> <p>Resident #5 did not attempt to feed herself during the lunch meal on 8/22/17, other than 2 tiny bites, and the staff did not offer or provide her with eating assistance for 38 minutes. Staff did not start the meal with a nutritional supplement, and ice cream was not provided as care planned.</p> <p>On 8/24/17 at 12:15 pm, Resident #5 and 3 other residents were observed at a table in the restorative area of the dining room. CNA #5 was seated across the table from Resident #5. The</p>	F 325			

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F 325	<p>Continued From page 41</p> <p>ST was standing next to Resident #5. The resident's meal was already on the table, it consisted of a piece of pizza on a saucer, which was in front of the resident. The pizza was surrounded by 3 bowls of food, 1 Boost pudding cup, 1 ice cream cup, 6 nosey cups of liquids, a strawberry health shake box and an unopened box of liquid Boost. The resident did not attempt to eat or drink anything.</p> <p>On 8/24/17 at 12:20 pm, the ST verbally cued Resident #5 to eat some soup and/or ice cream, then he left the area. At 12:26 pm, CNA #5 opened the liquid Boost and placed it in front of the resident. The resident took 3 sips of the Boost, but did not attempt to feed herself. At 12:32, CNA #4 verbally cued the resident to eat the soup. The resident said, "It's hot," but made no effort to eat the soup. At 12:37 pm, the CNA verbally cued the resident to eat the dessert. The resident ate 1 bite of the cranberry bar with whipped cream. The resident closed her eyes on and off during the meal. At 12:43 pm, CNA #4 asked RN #1 to assist the resident. At 12:44 pm, RN #1 sat by the resident and asked her what she would like to eat. The resident chose ice cream. RN #1 left the table briefly, then returned at 12:45 pm, and began feeding the resident. The resident ate most of the ice cream, 2 bites of dessert and drank several sips of the liquid Boost. The resident also drank 1 sip of the strawberry health shake and said she did not like it.</p> <p>A "Feeder Training Program" (restorative dining) from 8/1/17 to 8/24/17 documented: * Resident #5 was independent using a spoon and a glass during breakfast and lunch, except</p>	F 325			

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F 325	<p>Continued From page 42</p> <p>on 8/24/17 during lunch when she was noted as dependent and independent.</p> <p>* Breakfast food intake was 15% twice, 10% six times, 5% eleven times, and not recorded four times.</p> <p>* Lunch food intake was recorded once at 75%, 60%, 40%, 35% and 30%, four times at 50% (including 8/24/17), six times at 25%, three times at 20%, twice at 10% (including 8/22/17), twice at 5%, and not recorded twice.</p> <p>* Lunch fluid intake was recorded once for the following amounts: 360 cc, 340 cc, 270 cc, 240 cc and 80 cc; three times at 200 cc, four times at 180 cc, five times at 120 cc, five times at 100 cc, and not recorded twice.</p> <p>Resident #5's Nutrition Risk Review Progress Notes included the following documentation:</p> <p>* 7/25/17 - Weight loss of 6.9 pounds (7.5%) over 1 month, from 6/19/17 (93 pounds) to 7/18/17 (86 pounds). The Interdisciplinary Team (IDT) recommended an appetite stimulant and "[a diagnosis of] failure to thrive if acceptable."</p> <p>* 8/1/17 - Another 5 pound (5.8%) weight loss in 1 week, from 7/18/17 (86 pounds) to 7/25/17 (81 pounds). The IDT was "awaiting MD [physician] response..."</p> <p>* 8/8/17 - Another 3 pound (3.7%) weight loss in 1 week, from 7/25/17 (81 pounds) to 8/1/17 (78 pounds). The IDT recommendation was to continue with "failure to thrive per MD."</p> <p>* 8/15/17 - A 1 pound weight gain in 2 weeks, from 8/1/17 (78 pounds) to 8/14/17 (79 pounds). The IDT continued to monitor the resident.</p> <p>* 8/22/17 - No change, the resident's weight remained at 79 pounds from 8/14/17 to 8/22/17 and the IDT continued to monitor the resident.</p>	F 325			

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F 325	Continued From page 43 On 8/24/17 at 3:10 pm, the Certified Dietary Manager (CDM) said the resident had significant weight loss and was "placed back on RAR (Resident at Risk)" committee review in July.  On 8/25/17 at 11:35 am, CNA #5 said it was 30 minutes and longer before staff assisted Resident #5 to eat during lunch on 8/22/17 and 8/24/17. She added that on 8/24/17 the resident ate almost all of the ice cream and drank more Boost when staff assisted her to eat. CNA #5 said the resident "gets upset" when people try to feed her but that was not the case at lunch on 8/24/17 and the resident "did good."  Resident #5 was harmed when she experienced severe weight loss between 6/1/17 and 8/8/17. The facility failed to consistently implement the plan of care.	F 325			
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	F 431		10/18/17	

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F 431	<p>Continued From page 44 pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <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 staff interview, it was determined the facility failed to ensure controlled</p>	F 431	<p>Resident Specific: The DNS disposed of the expired</p>		

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F 431	<p>Continued From page 45</p> <p>medications were secured and locked, expired medications were not available for administration to residents, and that two nurses disposed of controlled medications. This was true for 4 of 15 sampled residents (#4, #5, #11, and #12) and one random resident (#16), and any resident for whom Geri-lanta or Naproxen may be needed/ordered. This failure created the potential for should residents access controlled medications, and if expired medications were used with less effectiveness. Findings include:</p> <p>1. On 8/23/17 at 11:00 am, the medication room was inspected with the DNS in attendance and the following was observed:</p> <p>a. An unlocked refrigerator contained a red box that was identified as "Narcotics," which was unsecured with Resident #12's Lorazepam 2 mg/ml suspension. The DNS said the red box that was labeled "Narcotics" should have been zip tied with a number on it and the refrigerator should have been locked.</p> <p>b. In the same refrigerator, a suppository of Prochlorperazine 25 mg for Resident #16, expired February 2017.</p> <p>c. On the shelf in the medication room, two bottles of Geri-lanta, expired June 2017.</p> <p>d. On the shelf, one bottle of Naproxen 220 mg, expired May 2017.</p> <p>The DNS verified expiration dates and disposed the expired medications.</p>	F 431	<p>medications on 08/23/2017. On 08/25/2017 the nursing staff were re-educated regarding the disposal of fentanyl patches and the facility process was updated to include two nurses signing the MAR when disposing of fentanyl pain patches.</p> <p>Other Residents: All residents using OTC medications, suppositorys and/or fentanyl patches have the potential to be effected by the deficient practice. An audit of the nurses carts, medication room and medication fridge was conducted on 09/26/2017 to ensure that there were no expired medications in the facility for resident use. An audit of all residents using fentanyl pain patches was conducted on 09/27/2017 to ensure that proper destruction of fentanyl patches has been documented on the MAR.</p> <p>Facility Systems: The MARs were updated to include an area for documentation of wasting fentanyl patches by two nurses. LP will be in-serviced on the regulatory requirements of F431, the facilities deficient practice, the new process for wasting fentanyl patches, the removal and disposal of expired medications, and the requirements of double locking narcotics on 09/28/2017. Beginning the week of 09/27/2017 the responsibility for verifying that refrigerated narcotic medications remain secured via double lock system will be assigned to be</p>		

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F 431	<p>Continued From page 46</p> <p>2. Resident #4 was admitted on 11/27/07 and readmitted on 3/9/17 with diagnoses including chronic pain syndrome.</p> <p>The Resident #4's July and August 2017 Physician Order Reports documented a fentanyl (narcotic pain medication) patch to be changed every 72 hours, and "remove prior patch before placing new one." The order was originated on 3/9/17.</p> <p>The Resident #4's July and August medication administration records documented the fentanyl patch every three days, and the Individual Narcotic Record documented a patch was used every three days. There was no documentation regarding the removal or destruction of the used patch.</p> <p>On 8/25/17 at 12:55 pm, RN #1 said two RNs (Registered Nurses) should dispose of narcotics. When asked to describe the process for changing a fentanyl patch, she said the old patch is removed from the resident, put on the medication cart until another nurse was present, then the nurses go in the back together and destroy it. RN #1 state the facility "may have one [nurse] sign coming on and one [nurse] going off." She did not respond when asked how the facility determined that two people witnessed the destruction of the used fentanyl patch.</p> <p>3. Resident #5 was admitted to the facility in 2013 and readmitted on 6/30/15 with multiple diagnoses including severe osteoporoses, chronic pain and mild dementia.</p> <p>Resident #5's Physician Order Report, effective</p>	F 431	<p>accounted for each shift change when the nurses are accounting for non-refrigerated narcotics. Initiating the week 10/01/2017, a facility audit will be implemented to audit the medication room and the medication refrigerator on an ongoing basis.</p> <p>Monitoring: Beginning the week of 10/01/2017, a weekly audit will be conducted by the DNS or designee to verify that there are no expired medications in the medication room, that the medication refrigerator remain locked, and that fentanyl patches are being wasted with two nurses present. This audit will continue weekly for one month, bi-weekly for two additional months and then monthly for two months. Results of these audits will be shared monthly at this facility's QAPI meeting. At the conclusion of the auditing process, based on the results of the audits, the QAPI committee will determine the need for and frequency of ongoing audits to maintain compliance with this regulation.</p>		

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F 431	<p>Continued From page 47</p> <p>8/1/17, included a 7/8/15 order for a fentanyl 25 microgram (mcg) patch to be applied every 72 hours (3 days) and to, "Remove prior patch before placing new one."</p> <p>Resident #5's medication administration records (MARs) for July and August 2017 contained the same order for fentanyl and documented the patch was applied as ordered. The MARs did not contain areas for documentation of wasting of used fentanyl patches.</p> <p>Resident #5's Individual Narcotic Records for fentanyl 25 mcg patches, dated 6/17/17 through 8/23/17, documented one nurse's signature each time the controlled medication was administered. There were no areas for documentation for wasting of used fentanyl patches.</p> <p>There was no documentation in Resident #5's clinical record that 2 nurses wasted any of the used fentanyl patches.</p> <p>On 8/25/17 at 11:40 am, RN #1 reviewed the resident's Individual Narcotic Records for fentanyl 25 mcg patches and said that 2 nurses did not sign as wasting or witnessing the wasting of the used patches.</p> <p>4. Resident #11 was admitted to the facility on 6/8/17 with multiple diagnoses including hypertension "suggestive of heart failure," a history of cerebrovascular accident (stroke), recent falls with 3 ribs fractures, and chronic abdominal pain of undetermined etiology. Hospice care was started on 7/26/17.</p> <p>A Telephone Order, dated 8/17/17, included an</p>	F 431			

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F 431	<p>Continued From page 48 order for fentanyl 12 mcg patch every 72 hours for pain and SOB.</p> <p>Resident #11's August 2017 MAR documented a fentanyl 12 mcg was administered as ordered.</p> <p>Resident #11's Individual Narcotic Record documented 2 nurses initialed the fentanyl patch on 8/17/17 and 8/20/17 but only 1 nurse initialed the patch on 8/23/17.</p> <p>On 8/25/17 at 11:50 am, RN #1 reviewed the Resident #11's Individual Narcotic Record for fentanyl 12 mcg patches. The RN said 2 nurses wasted the used fentanyl patches on 8/17/17 and 8/20/18 but not on 8/23/17.</p> <p>On 8/25/17 the Administrator provided the facility's policy for Discarding and Destroying Medications. He said the the facility did not have a specific policy regarding used fentanyl patches and that used fentanyl patches were covered in the policy he provided.</p> <p>The Discarding and Destroying Medications policy documented, "For unused, non-hazardous controlled substances...recommends destruction and disposal of the substance with other solid waste...Mix medication...with an undesirable substance...sand, coffee grounds, kitty litter, or other absorbent materials...Dispose...in the presence of two witnesses. Document the disposal on the medication disposition record. Include the signature(s) of at least two witnesses."</p> <p>The Nursing 2017 Drug Handbook documented the following nursing considerations regarding</p>	F 431			

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F 431	Continued From page 49 Fentanyl, "Fentanyl is an opioid agonist and schedule II controlled substance with potential for abuse. Be alert for signs of misuse, abuse, or diversion." It also documented, "Transdermal patches must be...disposed of properly to prevent poisonings or other harm...A patch that has been worn for 3 days may still contain enough Fentanyl to cause harm, or even kill a child or pet..."	F 431			
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		10/18/17	

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F 441	<p>Continued From page 50</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 51</p> <p>by: Based on observation, staff interview, and the facility's policy and procedure review, it was determined the facility failed to ensure staff completed hand hygiene and perineal care consistent with current standards of practice. This was true for 3 of 15 sampled residents (#4, #5, and #10) requiring ADL [Activity of Daily Living] care and peri care. This failure created the potential for harm by placing residents at risk of developing infections: Findings include:</p> <p>1. On 8/23/17 at 3:35 pm, the Infection Control Nurse was observed assisting CNA (Certified Nursing Assistant) #1 with peri care for Resident #10. The Infection Control Nurse started to clean Resident #10 from back to front and CNA #1 immediately stopped the Infection Control Nurse's hand and positioned it to go front to back and said "front to back." The Infection Control Nurse completed the peri care while saying "front to back."</p> <p>On 8/23/17 at 3:45 pm, the Infection Control Nurse said she was "just so nervous" having a surveyor observe her.</p> <p>On 8/23/17 at 4:30 pm, the Administrator was asked for the policy and procedure for peri care and was notified of the observation with the Infection Control Nurse.</p> <p>The facility's policy and procedure for Perineal Care, revised dated October 2010, documented step by step instructions for wiping from front to back.</p> <p>2. On 8/23/17 at 9:35 am, CNA #2, along with</p>	F 441	<p>Resident Specific: CNA #2 was educated on 08/23/17 by the NHA for proper hand washing. The Infection Control Nurse was educated by the NHA on 08/23/2017 for proper perineal care.</p> <p>Other Residents: All residents in the facility have the potential to be affected by these deficient practices. The Infection Control Nurse was removed from her position on 09/22/2017. A facility wide audit was conducted on 09/26/2017. Staff members were observed and audited while performing perineal cares to ensure proper infection control practices were followed as well as proper hand hygiene.</p> <p>Facility Systems: LP and CNA in-services regarding F441 regulatory compliance, infection control as related to perineal care and hand washing will be completed by 09/28/2017 and will be ongoing. In addition, the infection control nurse will conduct hand washing and perineal care audits on an ongoing basis as part of the infection prevention program.</p> <p>Monitoring: Beginning the week of 10/01/2017, a weekly audit will be conducted by the Infection Control Nurse to verify that proper hand washing and perineal care are taking place. This audit will continue weekly for one month, bi-weekly for two</p>		

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F 441	<p>Continued From page 52</p> <p>another CNA, was observed providing care to Resident #4, including dressing and transferring the resident from bed to wheelchair using a mechanical lift. When they finished, both CNAs removed their gloves and left the room without performing hand hygiene.</p> <p>Immediately afterward, CNA #2 was asked about appropriate hand hygiene. She said it should be done every time you enter a room and when you come out, and after assisting a resident to use the bathroom. When asked if she performed hand hygiene before she left Resident #4's room, CNA #2 said "No." She also said that she usually uses hand sanitizer, and that hands should be washed for "90 seconds."</p> <p>3. On 8/23/17 at 12:10 pm, CNA #1 and #2 were observed as they repositioned Resident #5 in bed. CNA #1 then moved the resident's over bed table closer to her bed and moved the resident's wheelchair. CNA #1 then removed her gloves and left the room without performing any type of hand hygiene.</p> <p>Immediately after leaving the resident's room, CNA #1 made contact with Resident #4 who was in her wheelchair in the hallway by Resident #5's room. CNA #1 patted Resident #4's left shoulder, wheeled Resident #4 around in her wheelchair by the nurse's station for a minute as they talked, then wheeled the resident into her room. Resident #4's room door was open and CNA #1 was observed as she positioned Resident #4's wheelchair by the bed, handled the television remote control, found a television channel for the resident then left the room, without performing any type of hand hygiene.</p>	F 441	<p>additional months and then monthly for two months. Results of these audits will be shared monthly at this facility's QAPI meeting. At the conclusion of the auditing process, based on the results of the audits, the QAPI committee will determine the need for and frequency of ongoing audits to maintain compliance with this regulation.</p>		

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F 441	Continued From page 53	F 441		
F 514 SS=D	<p>On 8/23/17 at 12:10 pm, the Administrator was present when CNA #1 said she made contact with Resident #4 when she left Resident #5's room and that she "should" have used hand sanitizer from the dispenser on the wall outside of Resident #5's room.</p> <p>483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>(i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p>	F 514		10/18/17

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F 514	<p>Continued From page 54</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review it was determined the facility failed to maintain complete and accurate medical records for 2 of 15 sampled residents (Resident #s 4 and #11). The deficient practice created the potential for harm if care decisions were made based on incomplete or inaccurate information. Findings include:</p> <p>1. Resident #4 was admitted on 11/27/07 and readmitted on 3/9/17 with diagnoses including chronic pain syndrome, anemia (low red blood cell count), congestive heart failure, and Type 2 diabetes.</p> <p>The resident's ADL (activities of daily living) Care Plan Flow Sheet for August 2017 documented multiple entries by CNAs (Certified Nursing Assistants) where the previous information was written over in the areas of bed mobility, transfers, and eating. There was no documentation regarding who changed the information or the date the information was changed. Specifically, there were 61 entries on the ADL Care Plan Flow Sheet where a number was entered then was changed to a 3, 4, or 5 by writing over the previous entry. There were no initials or date next to the corrected information.</p> <p>On 8/24/17 at 11:30 am, RN #1 said if a staff member documented something in error, they</p>	F 514	<p>Resident Specific:</p> <p>Resident #4's ADL care plan from August was pulled and audited on 09/22/2017. CNA staff members working with resident #4 on the days and shifts of the identified errors were called in to review the ADL Care Plan Flow Sheets and initial where they performed errors. Resident #11's Ambien order was discontinued on 07/19/2017.</p> <p>Other Residents:</p> <p>All residents in the facility have the potential to be effected by the deficient practices. A facility wide audit of resident ADL Care Plan Flow Sheets was conducted to identify other residents effected. In addition, a facility wide audit of Psychotropic Medication Consent Forms was conducted to identify any other effected residents. Corrections were made as necessary.</p> <p>Facility Systems:</p> <p>Beginning 10/01/2017, all Psychotropic Medication Consent Forms will be reviewed by the Medical Records department for accuracy after receipt of new orders. Consents noted to be out of compliance will be routed to the Behavior Care Nurse to be addressed promptly. LP</p>		

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F 514	<p>Continued From page 55</p> <p>should "write error, cross it out and initial." She also stated the CNAs have received training on how to enter the correct information when a documentation error has occurred.</p> <p>On 8/24/17 at 11:35 am, CNA #1 said if the documented information was not correct, she would initial it, cross it out, and enter the "right answer" and date.</p> <p>3. Resident #11 was admitted to the facility on 6/8/17 with multiple diagnoses including chronic insomnia.</p> <p>Resident #11's 6/15/17 MDS assessment documented moderate cognitive impairment and use of a hypnotic medication for the past for 7 days. His 8/1/17 significant change MDS assessment documented intact cognition and 6 days of hypnotic use.</p> <p>A sleep pattern disturbance care plan, originated 7/13/17, included an intervention for medications per physician orders.</p> <p>Resident #11's July 2017 Physician Order Report included a 6/8/17 order for Ambien every bedtime.</p> <p>A Telephone Order on 7/17/17 changed the Ambien from routine to "as needed". A Telephone Order 7/19/17 discontinued the Ambien altogether.</p> <p>Resident #11's medication administration record for July 2017 documented the Ambien was administered nightly from 7/1/17 to 7/16/17 and</p>	F 514	<p>will be in-serviced on F514 regulatory compliance and the facilities deficient practices on 09/27/2017. CNA staff will be in-serviced on the deficient practice by 09/28/2017 and educated on the correct way to chart an error on the ADL Care Plan Flow Sheets. The Medical Records Department will conduct regular audits of the CNA ADL Care Plan Flow Sheets to ensure continued compliance.</p> <p>Monitoring: Beginning the week of 10/01/2017, a weekly audit will be conducted by the Medical Records department verifying that resident Psychotropic Medication Consent Forms are completed accurately. In addition the Medical Records department will audit resident ADL Care Plan Flow Sheets weekly beginning 10/01/2017 to ensure compliance. This audit will continue weekly for one month, bi-weekly for two additional months and then monthly for two months. Results of these audits will be shared monthly at this facility's QAPI meeting. At the conclusion of the auditing process, based on the results of the audits, the QAPI committee will determine the need for and frequency of ongoing audits to maintain compliance with this regulation.</p>		

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F 514	<p>Continued From page 56 that "as needed" Ambien was not administered.</p> <p>A Psychotropic Medication Consent Form, dated 6/8/17, documented the resident did not consent to the use of Ambien.</p> <p>On 8/24/17 at 11:00 am, RN #1 was asked about the Ambien consent form. The RN reviewed the form then said the resident had been taking Ambien "for a long time" before he was admitted to the facility and the refusal on the consent form was an "error."</p> <p>On 8/25/17 at 1:00 pm, Resident #11 said Ambien was the "only thing that worked" and he was taking it when he came to the facility so "of course" he consented to Ambien.</p>	F 514		

Bureau of Facility Standards

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state relicensure survey conducted at the facility on August 21, 2017 to August 25, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Linda Kelly, RN Cecilia Stockdill, RN</p> <p>Abbreviations: RN = Registered Nurse</p>	C 000		
C 762	<p>02.200,02,c,ii When Average Census 60-89 Residents</p> <p>ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift.</p> <p>This Rule is not met as evidenced by: Based on review of a three-week nursing schedule and employee time records provided by the facility, it was determined the facility did not consistently meet the State requirement for Registered Nurse (RN) coverage on the day and the evening shift when the resident occupancy rate was between 60 and 89 residents. Inadequate RN coverage had the potential to</p>	C 762	<p>This Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because the provisions of the federal and state law</p>	10/18/17

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

TITLE

(X6) DATE

Electronically Signed

09/26/17

Bureau of Facility Standards

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C 762	<p>Continued From page 1</p> <p>negatively affect all residents living in the facility. Findings include:</p> <p>The three-week nursing schedule and time records for 7/30/17 through 8/19/17, documented there was no RN coverage on 3 day shifts as follows:</p> <ul style="list-style-type: none"> <li>* 7/30/17 when the resident census was 64;</li> <li>* 8/5/17 when the resident census was 65; and,</li> <li>* 8/6/17 when the resident census was 65.</li> </ul> <p>On 8/25/17 at 12:10 pm, the Human Resources Director said the day shift RN "called in" on 7/30/17, 8/5/17 and 8/6/17 and the facility could not find a replacement.</p> <p>On 8/25/17 at 3:00 pm, the Administrator said he knew there was insufficient RN coverage on the above 3 dates.</p>	C 762	<p>require it. This provider maintains that the alleged deficiencies do not individually, or collectively, jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of long term care facilities, and this Plan of Correction, in its entirety, constitutes this providers alleged compliance. Completion dates are provided for the procedural procession purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with requirements of participation or that corrective action was necessary.</p> <p>Resident Specific: All residents in the facility have the potential to be negatively affected by this deficient practice.</p> <p>Facility Systems: LP will be in-serviced by 09/27/2017 on the state requirements for RN coverage in skilled nursing facilities under C762. Effective immediately, the facility will maintain contracts with outside agencies to ensure the required daily RN coverage is consistently met. In addition, beginning October 1st 2017 the facility will implement a daily RN on call system to ensure that there is an RN available in the</p>	
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NAME OF PROVIDER OR SUPPLIER  <b>VALLEY VISTA CARE CENTER OF ST MARIES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 ELM STREET ST MARIES, ID 83861</b>
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(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) COMPLETE DATE
C 762	Continued From page 2	C 762	<p>event of an RN call off.</p> <p>Monitoring: Beginning the week of October 1st 2017, the NHA or designee will conduct weekly audits of the nursing schedule and RN on call system to ensure that daily RN coverage is scheduled appropriately. This audit will continue weekly for one month, bi-monthly for two additional months and then monthly for two months. Results of these audits will be shared monthly at this facility's QAPI meeting. At the conclusion of the auditing process, based on the results of the audits, the QAPI committee will determine the need for and frequency of ongoing audits to maintain compliance with this regulation.</p>	