



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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3232 Elder Street
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Boise, Idaho 83720-0009
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October 4, 2017

Trent Alder, Administrator
Franklin County Transitional Care
44 North First East
Preston, ID 83263-1326

Provider #: 135059

Dear Mr. Alder:

On **September 21, 2017**, a survey was conducted at Franklin County Transitional Care 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 14, 2015**. Failure to submit an acceptable PoC by **October 14, 2015**, may result in the imposition of penalties by **November 6, 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 26, 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 20, 2017**. A change in the seriousness of the deficiencies on **November 5, 2017**, may

result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 21, 2017** includes the following:

Denial of payment for new admissions effective **December 21, 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 20, 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 20, 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:

Trent Alder, Administrator
October 4, 2017
Page 4

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

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

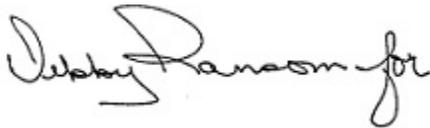
- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **October 16 2015**. If your request for informal dispute resolution is received after **October 16, 2015**, 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 "David Scott for". The signature is written in a cursive style.

David Scott, RN, Supervisor
Long Term Care

ds/dr
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: 135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/21/2017
NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH FIRST EAST PRESTON, ID 83263		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from September 18, 2017 through September 21, 2017.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Linda Kelly, RN Cecilia Stockdill, RN</p> <p>Survey Abbreviations:</p> <p>BG = Blood Glucose CM = Centimeter CNA = Certified Nurse Assistant CPR = Cardio-Pulmonary Resuscitation DON = Director of Nursing DNR = Do Not Resuscitate I & A = Incidents and Accidents LPN = Licensed Practical Nurse MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set MDT = Multidisciplinary Team OT = Occupational Therapy PRN = As Needed PT = Physical Therapy RAI = Resident Assessment Instrument ST = Speech Therapy TIA = Transient Ischemic Attack TID = Three Times a Day UTI = Urinary Tract Infection</p>	F 000			
F 155 SS=D	<p>483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>483.10</p>	F 155		10/23/17	

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

TITLE

(X6) DATE

Electronically Signed

10/13/2017

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 155	<p>Continued From page 1</p> <p>(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.</p>	F 155		

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F 155	<p>Continued From page 2</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interview, it was determined the facility failed to ensure the resuscitation code status was consistent throughout residents' records. This was true for 1 of 9 (#4) residents reviewed for Advanced Directives and had the potential for harm if residents' directives were not honored during life-threatening emergencies. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 9/2/16 with multiple diagnoses, including Type II diabetes mellitus and hypertension.</p> <p>Resident #4's annual Minimum Data Set (MDS) assessment, dated 8/10/17, documented the resident was cognitively intact.</p> <p>The resident's admission documents, dated 9/2/16, noted he chose not to receive Cardio-Pulmonary Resuscitation (CPR) in the event of a life-threatening emergency.</p>	F 155	<p>1) A Root Cause Analysis was performed on 10/9/2017 and it was determined that there was no process in place to coordinate and/or check for accuracy between the different types of Advanced Directives.</p> <p>2) It was determined that all residents could be affected. A sweep of every resident's physical chart and EMR was performed by 10/12/2017. The physician's orders were also reviewed at this time for each resident. Corrections to any discrepancies in the chart were corrected by 10/13/2017.</p> <p>3) At the time of every quarterly review, resident's physician's orders and written advanced directives will be compared to what is in the care plan. If it is not consistent, changes will be made to the care plan so it matches the resident's wishes. For new admissions; the code status will be written in the EMR</p>		

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F 155	Continued From page 3 The resident's September 2017 physician orders documented a "DNR" (Do Not Resuscitate) status, dated 4/10/17. Resident #4's current care plan included a 5/24/17 intervention documenting the resident was "Full Code," alerting staff to initiate CPR in the event of a life-threatening emergency. On 9/19/17 at 4:35 pm, Resident #4 said his code status should be DNR. On 9/20/17 at 2:55 pm, LPN #1 (Licensed Practical Nurse) said her Resident Roster documented Resident #4's status was "Full Code." She then reviewed the resident's hard chart at the nurses station and said Resident #4's code status was DNR. LPN #1 then viewed the resident's medical record on a computer said it also documented a DNR code status. LPN #1 then looked at the resident's care plan and said it documented Full Code. LPN #1 said the code status needed to be clarified due to conflicting information. On 9/21/17 at 4:10 pm, the Social Worker, who said she was responsible for residents' code status updates, stated she could not explain the code status discrepancy in Resident #4's clinical record.	F 155	and/or physical chart; a review of the physician's orders and written advanced directives will be done to ensure the correct code status is in the care plan within 48 hours. An advanced directives log was created to assist in the comparing of the different types of advance directives. 4) The advanced directives of the residents will be randomly checked by NHA/designee. Five residents will be randomly audited per week for 2 months, then until the Quality Management Committee determines compliance. 5) Compliance Goal Date: 10/23/2017		
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a	F 244		10/23/17	

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F 244	<p>Continued From page 4</p> <p>resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.</p> <p>(A) The facility must be able to demonstrate their response and rationale for such response.</p> <p>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on review of Resident Council meeting minutes, Resident Group interview, and staff interview, it was determined the facility failed to address Resident Council concerns. This was true for 7 of 7 residents in the Resident Group interview and those residents in the facility whose views and concerns were represented by the Resident Group. The deficient practice had the potential to cause psychosocial harm for residents frustrated by the perception their concerns were not valued or addressed by the facility. Findings include:</p> <p>Resident Council minutes for 6/6/17 and 7/26/17 documented residents were concerned about missing and misplaced clothing.</p> <p>The facility's response to the Resident Council concerns, dated 6/7/17 and 7/28/17, did not address the clothing issues.</p> <p>On 9/19/17 at 1:00 pm, during a Resident Group Interview, 7 of 7 residents said the laundry department did not respond to their concerns about missing and misplaced clothing, which</p>	F 244	<p>1- A root/cause analysis was performed on 10/6/2017 and it was discovered that the complaints in resident council were not being addressed in a timely fashion. It was discovered that some departments had not been trained in the Resident Council Grievance Process. It was also determined that new staff had not been trained to report grievances to Administration. Also, many of the residents do not attend Resident Council and don't have that forum to make complaints/grievances.</p> <p>2- All residents could have been affected by the previous process of not having complaints/grievances addressed via Resident Council.</p> <p>3- A sweep of all residents/resident representatives was performed during the period of 10/5/2017 and 10/13/2017. During this sweep, the resident/representative was questioned about multi facets of their care and asked</p>	

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F 244	<p>Continued From page 5</p> <p>remained an issue of concern for several residents attending the group interview.</p> <p>On 9/19/17 at 4:30 pm, the Activity Director said she forwarded the Resident Council's concern forms to the Housekeeping Manager after both Resident Council meetings, but had not yet received a response.</p> <p>On 9/21/17 at 11:00 am, the Housekeeping Manager said he had received at least one of the Resident Council concern forms, but did not realize he was to respond in writing on the form or address the Resident Council's concerns.</p> <p>On 9/21/17 at 4:00 pm, the Administrator said he may not have trained the Housekeeping Manager to Resident Council concern forms or his responsibility to help resolve issues of concern to residents.</p>	F 244	<p>if they had any grievances or complaints. All complaints or grievances by the resident/representative, were logged, addressed and tracked on the existing Complaint Log. The additions to the grievance/compliant process were explained to the resident/representative, as well, during this visit. Resident Council Grievances from the last three months were addressed by the Administrator in Resident Council on 10/10/2017.</p> <p>4-On 10/6/2017 it was requested of the Resident Council President, that a copy of the grievance/complaint that was sent to the department head also be sent to the Administrator to be logged and followed up on and that a few minutes of each Resident Council would be granted to the Administrator to report on past grievances/complaints. This process was reviewed on 10/10/2017 with the entire Resident Council and implemented at that time, per their permission. On 10/11/2017 the staff was instructed to report all grievances or complaints reported to them, to the Administrator and also regarding the new Resident Council grievance process. On 10/11/2017 a meeting was held to instruct the department heads/designees involved with the Nursing Home, regarding the Resident Council Grievance Process. These departments included: Maintenance, Housekeeping, Dietary, Restorative/Rehabilitation Services, Billing, IT, Pharmacy, Quality Management/Infection Control, Central</p>		

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F 244	Continued From page 6	F 244	<p>Supply, Lab, X-ray, Nursing, Activities, and Social Work. The instruction on how to respond was added to Resident Council Inquiry Form. The Complaint Resolution Policy was adjusted to describe the Resident Council Grievance Process in-depth and each effected department head/designee was given a copy. An adjustment was also made to this policy describing a quarterly visit to each resident/representative by the Administrator to ensure that all residents, not only those attending Resident Council, have another method to express complaints/grievances to administration and that the complaints/grievances are being tracked and addressed. An Administrator Quarterly Visit Log was created to ensure these visits happen and are recorded. Adjustments were made to the Resident Admission Agreement, Complaint Resolution Policy and the Grievance/Complaint Process on public display, to match the new process. The adjusted Grievance/Complaint process will be a part of the new employee orientation effective immediately.</p> <p>5- The Complaint Log will be monitored by Quality Manger/Designee to ensure that complaints are being logged and addressed: 5 times per week for 2weeks, then 3 times per week for two weeks, then weekly for a month, then monthly until the QM committee determines compliance. The Administrator Quarterly Visit Log and Resident Council Inquiry Form will be monitored by the Quality</p>		

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F 244	Continued From page 7	F 244	Manager/Designee for 6 months to ensure compliance with the new process.		
F 278 SS=D	<p>483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.</p> <p>(h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>(i) Certification (1) A registered nurse must sign and certify that the assessment is completed.</p> <p>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>(j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p>	F 278	6-Compliance Goal Date: 10/23/2017	10/23/17	

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F 278	<p>Continued From page 8</p> <p>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview, it was determined the facility failed to ensure residents' Minimum Data Set (MDS) assessments accurately documented the status of wounds. This was true for 1 of 12 (#2) residents reviewed for MDS accuracy and resulted in the potential for harm should residents not receive appropriate care and services. Findings include:</p> <p>Resident #2 was admitted to the facility on 8/22/17 with diagnoses that included heart failure, chronic pain, urinary tract infection (UTI) and Type II diabetes mellitus.</p> <p>Resident #2's Admission- and Significant Change MDS assessments, dated 8/28/17 and 9/7/17 respectively, documented severe cognitive impairment, risk for pressure ulcers, and 1 unstageable pressure ulcer measuring 0.3 by 0.6 cm (centimeters).</p> <p>Resident #2's 8/22/17 Skin Admission form documented both heels presented with skin impairment, an area on the right buttock was red and unblanchable, and an area on the left buttock was red, intact, and blanchable.</p> <p>On 9/21/17 at 10:32 am, Resident #2's heels were observed with no pressure ulcer present. A Stage II pressure ulcer was observed on the resident's right buttock.</p> <p>On 9/21/17 at 4:50 pm, the MDS nurse said a</p>	F 278	<p>A Root Cause Analysis was performed on 10/6/2017. It was determined that there was a flawed process for skin lesion documentation on the MDS which lent itself to error. The documentation was not entered into Point Click Care by the floor nurse; the MDS coordinator did not review the wound information with the Wound Nurse before entering it into the MDS.</p> <p>1) The MDS of the resident affected has been corrected and resubmitted as of 9/29/2017. The MDS coordinator was counseled regarding this issue as soon as it was determined it was an error. The MDS coordinator recognized this error and contacted Point Click Care (PPC) to assist in the correction.</p> <p>2) Any new resident admitted to the TCU or a resident with a significant change related to wounds could be affected. It was determined that there was not process for the skin assessment to be performed on all residents prior to their MDS assessment. All of the Nursing Home staff was educated at a mandatory staff meeting on October 11, 2017, regarding the changes.</p> <p>3) All MDSs performed relating to skin issues will be cross checked by an RN prior to being submitted. The MDS coordinator will discuss skin issues with the Wound Nurse/Wound Specialist prior</p>		

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F 278	<p>Continued From page 9</p> <p>therapist observed an unstageable pressure ulcer on Resident #2's heel that was not documented in the resident's clinical record. The MDS nurse said the therapist provided dimensions of the pressure ulcer and this information was entered into the resident's Admission MDS assessment. The MDS nurse said she did not personally assess the resident's reported wound, but "took his [therapist's] word for it."</p> <p>On 9/21/17 at 5:00 pm, LPN (Licensed Practical Nurse) #1 said she assessed Resident #2's heels on admission as the resident was kicking, but did not observe any pressure ulcers on the resident's heels.</p> <p>On 9/21/17 at 5:30 pm, Therapy Staff #1 said he received a report of a chronic sore on Resident #2's heel that was "just" intact dry skin.</p> <p>On 9/21/17 at 5:35 pm, the MDS nurse said there was no actual pressure ulcer as documented on Resident #2's MDS assessments.</p>	F 278	<p>to documentation on the MDS. The skin and wound assessment will be documented completely in PCC by the end of each nursing shift for new admissions and new wounds. A wound assessment will be performed on each resident within the look back period prior to the MDS completion. The MDS Coordinator will check for wound documentation before coding section M. The RN will review and double check documentation for section M before MDS submission. Whenever a stage 2 wound or above is noted by the skin nurse, it will be verified by another nurse or the wound care specialist to confirm or deny this finding. All skin assessments will be completed per policy within 1 hour of new admission. If a resident admits after hours when wound nurse/wound specialist is not available and a suspected staged ulcer is found, it will be described in detail in the skin observation tool and a picture taken of the concerning area. By the next day the skin nurse will review the information and the picture and stage the skin lesion. The Care Planning signature sheet will have a space for the skin nurse and the second witness to sign that evaluated the staged wound. The wound nurse/designee will perform/document in PPC a skin assessment for each resident prior to each MDS assessment. The Wound Nurse will be given a schedule of the necessary assessments by the MDS coordinator.</p> <p>4) All new admissions and new wounds will be audited by the Quality</p>		

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F 278	Continued From page 10	F 278	Manager/designee weekly for 3 months, to assure that the process is working. An audit will be performed for each MDS submission to ensure that the skin assessment was performed and/or documented in PCC. This will be audited by DON/designee for 3 months and until compliance is determined by Quality Management Committee. 5) Compliance goal date: 10/23/2017		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the	F 280		10/23/17	

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F 280	<p>Continued From page 11 right to participate in his or her treatment and shall support the resident in this right. The planning process must--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident</p>	F 280			

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F 280	<p>Continued From page 12 and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure care plans were appropriately reviewed and updated. This was true for 2 of 12 residents (#3 and #4) reviewed for care plan revision and created the potential for harm if residents did not receive appropriate care due to inaccurate care plan information. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 1/15/16 with diagnoses that included dementia, TIA (transient ischemic attack - a form of oxygen deprivation to the brain), anxiety and heart failure.</p> <p>Resident #3's 2 Significant Change- and 1 Quarterly MDS (Minimum Data Set) assessments, dated 1/5/17, 4/6/17, and 7/6/17 respectively, documented severe cognitive impairment, depression, anxiety, and delusions.</p> <p>A Falls Risk Care Plan, initiated 4/6/17 and revised on 7/10/17, documented Resident #3 was at moderate risk for falls and directed staff to</p>	F 280	<p>A Root Cause Analysis was performed on 10/6/2017 and it was determined that the process of sharing information regarding care on the floor, to the Plan of Care, was inadequate.</p> <p>1) Resident #3 has expired. Resident #4 has had his care plan updated for his catheter placement and care. His care plan has been reviewed with him. 2) All residents have the potential to be affected by this same deficient practice as all residents require care plans. 3) All nurses were educated regarding the updating of care plans in Point Click Care at the mandatory staff meeting on October 11, 2017. It was established in this meeting that the nurse also has responsibility to update the care plans. A Care Plan procedure was created on 9/28/2017 to assist the staff in their understanding of what is required on the care plan. The MDS coordinator will ask the charge nurses regarding issues listed on the care plan procedure each</p>		

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F 280	<p>Continued From page 13</p> <p>anticipate and meet her needs, follow a toileting schedule, and provide activities that minimized falls by diversion and distraction.</p> <p>a. An 8/4/17 Occurrence Report Summary documented Resident #3 fell from bed to the floor at 3:15 pm. The Summary documented an alarm sounded and the resident was heard calling for help. The Summary documented the resident appeared "to have hit [her] head on [the] floor as [there was an] abrasion on [her] forehead." A Steri Strip adhesive and Band-Aid were placed on the wound and a "louder alarm" was put into place.</p> <p>b. An 8/20/17 Occurrence Report Summary documented Resident #3 fell out of a wheelchair at 1:59 pm. The Summary documented Resident #3 repeatedly leaned back and forth, which may have caused the alarm to detach from her clothing. The resident was assessed with bruising to the right forehead and redness to the right shoulder.</p> <p>On 9/21/17 at 10:00, the MDS nurse stated Resident #3's Falls Risk Care Plan had not been updated with new falls prevention interventions, such as securing the tab alarm more securely to the resident's clothing, adjusting the height of the resident's bed, and/or placing a fall mat by the bed. The MDS nurse said Resident #3's care plan should have been updated.</p> <p>2. Resident # 4 was admitted to the facility on 9/21/16 with multiple diagnoses, including urinary incontinence and a history of neurogenic bladder.</p> <p>The resident's physician orders, dated 9/6/17, documented an order for a Foley catheter.</p>	F 280	<p>weekday. It will be done at the newly created Quick care plan meeting (QCPM) via the Quick Care Plan Meeting Form. It will be held at 10:30 AM each weekday to identify care plan changes for individual residents to include Skin, Infection, Behavior/mood, catheters, change in ADLs, psychotropic meds and all skilled residents. (See CP Procedure and collection form for the QCPM). To assist in the assurance that the care plans are appropriate, and updated to meet resident needs, the resident/representative will receive notification of the date and time of care plan meeting. If the time and date are not convenient, they will have the option to change that per their discretion. At the beginning of each month, family members will be notified per letter either through the mail or an email attachment. This letter contains the date and time of the letter, also with option to contact us if change to this is needed. A copy of each letter sent will be copied and kept on file and the mailing to family as well as the personal contact with resident will be documented in the EMR progress notes.</p> <p>4) The process will be audited to assure compliance by cross checking the actual care plan with the QCPM to ensure that the care plans are accurate. This audit will be performed 5 times per week for 2 weeks, 3 times per week for 2 weeks, then 1 time per week for one month by Quality Manager/designee. And will continue monthly audits until QM committee determines compliance. This process will be audited by the Quality</p>		

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F 280	Continued From page 14 The resident's current bladder incontinence care plan did not document the resident had a catheter. On 9/18/17 at 4:20 pm and on 9/19/17 at 9:23 am, 10:00 am, 2:25 pm, and 4:35 pm, the resident was observed in bed with a catheter in place. On 9/19/17 at 10:00 am, the resident said the catheter had been in a "week or two" and nursing staff had been performing appropriate catheter care. On 9/21/17 at 2:50 pm, the MDS coordinator said the resident's care plan had not been updated when the catheter was inserted because she was not informed the catheter had been placed. She said she had just revised the care plan to reflect the catheter placement after the surveyor began asking nursing staff questions regarding the catheter.	F 280	Manager/designee. 5) Compliance Goal date 10/23/2017		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure the neurological (neuro) status of residents was	F 281	A) Root Cause Analysis It was determined that although there was a procedure on the neuro form, there was	10/23/17	

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F 281	<p>Continued From page 15</p> <p>assessed after unwitnessed falls, physician orders for medications were followed, and medications were given with a valid physician's order. This was true for 1 of 12 residents (#3) reviewed for incidents and accidents, medications, and physician orders. This deficient practice created the potential for harm if changes in residents' neuro status were undetected, medications were not discontinued as ordered by the physician, and/or medications were given without a valid physician's order. Findings include:</p> <p>Resident #3 was admitted to the facility on 1/15/16 with diagnoses that included dementia, TIA (transient ischemic attack - a form of oxygen deprivation to the brain), anxiety, and heart failure.</p> <p>Resident #3's 2 Significant Change- and 1 Quarterly MDS (Minimum Data Set) assessments, dated 1/5/17, 4/6/17, and 7/6/17 respectively, documented severe cognitive impairment, depression, anxiety and delusions.</p> <p>a. An 8/4/17 Occurrence Report Summary documented Resident #3 fell from bed to the floor at 3:15 pm. The Summary documented an alarm sounded and the resident was heard calling for help. The Summary documented the resident appeared "to have hit [her] head on [the] floor as [there was an] abrasion on [her] forehead." A Steri Strip adhesive and Band-Aid were placed on the wound and a "louder alarm" was put into place.</p> <p>Resident #3's Quality Investigation Log, dated 8/7/17 at 6:05 pm, documented 72 hour</p>	F 281	<p>no actual procedure for neuro checks for the nurses to follow. This caused uncertainty by the staff as to when neuro checks should be done.</p> <p>1) Resident noted on this deficiency has expired.</p> <p>2) Any resident who has an unwitnessed fall or fall with head injury could be affected. DON will be notified of all falls so she can be aware to follow and assure that the data is taken as procedure directs and ensure that resident is not showing any ill effects from the fall.</p> <p>A policy regarding neuro checks was reviewed with the staff nurses to clarify the unwitnessed fall and how/ why the neurological checks are to be performed. This was reviewed at the mandatory staff meeting October 11, 2017. (See Neuro Check Procedure and Neuro check form updated)</p> <p>3) Will train all nurses on hire and semiannually regarding procedure for post fall neuro checks. SQSS reporting incident program has been updated with questions that will coach nurses to follow the post fall procedure including Neuro Checks and 72-hour monitoring. Use of the Just in Time Training was also reviewed.</p> <p>4) All unwitnessed falls will be monitored that neuro checks are done completely for the next 3 months. Documentation of the neuro checks post unwitnessed fall will be checked after every fall by the DON or designee to assure the assessment is complete and no ill side effects have</p>		

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F 281	<p>Continued From page 16 monitoring and neuro checks were completed and the resident was very sleepy.</p> <p>An 8/20/17 Occurrence Report Summary documented Resident #3 fell out of a wheelchair at 1:59 pm. The Summary documented Resident #3 repeatedly leaned back and forth, which may have caused the alarm to detach from her clothing. The resident was assessed with bruising to the right forehead and redness to the right shoulder.</p> <p>Resident #3's Neurological Flow Sheet documented vital signs and neuro checks were to be performed every 15 minutes for 1 hour, every 30 minutes for 1 hour, every 1 hour for 4 hours, then every 4 hours for 24 hours. Neuro checks and vital signs should have been documented at 8:20 pm on 8/20/17 then every 4 hours through 8:20 pm on 8/21/2017. Neuro checks and vital signs were not documented after 7:20 pm on 8/20/17 and were documented only at 8:00 am and 4:00 pm on 8/21/17. The final neuro check should have been performed at 8:20 pm on 8/21/17.</p> <p>On 9/21/17 at 4:40 pm, the Director of Nursing (DON) said neurological checks were performed as documented on the Neurological Flow Sheet after the fall on 8/20/17, but "we might [have] miss[ed] some."</p> <p>b. Resident #3's 9/14/17 Physician's Telephone Orders documented all medications were discontinued and the resident was to begin Alprazolam (antianxiety medication) TID (three times a day).</p>	F 281	<p>presented.</p> <p>5) Compliance Goal Date 10/23/2017</p> <p>B) Root Cause Analysis Nurse did not follow MD orders. At the time of survey the facility did not have standing orders for bowel and pain medications.</p> <p>1) Resident noted on the deficiency has expired</p> <p>2) Any resident with new or changed orders could be affected. Sweep was done of all residents to document that they have consistent signed orders regarding their medications. Also, to assure that no medications were given without an order.</p> <p>3) Education was completed on 10/11/2017 for nursing staff regarding following MD orders. Also that there must be an order to administer medications. Standing orders were established on 10/10/2017 for bowel and pain management. (See standard orders signed by MD □s).</p> <p>4) DON will monitor all new or changed orders daily x 5 days for 2 weeks, then 3 x week for 2 weeks, then weekly for one month. Continue monthly till QM committee determines compliance</p> <p>5) Compliance Goal Date 10/23/2017</p>		

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F 281	Continued From page 17 Resident #3's September 2017 Medication Administration Record (MAR) documented Senna-S (a stool softener) was still active and was administered twice a day from 9/14/17 through 9/18/17 and in the morning on 9/19/17. The following PRN (as needed) medications were also still active on the MAR: Acetaminophen suppository, Acetaminophen tablet, Milk of Magnesia Suspension (laxative), and Tylenol with Codeine #3 (a narcotic pain medication). All medications were not discontinued as ordered by the physician on 9/14/17 and the Senna-S was given without a valid physician's order. On 9/21/17 at 2:45 pm, the DON said she "did not have a problem" with the discontinued Senna-S and Tylenol remaining active orders for Resident #3.	F 281			
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 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);	F 441		10/23/17	

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F 441	<p>Continued From page 18</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> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective</p>	F 441			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 19 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, staff interview, and procedure review, it was determined the facility failed to ensure staff consistently adhered to standard infection control practices. This was true for 4 of 10 residents (#s 2, 9, 11 & 12). Failure to perform hand hygiene after direct contact with residents and to utilize a barrier for a multi-resident use glucometer in a resident's room created the potential for infection from cross contamination. Findings include:</p> <p>1. On 9/20/17 at 4:45 pm, LPN #3 was observed placing a clean glucometer on the sink counter in Resident #12's room without utilizing a barrier under the glucometer or cleaning/sanitizing the counter. LPN #3 then moved the glucometer to Resident #12's bed and placed it on a paper towel on the bed covers while she assessed the resident's blood glucose (BG). Upon completion of the BG assessment, LPN #3 returned to the sink and placed the glucometer on the counter, without utilizing a barrier. A smear of blood was observed on one side of the glucometer. LPN #3 then removed her gloves, picked up the glucometer with her bare hand and left the room. The LPN returned to the medication cart by the nurses' station and placed the used glucometer</p>	F 441	<p>A)1. Root Cause Analysis: Staff needs to be continually educated regarding proper Hand Hygiene. 2. This could potentially affect all patients. 3. Licensed staff and CNA's attended staff meeting on October 11, 2017 that included training by Infection Control Nurse. Training detailed 5 opportunities to wash hands (World Health Organization). Scenarios were discussed to identify opportunities and appropriate hand hygiene. https://www.slideshare.net/vlchung/5-month-hand-hygiene. 4. To ensure compliance, the NHA, Infection Control Nurse or designee will conduct audits of staff completing hand hygiene (HH). Infection Control Nurse or designee will monitor for appropriate washing, sanitizing, and opportunities for HH. These random observations will be conducted five days a week for two weeks, then three days per week for two weeks, then weekly for one month. This is in addition to our usual HH monitoring 5. Compliance goal date 10/23/17</p>		

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F 441	<p>Continued From page 20</p> <p>on top of the cart, again without utilizing a barrier. At the medication cart, LPN #3 confirmed a smear of blood was on the glucometer, said the glucometer was used for multiple residents, and stated she "probably" should have used a barrier. The LPN also said she did not perform any type of hand hygiene after removing the gloves or before leaving Resident #12's room.</p> <p>The facility's "Glucometers - Care and Cleaning" procedure, dated 6/2/17, documented, "Place barrier (paper towel) on area where you will place the cleaned glucometer ...Wash [your] hands before and after procedure."</p> <p>2. On 9/19/17 at 10:57 am, LPN #2 was observed assessing Resident #9's BG. After the BG assessment, LPN #2 removed her gloves, left the resident's room, and returned to the medication cart without performing any type of hand hygiene after removing the gloves or before leaving the resident's room.</p> <p>On 9/19/17 at 11:00 am, LPN #2 said she should have performed hand hygiene.</p> <p>3. On 9/19/17 at 11:05 am, LPN #2 was observed applying Triple Antibiotic ointment to Resident #11's toes. After applying the ointment, LPN #2 removed her gloves, left the resident's room, and returned to the medication cart. LPN #2 did not perform any type of hand hygiene after removing the gloves or before leaving the resident's room.</p> <p>Immediately afterward, LPN #2 said she should have sanitized her hands before leaving the resident's room.</p>	F 441	<p>B)1. Root Cause Analysis: Not all staff were aware of current policy/procedure for care/cleaning of Patient Care Devices.</p> <p>2. This could potentially affect all patients.</p> <p>3. Licensed staff and CNA's will attend staff meeting on October 11, 2017 that included training by Infection Control Nurse. Training reviewed Glucometers □ Care and Cleaning Procedure. Procedure has been changed to remove phrase □Place barrier (paper towel) on area where you will place the cleaned glucometer□. Instead the whole surface of the glucometer will be cleaned prior to and after use. Staff will be trained to follow policy. Individual cleansing cloth packages have been placed next to glucometers. Nurses will use wipe prior to entering residents room and will carry wipe with them to use in the residents room after use.</p> <p>4. To ensure compliance, the DON, Infection Control Nurse or designee will monitor staff use of glucometer to ensure proper cleaning before/after use is being completed per procedure. These audits will be conducted daily for a week, then twice weekly for a week then once a week for a month for three months and until the QM determines compliance.</p> <p>5. Compliance goal date 10/23/17</p>		

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F 441	<p>Continued From page 21</p> <p>4. Resident #2 was admitted to the facility on 8/22/17 with diagnoses that included heart failure, chronic pain, urinary tract infection (UTI), and Type II diabetes mellitus.</p> <p>Resident #2's 8/28/17 admission MDS (Minimum Data Set) assessment documented severe cognitive impairment; total dependence on staff for transfers, hygiene and bathing; and "always" incontinent of bowel and bladder. The 9/7/17 significant change MDS assessment documented severe cognitive impairment, extensive staff assistance required for transfers, hygiene, and bathing; and frequently incontinent of bowel and bladder.</p> <p>On 9/19/17 at 1:20 pm, CNA (Certified Nursing Assistant) #3 and CNA #4 were observed transferring Resident #2 from bed to a bedside commode with a gait belt. After assisting the resident with pericare, the two CNAs transferred the resident to a wheelchair. CNA #3 then removed her gloves and left the room without performing hand hygiene, while CNA #4 removed her gloves, handed the resident her water container, and brushed the resident's hair without first performing hand hygiene.</p> <p>When asked if she washed her hands or used hand sanitizer after removing her gloves, CNA #4 stated she did not, but should have cleaned her hands.</p> <p>CNA #3 returned to the room several minutes later and, when asked whether she should have performed hand hygiene after assisting the resident to use the commode, stated she "grabbed some hand gel" on the way down the</p>	F 441			

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F 441	Continued From page 22 hall.	F 441			
F 498 SS=D	483.35(c); 483.95(g)(1)(2)(4) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS 483.35 (c) Proficiency of Nurse Aides The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. 483.95 (g) Required in-service training for nurse aides. In-service training must- (g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. (g)(2) Include dementia management training and resident abuse prevention training. (g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure CNAs (Certified Nurse Assistants) demonstrated competency with gait belt assisted transfers. This was true for 1 of 9 (#6) residents reviewed for transfers and created the potential for harm if residents were injured during improper transfers. Findings include:	F 498	A Root Cause Analysis was performed on 10/6/2017 and it was determined that all staff have not passed off competencies related to proper use of the gait belt 1) Both of the aides involved in deficient practice were taught and directed by the restorative aide to the proper use of gait belts. At the Staff Meeting October 4th, the Physical Therapist demonstrated	10/23/17	

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F 498	<p>Continued From page 23</p> <p>Resident #6 was admitted to the facility on 7/23/15 with multiple diagnoses, including a history of falls.</p> <p>The current care plan, dated 4/4/17, documented Resident #6 required 2 staff and a gait belt for transfers.</p> <p>On 9/20/17 at 12:25 pm, CNA #1 and CNA #2 were observed assisting Resident #6 transfer from a recliner near the nurses' station to a four-wheeled walker. The CNAs wrapped the gait belt around the resident's upper chest area with the top of the gait belt one inch below the resident's armpits. Both CNAs stood on either side of the resident, used one hand to grab the back of the gait belt, placed the other hand underneath each of the resident's armpits, and assisted the resident to a standing position, where he could steady himself with the walker.</p> <p>On 9/20/17 at 12:30 pm, CNA #1 said he held onto the back of the gait belt with one hand and put the other hand under the resident's armpit, but did not exert excessive force on the resident's armpit.</p> <p>On 9/20/17 at 12:35 pm, CNA #2 said he did not place the gait belt near the resident's waist and that he used one hand to hold the back of the gait belt with the other hand under the resident's armpit to accomplish the transfer.</p> <p>On 9/20/17 at 2:00 pm, Resident #6's Interested Party said he/she relied on facility staff to transfer the resident correctly.</p> <p>On 9/21/17 at 10:05 am, the Restorative Aide</p>	F 498	<p>proper gait belt use and reviewed the gait belt policy. The staff was instructed to tighten the gait belt to reduce the risk of the gait belt sliding up on the resident's chest.</p> <p>2) Any resident who requires a gait belt for Stand by Assist could be affected by ineffective use of the gait belt. All aides will pass off on an annual basis their competency of proper use of gait belts by the restorative aide and it will be documented in their education record.</p> <p>3) All aides were trained on the proper use of gait belts during the 10/4/2017 staff meeting and the gait belt policy (See attached) was reviewed. All newly hired aides will be trained by a Restorative aide prior to working on the floor with the residents. The gait belt policy was formulated on 9/28/17 and will be reviewed with every employee on hire. Gait belt training was again demonstrated and reviewed at the mandatory Staff Meeting of October 11, 2017.</p> <p>4) The Restorative Aide or designee will do random checks of gait belt application at least 3 times a day, 5 days a week for 2 weeks and then 3 times a week for 2 weeks, then weekly for 2 months. The Restorative Aide/designee will involve different aides at different times of the day for her checks</p> <p>5) Completion Goal date 10/23/2017</p>		

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

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F 498	<p>Continued From page 24</p> <p>said she assisted in training and approving CNA competency with gait belt transfers, but CNAs #1 and #2 had not yet completed the facility's gait belt competency. She said the gait belt should be secured around the resident's waist and staff should not lift under the armpits as that could cause injury due to the pulling action.</p> <p>On 9/21/17 at 11:35 am, the Director of Nursing said she assumed CNAs received gait belt transfer training while enrolled in CNA courses. She said CNA #1 was hired a few months previously and CNA #2 had worked at the facility for about one year.</p>	F 498			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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October 27, 2017

Trent Alder, Administrator
Franklin County Transitional Care
44 North First East
Preston, ID 83263-1326

Provider #: 135059

Dear Mr. Alder:

On **September 21, 2017**, an unannounced on-site complaint survey was conducted at Franklin County Transitional Care. The complaint was investigated during a federal recertification and State licensure survey conducted at the facility from September 18, 2017 to September 21, 2017.

During the survey, observations were made of facility staff interactions with residents in general and during direct care, including peri-care and/or bedside commode use, for four individual residents. In addition, call light accessibility was also observed through out the survey.

Interviews were conducted with six residents in a Resident Group Interview, seven individual residents, five Certified Nursing Assistants, five Licensed Nurses, the Social Worker, the Director of Nursing and the Administrator.

Clinical records of ten residents, including the identified resident, were reviewed for quality of life and quality of care issues. In addition, the facility's investigations of allegations of abuse, grievances, and Resident Council meeting minutes were also reviewed, as was the facility's smoking policy.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007531

ALLEGATION #1:

Two aides performed peri-care, but did not provide an identified resident with a bath. The resident is capable of performing peri-care independently. The reporting party questions if this could be considered sexual abuse.

FINDINGS:

Based on observations, interviews and record reviews, there was no evidence of abuse or mistreatment.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident was left on a bedside commode for five minutes without a call light and had to ask the roommate to use his/her call light to summon assistance.

FINDINGS:

Call lights were observed to be accessible during survey. In addition, per observations of two residents using a bedside commodes and interviews with four residents who used bedside commodes, there were no identified or voiced concerns that call lights were not accessible.

The allegation could not be substantiated due to lack of evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

A "rude" nurse argued with an identified resident and made the resident cry.

FINDINGS:

Based on review of the identified resident's clinical record, multiple interviews with other residents, and review of the facility's Grievance File and Resident Council meeting minutes, there was no evidence to support the allegation.

Trent Alder, Administrator
October 27, 2017
Page 3 of 3

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

A "rude" nurse would not allow a Certified Nurse's Assistant to take an identified resident outside to smoke.

FINDINGS #4:

Per policy review, smoking was not allowed on facility property and the identified resident's clinical record contained documentation that the resident signed an agreement with the facility regarding this policy.

The allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson (L.S.W.)".

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

DS/lj