



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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September 21, 2017

Jon Smith, Administrator
Caribou Memorial Living Center
300 South Third West
Soda Springs, ID 83276-1559

Provider #: 135060

Dear Mr. Smith:

On **September 7, 2017**, a survey was conducted at Caribou Memorial Living Ctr 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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 **October 2, 2017**. Failure to submit an acceptable PoC by **October 2, 2017**, may result in the imposition of penalties by **October 25, 2017**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 12, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 6, 2017**. A change in the seriousness of the deficiencies on **October 22, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **December 6, 2017** includes the following:

Denial of payment for new admissions effective **December 6, 2017**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 6, 2018**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 6, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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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 **October 2, 2017**. If your request for informal dispute resolution is received after **October 2, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

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

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

DS/lj
Enclosures

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

PRINTED: 11/29/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/07/2017
NAME OF PROVIDER OR SUPPLIER CARIBOU MEMORIAL LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH THIRD WEST SODA SPRINGS, ID 83276		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from September 5, 2017 to September 7, 2017. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Keitha Bevins, RN Survey Abbreviations: BIMS = Brief Interview for Mental Status CNA = Certified Nurse Assistant MAR = Medication Administration Record MDS = Minimum Data Set assessment MG = Milligram MCG = Microgram RN = Registered Nurse	F 000			
F 252 SS=B	SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CFR(s): 483.10(e)(2)(i)(1)(i)(ii) (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 252		10/12/17	

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

TITLE

(X6) DATE

Electronically Signed

09/29/2017

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

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F 252	<p>Continued From page 1</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, and staff interview, it was determined the facility failed to provide a homelike environment when hallway floors were discolored. This was true of portions for 3 of 3 hallway corridors and had the potential adversely affect residents' ability to enjoy a homelike environment. Findings include:</p> <p>On 9/5/17 at 4:20 pm, the hallway floors between rooms 201-205, 210-211, and 217, the housekeeping closet, were observed with large sections of white patches and/or white streaks on the brown faux wood laminate floor.</p> <p>On 9/5/17 at 4:30 pm, 8 of 10 residents in a group interview said they did not have a concern regarding the floor; 2 of the 10 residents said they were not concerned about the floor because they had been told it would be replaced.</p> <p>On 9/6/17 at 9:30 am, the Administrator said the floor was only four or five years old and the facility had made various attempts to fix it, including a refinish and seal, but the white patches reappeared. He said there were plans to replace the defective floor and the facility was currently in the bidding process.</p>	F 252	<p>Completion Date: 10/12/2017 Identification of Other Residents Potentially Affected: Discolored flooring runs down 3 of 3 hallways, all of which are discolored. This has the potential to affect all residents of the facility. The CEO, along with Hogan Construction, have secured a solid surface commercial grade hardwood flooring to be installed in each of the 3 of 3 corridors. This is part of our facility master planning and reconstruction/upgrade project that is currently in place. Approval by the Board of Directors took place 9/26/2017 with a tentative completion date of 12/1/2017 (Attachment #1). The CNO/designee will conduct an environmental round every week for three months to identify any problems related to flooring and homelike environment (Attachment #2). The CNO/designee will reassess the needed frequency of the environmental round after the three months.</p>		

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F 252	Continued From page 2	F 252		
F 315 SS=D	<p>On 9/7/17 at 9:35 am, Resident #5 said it "would be good if they can replace them."</p> <p>NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3)</p> <p>(e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the</p>	F 315		10/12/17

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F 315	<p>Continued From page 3</p> <p>facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review and staff interview, it was determined the facility failed to ensure physician orders provided a clinical indication of use for indwelling (Foley) urinary catheters. This was true for 2 of 10 residents (Residents #2 and #8) reviewed for indwelling urinary catheters and had the potential for harm if residents' urinary status deteriorated as a result of inappropriate use of a catheter. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 1/20/17 with diagnoses that included urinary tract infection (UTI), diabetes mellitus, and dementia.</p> <p>A quarterly Minimum Data Set assessment (MDS), dated 7/19/17, documented Resident #2 was cognitively intact, able to make her needs known, frequently incontinent, and had been diagnosed with a UTI within the previous 30 days.</p> <p>A handwritten Physician Order, dated 8/22/17, documented Resident #2 had an indwelling urinary (Foley) catheter. The order did not specify the size of the catheter, amount of saline required for the catheter's anchor balloon, provision of cares, change schedule, or the clinical diagnosis/rationale for providing Resident #2 with an indwelling urinary catheter.</p> <p>Printed Physician Orders for September 2017 did</p>	F 315	<p>Completion Date: 10/12/2017 Resident #2 Deceased 9/23/17 Resident #8 will be reassessed for the medical necessity of an indwelling catheter. Any pertinent assessment findings will be reported to the responsible party and attending physician. New physician orders will be obtained/clarified and noted. Care plan will be updated as applicable.</p> <p>Identification of Other Residents Potentially Affected: All residents have the potential to be affected. 1.) Upon admission and as indicated, a Urinary Incontinence Assessment will be done by the nursing manager/nursing designee (Attachment #3 #4 #5) to identify the medical necessity of an indwelling catheter. If a catheter is indicated, the appropriate order will be obtained: 1. Specific Size, 2. Specific Balloon Size, 3. Provision of Care, 4. Change Schedule, 5. Clinical Diagnosis/Rationale. 2.) CNO/designee will conduct an inservice 9/25/2017 (Attachment #6) with staff development training scheduled 10/7/2017 (Attachment #7). The CNO/designee will conduct a monthly QA on all admission UI assessments as well as PRN assessments and foley catheter orders to validate the completion and accuracy of the assessment as well</p>		

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F 315	<p>Continued From page 4 not document Resident #2 had a Foley catheter.</p> <p>Resident #2's care plan, dated 8/24/17, documented the indwelling urinary catheter was ordered for urinary retention.</p> <p>An 8/22/17 Nurse's Note documented Resident #2 personally requested the indwelling urinary catheter to address increased urinary output following a dosage increase of Lasix, a diuretic.</p> <p>2. Resident #8 was admitted to the facility on 8/4/16 with diagnoses that included femur fracture, chronic kidney disease, hypertension, and hypothyroidism.</p> <p>An annual MDS assessment, dated 6/28/17, documented Resident #8 was cognitively intact, did not have an active infection, and had an indwelling urinary (Foley) catheter.</p> <p>A handwritten Physician Order, dated 8/3/17, documented, " ...leave Foley in for now ..." The order did not include a diagnosis for the catheter, catheter size, and change schedule, nor did the resident's clinical record include a medical indication for the use of an indwelling urinary catheter.</p> <p>Printed Physician Orders for September 2017 documented staff was to change Resident #8's Foley catheter as needed per facility protocol.</p> <p>On 9/5/17 at 4:15 pm, Unit Manager #1 stated Foley catheter orders should contain a diagnosis for use and size of the catheter, but physicians treating residents at the facility had not included this information in the 18 months he had worked</p>	F 315	<p>as criteria met for a foley catheter order (Attachment #8). The CNO/designee will reassess the needed frequency of the QA after six months.</p>		

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F 315	Continued From page 5 at the facility.	F 315			
F 323 SS=D	<p>The facility's Nursing Verification of Orders policy, dated 7/24/11, documented, "... incomplete orders which are not verified will result in follow-up by the nurse manager, supervisor or clinical coordinator ..."</p> <p>FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3)</p> <p>(d) Accidents. The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:</p>	F 323		10/12/17	

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F 323	<p>Continued From page 6</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure 3 Certified Nurse Aides (CNA #1, #2, and #3) and 1 Registered Nurse (RN) #1 transferred residents as physician ordered and via the correct use of a gait belt. This was true for 2 of 2 residents reviewed for transfers (Residents #7 and #8) and had the potential for harm if residents were injured during improper transfers. In addition, it was determined the facility failed to ensure the environment was free of potential hazards in resident rooms for 1 of 10 residents whose rooms were reviewed for environmental safety. This had the potential for harm should residents become injured from unsafe conditions. Findings include:</p> <p>1. Resident #7 was admitted to the facility on 12/1/14 with diagnoses that included hemiplegia, convulsions, and edema.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 7/5/17, documented Resident #7 experienced severe cognitive impairment, was inattentive, was rarely understood, required extensive staff assistance with transfers, and did not have full use of one lower extremity.</p> <p>Physician Orders for September 2017 documented staff was to transfer Resident #7 by use of a mechanical lift.</p> <p>Resident #7's care plan, dated 7/20/17, documented 2 staff were to assist Resident #7 transfer with a mechanical lift.</p> <p>On 9/5/17 at 7:32 am, CNA #3, RN #1 and a Unit Manager were observed transferring Resident #7</p>	F 323	<p>Completion Date: 10/12/2017 Resident #7 Deceased 9/23/17 Resident #8 will be reassessed for the need of a mechanical lift. Any pertinent assessment findings will be reported to the responsible party and attending physician. New physician orders will be obtained/clarified and noted (Attachment #9). Care plan will be updated as applicable (Attachment #10). Resident #1 had oxygen cylinder immediately removed from the room when found by state surveyors. Both family and resident were educated on the importance of securing an oxygen tank and checking in with facility management when bringing in personal medical equipment so we can ensure the safety of the resident. Identification of Other Residents Potentially Affected: All residents have the potential to be affected. 1.) The CNO/designee will conduct a sweep of all resident orders to ensure that orders for the use of a mechanical lift and care plan are updated (Attachment #11). 2.) The CNO/designee will conduct a sweep of facility to ensure that there are no oxygen cylinders that are not secured in a pull cart or oxygen storage cart (Attachment #12). 3.) Admission agreement has been updated to include the statement that all personal medical equipment must be checked in upon the item's arrival (Attachment #13). 4.) CNO/designee will conduct an inservice 9/25/2017 (Attachment #6) with staff development training scheduled 10/7/2017 (Attachment</p>		

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F 323	<p>Continued From page 7</p> <p>from a wheelchair to a recliner using a gait belt. The Unit Manager held onto the gait belt while CNA #3 and RN #1 placed their arms in a hooking motion under Resident #7's armpits during the transfer.</p> <p>On 9/5/17 at 3:56 pm, CNA #3 stated she was not aware Resident #7 should not be transferred in this manner, nor that she should not have hooked her arm under the resident's armpits while performing a transfer with a gait belt.</p> <p>Neither CNA #3 nor CNA #4 explained why they transferred Resident #7 with a gait belt rather than a Hoyer mechanical lift as ordered by the physician and directed by the resident's care plan.</p> <p>On 9/5/17 at 3:58 pm, RN #1 stated she knew she should not have placed her arm under Resident #7's armpit during a gait belt assisted transfer. RN #1 said Resident #7 normally transferred with a mechanical lift.</p> <p>2. Resident #8 was admitted to the facility on 8/4/16 with diagnoses that included fracture of the left femur, chronic kidney disease, and hypertension.</p> <p>A quarterly MDS assessment documented Resident #8 experienced moderate cognitive impairment, was able to make her needs known, and required extensive staff assistance with transfers.</p> <p>September 2017 Physician Orders directed staff to use a Hoyer mechanical lift when transferring Resident #8.</p>	F 323	<p>#7).</p> <p>The CNO/designee will conduct an environmental round every week for three months to identify any problems related to unsecured oxygen cylinders (Attachment #2). The CNO/designee will conduct a monthly QA for three months on 15 random lifts to validate that the transfer was done according to policy and care plan. This is to include a sample from day/evening/night shift and certified/licensed staff (Attachment #14). The CNO/designee will reassess the needed frequency of the QA after three months.</p>		

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F 323	<p>Continued From page 8</p> <p>Resident #8's care plan, dated 7/6/17, documented 2 staff using a gait belt were required for all transfers.</p> <p>On 9/6/17 at 7:32 am, CNA #1 and CNA #2 were observed placing one arm each under Resident #8's armpits and one hand each on a gait belt while transferring Resident #8 from a shower chair to a wheelchair.</p> <p>On 9/6/17 at 7:35 am, CNA #2 stated she should not have placed her arm under the resident's armpit for the transfer and that instead she should have asked for additional staff assistance.</p> <p>On 9/6/17 at 8:12 am, CNA #1 stated she should have not placed her arm under Resident #8's armpit to transfer the resident from the shower chair to the wheelchair.</p> <p>The facility's Skills-Transferring the Person to a Chair or Wheelchair policy, dated 4/8/11, documented, "... grasp the transfer belt at both sides and if no gait belt is used place your hands under the arms with your hands around the person's shoulder blades ..."</p> <p>3. Resident #1 was admitted to the facility on 1/5/17 with diagnoses that included Methicillin Resistant Staphylococcus Aureus (MRSA) infection and Multiple Sclerosis.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 6/21/17, documented Resident #1 was cognitively intact.</p> <p>On 9/5/17 at 1:50 pm and 3:35 pm, Resident #1's</p>	F 323			

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F 323	Continued From page 9 room was observed with an unsecured oxygen cylinder in front of the bed near cabinets. On 9/6/17 at 10:15 pm and 3:35 pm, Resident #1's room was observed with an unsecured oxygen cylinder in front of the bed near cabinets. On 9/6/17 at 10:20 am, a Unit Manager was informed of the observation and he immediately removed the oxygen cylinder and secured it in a locked oxygen filling room. The Unit Manager stated oxygen cylinders should not be stored unsecured in a resident's room, and noted Resident #1 did not use a portable oxygen cylinder. The cylinder's gauge was at the 2000/150 pressure per square inch (psi) mark. On 9/6/17 at 10:30 am, Registered Nurse (RN) #1 stated she had not noticed the unsecured oxygen cylinder in Resident #1's room during her earlier rounds. On 9/6/17 at 1:11 pm, the Administrator stated oxygen cylinders should be secured in a four point restraint or with a bungie cord, and should not be left in a free standing position. The facility's Respiratory Therapy-Oxygen Storage policy, dated 7/11/12, documented "...individual [oxygen] tanks are placed in pull carts for patient use and at no time are the tanks to be left outside of the cart or pull carts ..."	F 323			
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1) (f) Medication Errors. The facility must ensure that its-	F 332		10/12/17	

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F 332	<p>Continued From page 10</p> <p>(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure medications were administered per physician order and standard of practice. This was true for 1 resident (#11) observed during the administration of 30 medications to various residents during medication pass and had the potential for harm should residents receive the wrong medication from an unlabeled container or at the wrong time. Findings include:</p> <p>1. Resident #11 was admitted to the facility on 12/1/14 with diagnoses that included heart failure, hypertension, pain, and hypothyroidism.</p> <p>Resident #11's Physician Orders for September 2017 documented staff was to administer Levothyroxine 50 mcg (micrograms) once a day and Aspirin 81 mg (milligrams) daily.</p> <p>The Nursing 2016 Drug Handbook documented Levothyroxine should be administered "at [the] same time each day on an empty stomach, preferably [one-half hour] to 1 hour before breakfast." The facility's posted time for breakfast was from 7:30 am to 9:00 am.</p> <p>On 9/6/17 at 8:00 am, Registered Nurse (RN) #1 was observed crushing one Levothyroxine 50 mcg tablet and one Aspirin 81 mg tablet, mixing the medications with applesauce, and then placing the unlabeled container of medications and applesauce into the medication cart when</p>	F 332	<p>Completion Date: 10/12/2017 Resident #11 was immediately assessed for any signs/symptoms of adverse reactions related to receiving late medication. There were no significant findings and assessment was given to provider who indicated there was no need for further assessment at this time. Identification of Other Residents Potentially Affected: All residents have the potential to be affected. 1.) Interdisciplinary group to meet 10/2/2017 to update facility wide medication administration policy. 2.) Practice change: CNA will check with nursing prior to taking residents into meals to make sure that proper medication administration is completed. 3.) CNO/designee will conduct an inservice 9/25/2017 (Attachment #15) with staff development training scheduled 10/7/2017 (Attachment #7). The CNO/designee will conduct a medication administration observation QA weekly x 3 months then monthly on each shift for six months to identify any problems related to medication administration (Attachment #16). The CNO/designee will reassess the needed frequency of the QA after nine months.</p>		

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F 332	Continued From page 11 Resident 11 was in the dining room for breakfast and not available for administration. On 9/6/17 at 8:22 am, Unit Manager #1 stated any medication dispensed and mixed with applesauce should be administered immediately and discarded if there is a delay between preparation and administration. On 9/6/17 at 3:25 pm, RN #1 stated she felt it was acceptable to store prepared medications that had been labeled. The facility's Medication Administration policy, dated 7/24/11, documented, "... medication would be prepared immediately prior to administration and if a medication has been opened and is refused by a resident it is to be destroyed. This applies to medications held because of nurse discretion ..."	F 332			
F 441 SS=E	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment	F 441		10/12/17	

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F 441	Continued From page 12 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 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 441			

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F 441	<p>Continued From page 13</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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to prevent indwelling (Foley) catheter tubing and collection bags from coming into contact with the ground. This was true for 2 of 3 residents (Resident #2 and #8) and had the potential for harm if residents developed infections from inadequate infection control practices. Additionally, it was determined the facility failed to practice universal precautions to prevent the spread of infection while providing pericare. This was true for 1 of 11 residents (Resident #4) reviewed for infection control practices. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 1/20/17 with diagnoses that included urinary tract infection (UTI), diabetes mellitus, and dementia.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 7/19/17, documented Resident #2 was cognitively intact and had contracted a UTI within the previous 30 days.</p> <p>On 9/5/17 at 3:42 pm, Resident #2 was observed</p>	F 441	<p>Completion Date: 10/12/2017 Resident #2 Deceased 9/23/2017 Resident #8 was assessed for signs/symptoms of a urinary tract infection with no significant findings related to catheter tubing being placed on the floor. The catheter tubing was placed in a privacy bag and has been lifted off the floor. Resident #4 was assessed for signs/symptoms of infection related to CNA's not performing hand hygiene after peri-care then readjusting nasal cannula and using mechanical lift. No significant findings were related to inappropriate practice. Identification of Other Residents Potentially Affected: All residents have the potential to be affected. 1.) PDI Super Sani Cloth Germicidal Disposable Wipes (individual packets) were ordered for CNA use on equipment prior to taking equipment out of residents' room (Attachment #17). 2.) Urinary catheter bags were ordered for use with</p>		

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F 441	<p>Continued From page 14</p> <p>with her Foley catheter collection bag and tubing on the floor under her wheelchair in the dining room.</p> <p>On 9/5/17 at 4:37 pm, Resident #2's Foley catheter collection bag and tubing was observed on the floor under her wheelchair in the activity room.</p> <p>On 9/6/17 at 8:08 am, a Unit Manager stated Foley catheter bags, dignity bags and tubing should not be on the floor.</p> <p>2. Resident #8 was admitted to the facility on 8/4/16 with diagnoses that included femur fracture, chronic kidney disease, hypertension, and hypothyroidism.</p> <p>An annual MDS assessment, dated 6/28/17, documented Resident #8 was able to understand others and make her needs known, was diagnosed with a UTI, and had a history of UTIs.</p> <p>On 9/6/17 at 7:40 am, Resident #8 was observed being assisted by staff down a hallway in a wheelchair with a Foley catheter collection bag and tubing dragging along the floor.</p> <p>On 9/7/17 at 9:48 am, Resident #8 was observed sleeping in a recliner in her room with the Foley catheter collection bag within a privacy covering, and tubing, on the floor under the foot rest of the recliner.</p> <p>The facility's Nursing-Acute Care-Foley Catheters policy, dated 7/22/11, documented, "... do not rest the [urinary collection] bag on the floor ..."</p>	F 441	<p>wheelchairs to secure the catheter tubing off the floor. (Attachment #18). 3.) Rings were secured to recliners to clip the catheter tubing in order to secure tubing off the floor. 4.) CAUTI policy developed along with CAUTI process map (Attachment #19, #20). 5.) CNO/designee will conduct an inservice 9/25/2017 (Attachment #6) with staff development training scheduled 10/7/2017 (Attachment #7).</p> <p>The CNO/designee will conduct a monthly QA weekly for three months on fifteen random staff members to validate proper hand hygiene and disinfection of medical equipment. This is to include a sample from day/evening/night shift and certified/licensed staff (Attachment #21). The CNO/designee will conduct a monthly QA for three months on fifteen random staff members to validate proper infection control practice in relation to catheter tubing according to policy/protocol. This is to include a sample from day/evening/night shift and certified/licensed staff (Attachment #22). The CNO/designee will reassess the needed frequency of the QA after three months.</p>		

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F 441	Continued From page 15 3. The facility's Hand Hygiene and Management of Clean Equipment policies documented that after performing pericare, staff were to remove their gloves and wash their hands or use alcohol-based hand sanitizer when hands were not visibly soiled, and equipment shared between residents should be disinfected between each use. On 8/6/17 at 9:40 am, Certified Nurse Assistants (CNA) #3 and #4 were observed transferring Resident #4 from a wheelchair to a bed via mechanical lift. Both CNAs wore disposable gloves during the transfer, while performing pericare for the resident, and as they placed a new adult incontinent brief on the resident. CNA #3 and CNA #4 then removed their gloves and without first washing or sanitizing their hands, the CNAs repositioned the mechanical lift, placed the lift's sling around Resident #4, and transferred the resident back into the wheelchair. CNA #4 then assisted Resident #4 adjust her oxygen nasal cannula, gripped the wheelchair handles, assisted the resident from the room, and then used a wall mounted dispenser to sanitize her hands in the hallway outside the resident's room. CNA #3 repositioned the Hoyer mechanical lift to allow CNA #4 space to assist Resident #4 from the room and then used the hand sanitizer dispenser attached to the wall just inside the room door. CNA #3 then changed places with CNA #4 and pushed the resident in the wheelchair down the hallway and into the facility dayroom. CNA #4 moved the mechanical lift down the hallway, where she placed it in a storage space and left the area.	F 441			

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F 441	<p>Continued From page 16</p> <p>On 8/6/17 at 9:50 am, CNA #3 said neither she nor CNA #4 washed their hands or used hand sanitizer after performing pericare and prior to handling the mechanical lift.</p> <p>On 8/6/17 at 9:52 am, CNA #4 said neither she nor CNA #3 washed their hands or used hand sanitizer after performing pericare and prior to handling the resident's oxygen tubing or wheelchair handles. She said she did not disinfect the mechanical lift because "night shift cleans them."</p> <p>On 9/7/17 at 2:10 pm, the Long Term Care Manager said he expected staff to perform hand hygiene after pericare and before touching any other surface or person. The LTC Manager stated mechanical lifts should be cleaned with a disinfectant cloth after each use as night shift staff "deep cleaned" the mechanical lifts each night.</p>	F 441			