



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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September 22, 2017

Jeff Corriher, Administrator
Kindred Nursing And Rehabilitation-- Nampa
404 North Horton Street
Nampa, ID 83651-6541

Provider #: 135019

Dear Mr. Corriher:

On **September 7, 2017**, a survey was conducted at Kindred Nursing And Rehabilitation - Nampa 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 a widespread deficiency 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

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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 cursive script that reads "Nina Sanderson (L.S.W.)".

Nina Sanderson, L.S.W, Supervisor
Long Term Care

NS/lj
Enclosures

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

PRINTED: 11/02/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/07/2017
NAME OF PROVIDER OR SUPPLIER ORCHARDS OF CASCADIA, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 404 NORTH HORTON STREET NAMPA, ID 83651		
(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 September 5, 2017 to September 7, 2017. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Linda Kelly, RN Cecilia Stockdill, RN Ann Monhollen, RN Abbreviations: ADLs = Activities of Daily Living CBC = Complete Blood Count CT = Computed Tomography scan DNS = Director of Nursing Services GERD = Gastroesophageal Reflux Disease I&A = Incident and Accident MAR = Medication Administration Record MDS = Minimum Data Set mg = Milligram Neuro = Neurological NPO = Nothing by mouth NOC = night OT = Occupational Therapy PHI = Personal Health Information PT = Physical Therapy RNA = Restorative Nursing Assistant RN = Registered Nurse ST = Speech Therapist	F 000			
F 156 SS=E	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary	F 156		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 156	<p>Continued From page 1 care professionals responsible for his or her care.</p> <p>§483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.</p> <p>(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:</p> <p>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -</p> <p>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;</p> <p>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.</p> <p>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit;</p>	F 156			

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F 156	Continued From page 2 and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)]	F 156			

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F 156	<p>Continued From page 3</p> <p>(v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.</p> <p>(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:</p> <p>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and</p> <p>(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the</p>	F 156			

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F 156	<p>Continued From page 4</p> <p>advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.</p> <p>(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.</p> <p>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.</p> <p>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.</p> <p>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;</p> <p>(g)(17) The facility must--</p> <p>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-</p> <p>(A) The items and services that are included in</p>	F 156			

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F 156	<p>Continued From page 5</p> <p>nursing facility services under the State plan and for which the resident may not be charged;</p> <p>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and</p> <p>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section.</p> <p>(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually</p>	F 156			

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F 156	<p>Continued From page 6</p> <p>resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on document review and staff interview, it was determined the facility failed to ensure residents were provided notice prior to changes in facility charges, and that residents' private information was protected. This was true for all residents in the facility who signed the Admission Agreement dated 01/2017. This failed practice had the potential for harm if residents had undue financial worry should the facility increase their rates, or their private information was shared inappropriately. Findings include:</p> <p>a. Page 6, section iv of the 01/2017 Admission Agreement documented "If a change in the Resident's level of care warrants an increase or decrease in the daily rate to reflect the Resident's new level of care, the Center may adjust the daily rate without prior notice. Any rate adjustment shall be considered as agreed to by the parties on the date the notice is mailed."</p> <p>On 9/7/17 at 3:15 pm, Administrative Staff #1 said the facility gives a 30 day notice to the</p>	F 156	<p>F156 Resident Specific The interdisciplinary (ID) team review residents admitted after January 1, 2017 and who still reside in the facility. These residents and/or responsible party were provided a copy of the revised Cascadia admission agreement.</p> <p>Other Residents The admission agreement is updated for use with admission after October 1, 2017 Adjustments have been made as indicated.</p> <p>Facility Systems The admissions coordinator and admission staff are educated to completing an admission agreement with resident entry to the center. Re-education and an updated admission agreement</p>		

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F 156	<p>Continued From page 7</p> <p>Resident if the daily room rate changes, and acknowledged that the resident should be informed prior to any changes in room rates.</p> <p>On 9/7/17 at 7:23 pm, the Administrator said there is only one room rate, it's a "flat rate" and the rate won't change. When asked about the section of the Admission Agreement that documents the Center may adjust the daily rate without prior notice, the Administrator said it was probably referring to a situation such as if the Resident moves to Assisted Living, then it would be under a different rate.</p> <p>b. Page 3, Attachment D of the 01/2017 Admission Agreement documented that "with few exceptions" the facility may use resident Personal Health Information (PHI) for marketing purposes and may sell PHI. The agreement also documented that the facility may use "limited" health information to contact residents for fundraising efforts, unless the resident exercised "one of the opt out methods we provide." There was no documentation regarding the exceptions where the facility may sell the Resident's health information without written authorization. The agreement did not describe the "opt out" methods for fundraising, specify which private information would be used for those efforts, or state whether the resident could still be admitted to the facility if they chose to "opt out."</p> <p>On 9/7/17 at 3:15 pm, Administrative Staff #1 was asked about the exceptions where the facility may sell the Resident's health information without written authorization. Said she could not answer the question.</p>	F 156	<p>was provided by the Executive Director to include but not limited to, notice of rate changes and privacy of information. The system is amended to include an updated admission agreement template for use after October 1, 2017.</p> <p>Monitor The Executive Director (ED) and/or designee will audit 2 admissions for use of the updated admission agreement weekly for 8 weeks. Starting the week of October 9 the, 2017 review will be documented on the performance improvement (PI) audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance October 12, 2017</p>		

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F 156	Continued From page 8 On 9/7/17 at 7:23 pm, the Administrator said he thought it was an oversight that the Admission Agreement contained this information.	F 156			
F 202 SS=D	483.15(c)(2)(ii) DOCUMENTATION FOR TRANSFER/DISCHARGE OF RES (c)(2) Documentation. (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- [483.15(c)(2)(i) will be implemented beginning November 28, 2017 (Phase 2)] (A) The resident's physician when transfer or discharge is necessary under paragraph 483.15(c)(1)(A) or (B) of this and (B) A physician when transfer or discharge is necessary under paragraph 483.15(c)(1)(i)(C) or (D). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the physician documented the necessity for discharge, or that resident information was made available to the receiving provider to ensure continuity of care. This was true for 1 of 2 discharged residents (#15) sampled. The deficient practice created the potential for harm if the resident's receiving caregivers were unaware of clinical or care needs. Findings include: Resident #15 was admitted on 6/27/13 with diagnoses including unspecified osteoarthritis, atrial fibrillation (irregular heartbeat), major depressive disorder, osteoporosis, muscle weakness, long term use of anticoagulants	F 202	F202 Resident Specific Resident #15 has discharged from the facility. Other Residents The clinical management team reviewed other residents with potential or imminent discharge for complete discharge planning documentation. Adjustments have been made as indicated. Facility Systems Social service staff and licensed nurses	10/12/17	

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F 202	<p>Continued From page 9 (blood thinners), and asthma.</p> <p>The 6/15/17 quarterly MDS (Minimum Data Set) assessment documented moderate cognitive impairment, presence of anxiety and depression, use of a wheelchair, and occasional bowel incontinence.</p> <p>The resident's 8/8/17 physician's Compliance Visit/Progress Note documented the resident had a fracture of a large bone spur in the left heel and generalized weakness that, "makes the patient require long-term care..."Restorative therapy and/or occupational therapy services were to continue. The note also documented the resident "will remain in our facility for long-term care and will need followup with orthopedics or podiatry..."</p> <p>Resident #15's interdisciplinary Progress Notes from 6/1/17 at 10:14 am through 8/30/17 at 8:15 am did not document a plan for the resident to discharge, or that the resident was discharged or transferred from the facility.</p> <p>Resident #15's clinical record did not include a physician's order to discharge the resident.</p> <p>On 9/1/17, a discharge MDS assessment for Resident #15 documented the resident had discharged from the facility and was not anticipated to return.</p> <p>On 9/7/17 at 2:50 pm, the DNS (Director of Nursing Services) said the resident went to a memory care unit at another facility, and she would look for additional documentation regarding the resident's discharge from the facility. No additional documentation was</p>	F 202	<p>are educated to discharge planning. Re-education was provided by the Staff Development Coordinator (SDC) and/or the Director of Nursing (DON)to include but not limited to, documentation of the request and receipt of an MD order for discharge, communication with community provider, equipment needs, planned discharge summary with signature and date, and progress note upon leaving the center. The system is amended to include review discharge documentation in clinical meeting prior to and post resident discharge.</p> <p>Monitor The medical records clerk and/or designee will audit 2 discharges for complete discharge documentation weekly for 8 weeks. Starting the week of October 9, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance October 12, 2017</p>		

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F 202	Continued From page 10 provided by the facility.	F 202			
F 281 SS=D	<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, review of Fall Investigation Reports, Incident and Accident Reports [I&As], and resident records, it was determined the facility failed to ensure the neurological (neuro) status of residents was assessed after unwitnessed falls. This was true for 1 of 2 residents (#5) sampled for falls. The deficient practice created the potential for harm if changes in residents' neuro status occurred. Findings include:</p> <p>Resident #5 was admitted on 3/26/16 and was readmitted on 4/28/17 and 7/22/17 with diagnoses including a history of falling.</p> <p>Resident #5's 5/5/17 annual and 8/2/17 quarterly MDS (Minimum Data Set) assessments documented severe cognitive impairment, extensive assistance required with bed mobility and transfers, and use of a wheelchair.</p> <p>On 4/29/17 at 4:30 am, Resident #5's Post Fall Investigation form documented the resident had an unwitnessed fall in her room. The resident was found crawling on the floor on her hands and</p>	F 281	<p>F281 Resident Specific Resident #5 has discharged from the facility.</p> <p>Other Residents The ID team clinical management team reviewed other residents for unwitnessed falls without neurological assessment that occurred in post survey. Resident's identified as having incomplete neurological assessment post unwitnessed fall were assessed for current neurological status and the physician updated. No adverse findings were identified.</p> <p>Facility Systems Licensed nurse are educated to post fall assessment. Re-education was provided by the SDC and/or DON to include but not limited to, documentation of complete neurological assessment post</p>	10/12/17	

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F 281	Continued From page 11 knees. On 4/29/17 at 10:35 pm, Resident #5's Progress Note documented the resident was found "half off the bed" with her knees in contact with the blue protective mat. There were no documented neuro checks after the two falls on 4/29/17. On 5/11/17 at 4:45 am a Post Fall Investigation form documented Resident #5 had an unwitnessed fall in her room. The resident was found "Lying on [a] padded mat in [the] fetal position on right side..." Resident #5's Neurological Record form, dated 5/11 and 5/12/17, was blank at multiple time points in the areas of Pupil Response, Eye Response, Level of Consciousness, Speech, and Motor Response. The entire neuro check section of the 5/12, 5/13, and 5/14/17 Neurological Record was blank. On 9/6/17 at 3:30 pm, the resident was asleep in her bed with the bed in low position and blue fall mat on the floor next to her bed. On 9/7/17 at 2:40 pm, the DNS said the neuro checks should have been completed and documented.	F 281	unwitnessed falls. The system is amended to include review of neurological assessment documentation in the clinical meeting for residents post fall through completion. Monitor The DON and/or designee will audit resident's post unwitnessed falls for neurological assessment weekly for 8 weeks. Starting the week of October 9, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance October 12, 2017		
F 284 SS=D	483.21(c)(1)(2)(iv) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN (c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the	F 284		10/12/17	

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F 284	<p>Continued From page 12</p> <p>reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-</p> <p>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.</p> <p>(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.</p> <p>(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.</p> <p>(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.</p> <p>(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.</p> <p>(vi) Address the resident's goals of care and treatment preferences.</p> <p>(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.</p> <p>(A) If the resident indicates an interest in</p>	F 284			

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F 284	<p>Continued From page 13</p> <p>returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.</p> <p>(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.</p> <p>(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.</p> <p>(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.</p> <p>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's</p>	F 284			

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F 284	<p>Continued From page 14 discharge or transfer.</p> <p>(c)(2) Discharge Summary</p> <p>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:</p> <p>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to develop and implement resident discharge plans. This was true for 2 of 2 sampled resident's (#14 and #15) reviewed for discharge from the facility. This failure created the potential for harm when the residents' discharge goals and participation was not included in the discharge process, which could result in a preventable readmission or an interruption in the continuity of care. Findings include:</p> <p>The facility's policy and procedure for Discharge Plan, dated 4/28/09, documented, "The resident and interdisciplinary team set goals that the resident is capable of accomplishing prior to discharge from the center. The discharge plan is incorporated into the initial plan of care and the</p>	F 284	<p>F284 Resident Specific Resident #s 14 and 15 have discharged from the facility.</p> <p>Other Residents See F202</p> <p>Facility Systems See F202</p> <p>Monitor See F202</p>		

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F 284	<p>Continued From page 15</p> <p>comprehensive plan of care. The Ready to Go Plan is a method of discharge planning." The facility's procedure for a resident discharge included the nurse or social worker to meet with the resident to discuss any questions or concerns prior to discharge and provide the resident with contact information that may be included in discharge planning, such as home health services, resident's health condition, medications, medical equipment, physician appointments, support groups, and a summary of resident's current health status upon discharge.</p> <p>1. Resident #14 was admitted to the facility on 5/5/17 and was discharged on 6/15/17 with multiple diagnoses, including a hip fracture and pelvis fractures.</p> <p>A Nurse's Notes, dated 6/15/17 at 10:33 am, documented Resident #14 was discharged with a family member, ambulated with a front wheeled walker, narcotics were sent with the resident, and "all the paperwork was signed." The Nurse's Notes did not document where the discharge location or what services were needed.</p> <p>A Home Evaluation form for Resident #14, dated 6/9/17, documented recommendation for a safe discharge for the resident included PT [Physical Therapy] and OT [Occupational Therapy] at home.</p> <p>Resident #14's record did not include a physician's order for discharge, follow-up therapy services,. There was no documentation the recommended follow-up services were offered or arranged for the resident, or that the resident declined the services.</p>	F 284	Date of Compliance October 12, 2017		

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F 284	<p>Continued From page 16</p> <p>A Planned Discharged Summary, dated 6/14/17 at 6:21 pm, contained an area to check where Resident #14 was discharging, what equipment needed for transfers, who accompanied Resident #14, and what referral services were needed for Resident #14. The Planned Discharge Summary form included an area to check reason for discharge, medication reconciliation with Resident #14 prior to discharge, and Resident #14 was to sign, date, and time of discharge with the original to be left in the clinical record. The areas were not checked and the signature was left blank.</p> <p>On 9/7/17 at 4:30 pm, the Social Services Assistant said the discharge summary should have been completed by a nurse and reviewed with Resident #14, with both signing the form. The Social Services Assistant stated a copy of the form should have been sent with Resident #14, and the original placed in the resident's clinical record. The Social Services Assistant confirmed the Planned Discharge Summary was incomplete and was unable to verify the medication list was reviewed, any medications needed to be ordered, or if a copy of the medication list was part of the "paperwork " that was sent home with Resident #14. The Social Services Assistant said Resident #14 discharged home without home health services because his son was a Physical Therapist, but was unable to provide documentation for the discharge plan of care for Resident #14.</p> <p>2. Resident #15 was admitted on 6/27/13 with diagnoses including unspecified osteoarthritis, atrial fibrillation (irregular heartbeat), major depressive disorder, osteoporosis, muscle</p>	F 284			

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F 284	<p>Continued From page 17</p> <p>weakness, fracture of one rib, long term use of anticoagulants (blood thinners), disease of the esophagus, and asthma.</p> <p>The 6/15/17 quarterly MDS (Minimum Data Set) assessment documented moderate cognitive impairment, presence of anxiety and depression, use of a wheelchair, and occasional bowel incontinence.</p> <p>A 6/27/17 Compliance Visit note documented the resident had swelling, bruising, and tenderness to her left foot. The resident reported the symptoms occurred after hitting her foot on a metal piece under her bed. The resident continued to need assistance with mobility and ADLs (activities of daily living), and an x-ray of her left foot was initiated.</p> <p>On 8/8/17, Resident #15's physician's progress notes documented the resident had a fracture of a large bone spur in the left heel, and generalized weakness that "makes the patient require long-term care." The note also documented the resident "will remain in our facility for long-term care and will need followup with orthopedics or podiatry..."</p> <p>Resident #15's interdisciplinary progress notes between 6/1/17 through 8/30/17 did not document the resident was discharged or transferred from the facility, and no discharge summary or planning were documented.</p> <p>Resident #15's record did not contain an order to discharge from the facility.</p> <p>On 9/1/17, a discharge MDS assessment for</p>	F 284			

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F 284	Continued From page 18 Resident #15 documented the resident had discharged from the facility and was not anticipated to return. The 9/5/17 Stand-Up Meeting form, "Previous Days Discharges," documented the resident was discharged from the facility on 9/1/17. On 9/7/17 at 2:50 pm, the DNS (Director of Nursing Services) said the resident went to memory care at another facility and she would contact the Social Worker to obtain discharge summaries for the resident. The facility provided no additional information.	F 284			
F 310 SS=D	483.24(a)(b) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE (a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: (1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section, ... (b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 310		10/12/17	

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F 310	<p>Continued From page 19</p> <p>(1) Hygiene -bathing, dressing, grooming, and oral care,</p> <p>(2) Mobility-transfer and ambulation, including walking,</p> <p>(3) Elimination-toileting,</p> <p>(4) Dining-eating, including meals and snacks,</p> <p>(5) Communication, including</p> <p>(i) Speech,</p> <p>(ii) Language,</p> <p>(iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record and policy review and staff interview, it was determined the facility failed to ensure care and services were provided to maintain residents' eating abilities. This was true for 1 of 9 residents (#2) sampled for Activities of Daily Living (ADL) maintenance. This deficient practice created the potential for harm when the resident was not appropriately assisted or cued during meals. Findings include:</p> <p>Resident #2 was admitted on 12/12/14 with diagnoses including convulsions, hypertension (high blood pressure), cerebral infarct (stroke), hemiplegia (weakness on one side of the body), and difficulty eating.</p> <p>The 4/25/17 quarterly and 7/25/17 quarterly MDS (Minimum Data Set) assessments documented Resident #2 was cognitively intact and required</p>	F 310	<p>F310 Resident Specific The clinical management team assessed resident #2 for appropriate dining assistance and support. The care plan was updated as indicated. Observation shows staff assistance is provided for restorative dining residents as indicated.</p> <p>Other Residents The clinical management team reviewed other residents for dining assistance needs. Observation shows staff assistance is provided for restorative dining residents as indicated.</p> <p>Facility Systems</p>		

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F 310	<p>Continued From page 20</p> <p>"supervision-oversight, encouragement or cueing" for eating.</p> <p>Resident #2's nutritional decline care plan documented RNA (Restorative Nursing Assistant) dining interventions were initiated on 1/27/17. Care planned interventions included physically and/or verbally cueing the resident, reminding the resident to swallow and take small bites and small sips.</p> <p>The facility's Restorative Dining Policy, Release Date 09/27/2016, documented, "Maintenance and restorative dining programs are provided that contributes [sic] to the resident achieving and maintaining their highest practicable outcome in their ability to eat and drink by mouth."</p> <p>The Speech Therapy (ST) Plan Of Care, dated 10/3/2016, documented the resident was referred to speech therapy due to a choking episode that required evaluation in the emergency room.</p> <p>Resident #2's "Swallowing Instructions" documented the resident was to eat small bites at a slow pace, needed to alternate liquids with solids, needed encouragement to swallow twice after each bite, and needed cues to stay awake while eating for safety.</p> <p>The 6/27/2017 ST Progress & Discharge Summary documented the resident was at risk for aspiration (food or liquids going into the lungs) and to continue restorative dining assistance.</p> <p>Resident #2 was observed at a restorative dining table on 9/6/17 from 8:57 am through 9:13 am. Staff members brought a container of milk and</p>	F 310	<p>Nursing staff are educated to the restorative nursing program. Re-education was provided by the SDC and/or DON to include but not limited to, use of the tray card system to communicate restorative eating needs, reassignment of staff when restorative nursing assistant (RNA) is not available, and process to update the eating directives when indicated. The system is amended to include licensed nurse oversight responsibility for restorative dining.</p> <p>Monitor The DON and/or designee will observe restorative dining needs assistance 3 times weekly for 8 weeks. Starting the week of October 9, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p>Date of Compliance October 12, 2017</p>		

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F 310	Continued From page 21 poured most of it over the resident's cereal. No other liquids were on the table. No RNA staff were present and no other staff members cued the resident at any time during all the observed meals. The resident fed herself several bites of cereal in a row without taking a drink. She did not consistently swallow between bites. On 9/7/17 at 8:55 am, Resident #2 was sitting at the restorative table in the dining room. CNA (Certified Nursing Assistant) #3 served the resident's breakfast tray, but there were no staff cueing or assisting residents at the restorative table. CNA #3 said there was supposed to be RNA staff present, but he did not know where they were. On 9/7/17 at 9:28 am, CNA #2 said there was supposed to be RNA staff present, but she did not know where they were. On 9/7/17 at 12:47 pm, Therapy Staff #1 said Resident #2 should still receive cueing during meals and the RNA interventions were still applicable.	F 310			
F 441 SS=E	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	F 441		10/12/17	

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F 441	<p>Continued From page 22</p> <p>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);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p>	F 441			

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F 441	Continued From page 23 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 policy review, it was determined the facility failed to maintain accepted infection control standards with the sanitation of respiratory equipment for 2 of 15 sample residents (#4 & #10), and 3 random residents (#16, #17 & #18). The deficient practice created the potential for harm if residents experienced respiratory infections from unclean equipment. Findings include: On 9/5/17 at 9:15 am the nebulizer mist treatment (NMT) (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) set-ups for Resident #s 4, #10, #16, and #17 were observed still intact, with the masks and medication cups still attached to the tubing, not contained in closed plastic bags. Condensation was noted in the medication cups. On 9/6/17 at 9:00 am the NMT set-ups for Resident #s 4, #10, #16, and #17 were observed	F 441	F441 Resident Specific The clinical management team reviewed resident #s 4, 10, 16, 17, & 18. Observation shows that the respiratory equipment is cleaned and stored to meet infection control standards. Other Residents The clinical management team reviewed other residents with respiratory equipment. Observation shows that the respiratory equipment is cleaned and stored to meet infection control standards. Facility Systems Licensed nurses are educated on management of respiratory equipment. Re-education was provided by the SDC		

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F 441	<p>Continued From page 24</p> <p>still intact, with the masks and medication cups still attached to the tubing, not contained in closed plastic bags. Condensation was noted in the medication cups.</p> <p>On 9/6/17 at 9:35 am, Resident #4 stated he received an NMT three times a day, the nurse put the medication in the medication cup and he started and stopped the NMT. He further stated when the NMT was completed, he puts the NMT mask on the machine. He stated he has not observed any of the nursing staff cleaning the NMT mask after use. Condensation was noted in the medication cup.</p> <p>On 9/6/17 at 10:30 am, Resident #18 was observed receiving an NMT. Licensed Practical Nurse (LPN) #1 was observed to enter Resident #18's room at the completion of the NMT and placed the intact mouthpiece on the NMT machine. The mouthpiece was not taken apart, rinsed out or placed in a protective plastic bag. Condensation was noted in the medication cups.</p> <p>On 9/6/17 at 2:00 pm, the NMT set-ups for Resident #s 4, #10, #16, #17, and #18 were observed still intact, with the masks or mouthpieces and medication cups still attached to the tubing, not contained in closed plastic bags. Condensation was noted in the medication cups.</p> <p>On 9/7/17 at 9:00 am, the NMT set-ups for Resident #s 4, #10, #16, #17 and #18 were still intact, with the masks and medication cups still attached to the tubing, not contained in closed plastic bags. Condensation was noted in the medication cups.</p>	F 441	<p>and/or DON to include but not limited to, sanitation and care of the nebulizer chamber and mouth piece. The system is amended to include updated competency and observation.</p> <p>Monitor The SDC and/or designee will observe for nebulizer sanitation and storage on 4 residents weekly for 8 weeks. Starting the week of October 9, 2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p>Date of Compliance October 12, 2017</p>		

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F 441	<p>Continued From page 25</p> <p>On 9/7/17 at 9:30 am, Resident #10 was observed with an intact NMT mouthpiece laying on his lap. He stated he just finished his NMT and was waiting for "someone to put it away." CNA #1 entered the room at 9:35 a.m., picked up the mouthpiece, placed it in a plastic bag and set it on his nightstand. Resident #10 stated the nurse puts the medication in the cup and he turned the machine on when he was ready and shut it off when he was done. He stated he has not observed any of the nursing staff clean it after he has used it. Condensation was noted in the medication cup.</p> <p>On 9/5/17 and 9/6/17 LPN #2 was observed caring for Resident #s 4, #10, #16 and #17 after their NMT treatments. The LPN was not observed to clean the residents' NMT masks or mouthpieces.</p> <p>On 9/7/17 LPN #3 who was caring for Resident #s 4, #10, #16 and #17 after their NMT treatments, was not observed to clean the NMT masks or mouthpieces.</p> <p>On 9/6/17 and 9/7/17 LPN #1, who was caring for Resident #18 was not observed to clean NMT mouthpiece after the treatment was administered.</p> <p>On 9/7/17 at 2:15 pm, LPN #1 stated he had been taught to clean, or rinse out, the NMT after completion, after which the mask, but not the mouthpiece, should be stored in a plastic bag. He stated the mouthpieces get stored, uncovered, on the NMT machine.</p>	F 441			

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F 441	<p>Continued From page 26</p> <p>On 9/7/17 at 11:00 am, the Director of Nursing (DNS) stated the NMT set-ups were to be changed weekly and "we just had a house wide training on NMT maintenance earlier this year." The facility's training materials documented the training conducted during the week of March 2017 and first week of April 2017, and included cleaning and storage of NMT set-ups.</p> <p>Review of the "Nebulizer Therapy" competency checklist dated 10/31/09 documented, " ...Step 16 Clean nebulizer once treatment is completed. A. Dismantle and rinse under a strong stream of warm (sic); B. Allow to air dry on a paper towel; C. Reassemble and place in plastic storage bag."</p> <p>The facility's "Nebulizer Therapy" competency checklists documented LPN #1 had an undated competency checklist which was partially completed. "Step 16 Clean nebulizer once treatment is completed," was checked "satisfactory," however sub-parts A, B and C were not documented as complete. LPN #2's completed "Nebulizer Therapy" competency checklist, dated 4/3/17, documented LPN #2 had satisfactory competence in all parts of Step 16. LPN #3's completed "Nebulizer Therapy" competency checklist, dated 3/31/17, documented satisfactory competence in all parts of Step 16.</p> <p>On 9/7/17 at 1:00 pm, the DNS stated there was not a "formal company policy on NMT's. They follow the NMT competency"</p> <p>According to "Air Care," NMT manufacturer's website, instructions for cleaning after each use were "Rinse the mask or mouthpiece with warm</p>	F 441			

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F 441	Continued From page 27 water for at least half a minute. Shake off excess water and place parts on a clean towel for air-drying."	F 441			
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 514		10/12/17	

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F 514	<p>Continued From page 28</p> <p>services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure that physician orders were transcribed accurately for 1 of 15 sample residents (#5). This deficient practice placed residents at risk of harm when medication orders were inaccurately transcribed. Findings include:</p> <p>Resident #5 was admitted on 3/26/16 and was re-admitted on 4/28/17 and 7/22/17 with diagnoses including malignant neoplasm of the breast (cancer), atrial fibrillation (irregular heartbeat), dementia, depression, and history of falling.</p> <p>Resident #5's Anesthesia Physician's Orders for Pre-Surgery Admission form, dated 8/31/17 documented, "Make sure all aspirin...have been discontinued for 7-10 days prior to surgery OR per Surgeon's orders." The form documented the resident was scheduled for an outpatient surgical procedure on 9/6/17.</p> <p>The September 2017 Medication Administration Record (MAR) documented Resident #5's aspirin tablet 81 mg (milligrams) was to be held from 9/1/2017 at midnight to 9/6/2017 at 7:59 am. It also documented the aspirin was given on 9/6/17 at 8:00 am, prior to her surgical procedure.</p> <p>On 9/7/17 at 12:00 pm, LPN #5 said the MAR documented the aspirin could be given as of 8:00 on 9/6/17 and that the order was transcribed incorrectly. LPN #5 stated the MAR should have documented the aspirin should be held until after</p>	F 514	<p>F514 Resident Specific Resident #5 has discharged from the facility.</p> <p>Other Residents The clinical management team reviewed other residents for transcription accuracy with a focus on medications on hold, orders with stop dates, pre-op medications, and other procedural physician directives/orders. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses and medical records staff are educated to order transcription and entry. Re-education was provided by the SDC and/or DON to include but not limited to, medications on hold, orders with stop dates, pre-op medications, and other procedural physician directives/orders. The system is amended to include review of medications with stop dates for accuracy of transcription in clinical meeting.</p> <p>Monitor The medical records clerk and/or designee will audit 3 residents per week for orders transcription accuracy for 8 weeks. Starting the week of October 9,</p>		

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F 514	Continued From page 29 the procedure was complete.	F 514	2017 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate. Date of Compliance October 12, 2017		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001550	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/07/2017
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state re-licensure survey conducted at the facility on September 5, 2017 to September 7, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Linda Kelly, RN Cecilia Stockdill, RN Ann Monhollen, RN</p> <p>Abbreviations:</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 staffing record review and staff interview, it was determined the facility, with an average occupancy rate of 60 or more residents, failed to provide a Registered Nurse (RN) on duty for 8 hours during the evening shift. This was true for 1 of 21 days of the staffing records reviewed. Findings include:</p> <p>Review of staffing records for 8/13/17 to 9/2/17 documented on 8/25/17 there was an occupancy</p>	C 762	<p>C762 Resident Specific No specific residents were cited.</p> <p>Other Residents Resident population is affected. No current negative outcomes identified.</p> <p>Facility Systems Continue to advertise, interview, hire, and</p>	10/12/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 09/29/17
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C 762	Continued From page 1 rate of 67 residents. During the evening shift (2:00 pm to 10:00 pm) on 8/25/17, an RN was on duty for three hours, from 5:27 to 8:26 pm. On 9/7/17 at 2:30 pm, the DNS said she would check to see if agency RNs were present to cover additional hours for the evening shift on 8/25/17. Additional staffing records provided by the Administrator on 9/7/17 at 7:30 pm did not document agency nurse coverage or additional RN coverage for the evening shift on 8/25/17.	C 762	orient registered nurses (RN) to provide am and pm shift coverage daily. The schedule is completed with current staff, agency is contacted to fill additional vacancies as able. The system is amended to include clinical management team rotation to cover unfilled pm shifts for RN coverage. Monitor The Executive Director (ED) and/or designee will validate schedule has RN coverage for am and pm shifts weekly for 8 weeks. The review will be evident on the nursing schedule. Any concerns will be addressed immediately and discussed with the PI committee. Date of Compliance Oct. 12 , 2017	