



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

October 23, 2017

Josh Smith, Administrator
Oak Creek Rehabilitation Center Of Kimberly
500 Polk Street East
Kimberly, ID 83341-1618

Provider #: 135084

Dear Mr. Smith:

On **October 4, 2017**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **October 4, 2017**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- F0280 -- S/S: D -- 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) -- Right To Participate Planning Care-Revise Cp**
- F0281 -- S/S: D -- 483.21(b)(3)(i) -- Services Provided Meet Professional Standards**
- F0309 -- S/S: D -- 483.24, 483.25(k)(1) -- Provide Care/services For Highest Well Being**
- F0312 -- S/S: D -- 483.24(a)(2) -- ADLCare Provided For Dependent Residents**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 2, 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.
- 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*.

As noted in the Bureau of Facility Standards' letter of **August 4, 2017**, following the survey of **July 21, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions **October 21, 2017** and termination of the provider agreement on **January 20, 2018**, if substantial compliance is not achieved by that time. The findings of non-compliance on **October 4, 2017**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **October 21, 2017**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **October 21, 2017**
- Civil money penalty

Please note that this notice does not constitute formal notice of imposition of alternative remedies

Josh Smith, Administrator
October 23, 2017
Page 3 of 3

or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe the 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, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **November 2, 2017**. If your request for informal dispute resolution is received after **November 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,



Nina Sanderson, LSW, Supervisor
Long Term Care

Josh Smith, Administrator
October 23, 2017
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NS/lj

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: 135084	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 10/04/2017
NAME OF PROVIDER OR SUPPLIER OAK CREEK REHABILITATION CENTER OF KIMBERLY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(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 An on-site revisit survey was conducted at the facility from October 2, 2017 to October 4, 2017. The surveyors conducting the survey were: Jenny Walker, RN , Team Coordinator Teresa Kobza, RDN, LD Definitions Include: ADL - Activity of Daily Living ADNS - Assistant Director of Nursing Services bpm - Beats per minute CNA - Certified Nursing Assistant HTN - Hypertension LN - Licensed Nurse LPN - Licensed Practical Nurse MAR - Medication Administration Record MDS - Minimum Data Set mg - Milligram RNC - Regional Nurse Consultant s/s - signs and symptoms	{F 000}			
{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	{F 280}		11/13/17	

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

TITLE

(X6) DATE

Electronically Signed

10/31/2017

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 280}	<p>Continued From page 1</p> <p>expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.</p> <p>(iv) The right to receive the services and/or items included in the plan of care.</p> <p>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.</p> <p>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>483.21</p> <p>(b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p>	{F 280}		

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{F 280}	Continued From page 2 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' care plans were reviewed and/or revised to reflect their current needs. This was true for for 3 of 6 residents (#3, #8 & #9) reviewed for care plan revision. Resident #3's care plan was not updated to reflect speech therapy recommendations or the resident's positioning preferences. Resident #s 3, #8 and #9's care plans were not revised or updated regarding psychoactive medication use. In	{F 280}	1. Resident #3 no longer resides in facility. Residents #8 and #9 care plan updated for psychoactive medications. Resident #8 care plan updated to reflect dialysis interventions. 2. All residents with speech therapy orders, psychoactive medications and dialysis interventions have the potential to be affected. All residents with these items reviewed and revised as appropriate.		

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{F 280}	<p>Continued From page 3</p> <p>addition, Resident #8's care plan did not include relevant dialysis care interventions. The deficient practice had the potential to cause harm if residents did not receive appropriate care and interventions due to inaccurate information on the care plan. Findings include:</p> <p>1. Resident #3 was readmitted to the facility on 8/22/17 with diagnoses that included aspiration pneumonia, muscle spasms, and fibromyalgia.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 8/29/17, documented Resident #3 had moderate cognitive impairment and was totally dependent on 2 staff members for transfers and totally dependent on 1 staff member for Activities of Daily Living (ADLs), including bed mobility, toilet use, dressing, bathing and locomotion.</p> <p>a. The ADL Care Plan, dated 8/15/17, documented Resident #3 required total assistance of 2 staff for transfers and bathing and required total assistance of 1 staff member for bed mobility, toilet use, personal hygiene, eating, and dressing. The care plan did not document that the resident refused cares.</p> <p>A Speech Therapy Discharge Summary, dated 9/15/17 documented Resident #3 had been re-admitted to the facility after being hospitalized with aspiration pneumonia, dysphagia, and acute respiratory failure. The summary documented Resident #3 "showed a lack of progress and required verbal and tactile cues to maintain proper positioning." The Discharge Summary recommended Resident #3 required "close supervision" for oral intake and instructed staff</p>	{F 280}	<p>3. Care plan training has been implemented for IDT team for proper care planning procedures. Psychoactive care plan audits will be completed by DON/designee weekly x4, then monthly x3.</p> <p>4. Review of audits conducted monthly at QAPI to monitor compliance.</p>		

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{F 280}	<p>Continued From page 4</p> <p>that Resident #3 was to be in an upright position for meal and for 30 minutes after meals. The summary documented staff members were to encourage Resident #3 to eat while sitting in his wheelchair and to alternate liquids and solids while assisting him with meals. Resident #3's care plan did not document positioning requirements from the Speech Therapy Discharge Summary for Resident #3 when he ate and or after eating.</p> <p>An Alteration in Skin Integrity Risk Care Plan, dated 8/14/17, documented Resident #3 was to have his heels floated at night and he was to have blue padded boots to his feet placed on in the morning and taken off at night.</p> <p>On 10/2/17 at 2:20 pm, Resident #3 was observed in his bed positioned on his back with his heels and feet touching the mattress and there were no blue boots on his feet. Resident #3 stated he did not always like to wear the blue boot "especially at night." He stated he would ask staff to take the boot off at night sometimes because "he wanted a good night sleep." He stated staff did not always remove the blue boots at night and he wanted a break from the boots. Resident #3 stated he did not like to float his heels all the time.</p> <p>On 10/2/17 at 2:25 pm, CNA #2 assisted Resident #3 to drink while he was in bed. Resident #3's bed was not elevated as he drank.</p> <p>On 10/3/17 at 8:34 am, CNA #1 was observed delivering assisted Resident #3's breakfast tray, and assisted him to eat.</p>	{F 280}		

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{F 280}	<p>Continued From page 5</p> <p>On 10/3/17 at 9:05 am, CNA #1 was observed removing the meal tray from Resident #3's room. Resident #3 was observed lying flat on his back. Resident #3 stated he liked to lay down and be flat of his back due to "increased pain with sitting up too much." Resident #3 stated he had enjoyed his oatmeal for breakfast.</p> <p>On 10/3/17 at 10:50 am, the Assistant Director of Nursing Services (ADNS) stated he thought the care plan contained the missing information above and he would investigate the issues. He stated he could not determine from the care plan if Resident #3 refused to wear blue boots or float his heels. The ADNS did not know that Resident #3 was refusing to stay upright after meals.</p> <p>b. Resident #3's physician's orders documented he received 40 mg of Cymbalta daily for depression beginning 9/22/17, and 150 milligrams (mg) of Seroquel daily for delusional disorder beginning 9/29/17.</p> <p>A Psychotropic Medication Care Plan, dated 9/9/17, documented Resident #3 was taking psychotropic medications for bipolar disorder and dementia. The care plan's identification of the reasons for psychotropic medication use did not match the diagnoses in the physician's orders.</p> <p>A Psychosocial Care Plan, dated 4/18/17, documented Resident #3 had depression and he worried about his wife. The care plan did not document how staff were to intervene when the resident expressed concern about his wife.</p> <p>On 10/3/17 at 10:50 am, the ADNS stated he was not sure what the Seroquel was being used to</p>	{F 280}		

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{F 280}	<p>Continued From page 6</p> <p>treat and he stated the order would document the reason for the medications use. The ADNS stated the Psychotropic Medication Care plan was inconsistent with the physician orders.</p> <p>c. A Socially Inappropriate Behavior Care Plan, dated 4/18/17, documented Resident #3 would yell and disrupt the environment around him. Interventions included offering him a quiet place away from his peers.</p> <p>On 10/2/17 at 2:20 pm, Resident #3 was observed in bed and he stated he preferred to stay in his room unless his family came to visit him.</p> <p>On 10/3/17 at 1:33 pm, the Administrator stated he was not aware of that Resident #3 had "Socially Inappropriate Behaviors" and that Resident #3 stayed in his room the majority of the time. He stated he would have his staff look at the validity of the Socially Inappropriate Care Plan.</p> <p>An ADL Care Plan, dated 8/15/17, documented Resident #3 required total assistance of 2 staff for transfers and bathing and required total assistance of 1 staff member for bed mobility, toilet use, personal hygiene, eating, and dressing. The care plan did not address frequency of positioning, frequency of bathing, or toileting frequency.</p> <p>On 10/3/17 at 10:50 am, the Assistant Director of Nursing Services (ADNS) stated he thought the care plan contained the missing information above and he would investigate the issues. He stated he could not determine from the care plan</p>	{F 280}			

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{F 280}	<p>Continued From page 7</p> <p>how often Resident #3 required repositioning, incontinence care, or bathing.</p> <p>2. Resident #8 was readmitted to the facility on 12/9/16 with diagnoses that included end stage renal disease with dialysis.</p> <p>Resident #8's quarterly MDS assessment, dated 9/11/17, documented she was cognitively intact and dependent on staff for most care needs.</p> <p>a. Resident #8's Dialysis Care Plan, dated 10/28/15, documented her dialysis schedule, to avoid blood pressures in the arm where her shunt was placed, and to monitor the resident's weight and edema. The care plan did not document the need to monitor the dialysis access site for infection, bleeding, or thrill and bruit; if and how often the resident's vital signs needed to be monitored following dialysis; what kind of information needed to be communicated between the dialysis center and facility; and whether the dressing covering the dialysis site was to be removed or changed after the resident returned to the facility.</p> <p>On 10/4/17 at 9:56 am, the Regional Nurse Consultant (RNC) stated the dialysis care plan should have included the information that was found to be missing.</p> <p>b. A 12/9/16 Physician's Order documented Resident #8 received 20 mg of Celexa at bedtime for depression.</p> <p>A Psychotropic Drug Use Care Plan, dated 9/7/17, documented Resident #8 received Celexa for depression. The care plan did not document</p>	{F 280}			

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{F 280}	<p>Continued From page 8</p> <p>interventions to monitor for the effectiveness of the medication or resident-specific symptoms of depression.</p> <p>On 10/3/17 at 1:33 pm, the RNC stated she would look into the concerns with the care plans and she was aware of the issues.</p> <p>3. Resident #9 was readmitted to the facility on 9/15/17 with diagnoses that included personality disorder, single episode of major depression, anxiety disorder, dementia, and insomnia.</p> <p>Resident #9's quarterly MDS assessment, dated 8/7/17, documented he was cognitively intact with signs of mild depression and was dependent on staff for all care needs.</p> <p>Resident #9's October 2017 Physician Orders included:</p> <ul style="list-style-type: none"> * 120 mg of Cymbalta one time a day for depression. * 0.5 mg of Ativan three times a day for anxiety. * 4 mg of Rexulti one time a day for depression. * 100 mg of Trazodone one time a day for insomnia. <p>A Psychotropic Drug Use Care Plan, dated 8/7/15, documented Resident #9 received Trazodone, Cymbalta, Ativan, and Rexulti for his diagnoses of major depression, personality disorder, anxiety and insomnia. Interventions included the administration of medications as ordered, tracking target behaviors, and monitoring for side effects of the medications. The care plan did not document resident specific symptoms of depression or anxiety or</p>	{F 280}			

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{F 280}	Continued From page 9 evaluations for periodic dosage reductions. The care plan did not document non-pharmacological interventions to be attempted when the resident experienced insomnia, or the need to monitor the effectiveness of medications used.	{F 280}			
{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 observation, staff and resident interview, and record review, it was determined the facility failed to ensure administration of medications, and assessments of residents were completed according to accepted standards of practice and physician's orders for 2 of 6 residents (#3 and #9) reviewed for medication administration and positioning during meals. Specifically, the facility failed to: a) Ensure Physician orders were followed for positioning during meal times for Resident #3. b) Monitor blood pressure prior to administering cardiac medications to Resident #9. These failures created the potential for harm if residents received medication without indication	{F 281}	1. Resident #3 no longer resides in facility. Resident #9 was impacted regarding beta blockers/ cardiac medication. Education provided to LNs regarding guidelines for beta blockers/ cardiac medications and MAR revised to require documentation for blood pressure and pulse regarding these medications. 2. All residents with speech therapy or receiving beta blockers/ cardiac medications have the potential to be affected. MAR review for residents with orders for beta blockers and cardiac medications reviewed. Care plans reviewed and revised as needed.	11/13/17	

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{F 281}	<p>Continued From page 10</p> <p>for use, in a manner that caused undesirable changes in blood pressure, and/or experienced aspiration when poorly positioned during meals. Findings include:</p> <p>1. Resident #3 was readmitted to the facility on 8/22/17 with diagnoses that included aspiration pneumonia.</p> <p>Resident #3's Admission Minimum Data Set (MDS) assessment, dated 8/29/17, documented moderate cognitive impairment and assistance of 1 staff member required with eating.</p> <p>A Speech Therapy Discharge Summary, dated 9/15/17, documented Resident #3 had been readmitted to the facility after being hospitalized with aspiration pneumonia, dysphagia, and acute respiratory failure. The summary documented Resident #3 "showed a lack of progress and requires verbal and tactile cues to maintain proper positioning." The Discharge Summary recommended Resident #3 required "close supervision" for oral intake and "thoroughly educated" staff that Resident #3 was to be in an upright position for meals and for 30 minutes after meals. The summary documented staff members were to encourage Resident #3 to eat while sitting in his wheelchair and to alternate liquids and solids while assisting him with meals.</p> <p>An 8/15/17 Activity of Daily Living (ADL) Care Plan did not document positioning requirements from the Speech Therapy Discharge Summary for Resident #3 when he ate and or after eating.</p> <p>An 8/22/17 ADL Kardex (pocket care plan for direct care staff) did not document positioning</p>	{F 281}	<p>3. Care plan and kardex will be reviewed and updated, and staff educated on these items. Residents with speech therapy orders for positioning after meals will be given Risk vs. Benefits regarding these orders and the residents' wishes will be honored. Audits for residents with positioning recommendations will be audited daily x5, then daily x2 for 1 week, then weekly x4 for proper positioning after meals. These audits will be conducted by DON/ designee. eMAR will be audited for proper documentation and administration regarding beta blockers/cardiac medication weekly x4 and monthly x3 by DON/designee.</p> <p>4. Review of audits conducted monthly at QAPI to monitor for compliance.</p>		

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{F 281}	<p>Continued From page 11 requirements from the Speech Therapy Discharge Summary for Resident #3 when he ate and or after eating.</p> <p>On 10/2/17 at 2:25 pm, CNA #2 assisted Resident #3 to drink while the resident was in bed, but did not elevate the head of the bed while doing so.</p> <p>On 10/3/17 at 8:34 am, CNA #1 was observed delivering and assisted Resident #3 with his breakfast tray. On 10/3/17 at 9:05 am, CNA #1 was observed removing the meal tray from Resident #3's room. Resident #3 was observed lying flat on his back. Resident #3 stated he liked to lay down and be flat of his back due to "increased pain with sitting up too much."</p> <p>On 10/3/17 at 10:50 am, the Assistant Director of Nursing Services (ADNS) was not aware that Resident #3 was refusing to stay upright after meals.</p> <p>On 10/3/17 at 1:33 pm, the Regional Nurse Consultant (RNC) stated when a resident refused treatment the facility would try and educate the resident on the risk verses benefits and document that it was completed. She agreed that if a resident gave a reason for the refusal the facility should attempt to resolve the concern.</p> <p>On 10/4/17 at 10:54 am, the Resident Services Director stated she was aware Resident #3 was working with speech therapy to stay upright after meals and she was not aware that Resident #3 was refusing to stay upright after meals. She stated staff should come to her with concerns and she would discuss the concerns with the</p>	{F 281}			

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{F 281}	<p>Continued From page 12 resident to try and resolve them.</p> <p>2. Resident #9 was readmitted to the facility on 9/15/17 with diagnoses that included hypertension (HTN).</p> <p>Resident #9's quarterly MDS assessment, dated 8/7/17, documented he was cognitively intact with signs of mild depression and was dependent on staff for all care needs.</p> <p>According to the 2018 Nursing Drug Handbook, Metoprolol, an antihypertensive, should not be administered without first assessing the apical (taken on the chest) pulse rate. If the apical heart was less than 60 beats per minute (bpm), the medication should be held and the physician contacted "immediately."</p> <p>Resident #9's Physician's Orders documented the resident received 100 milligrams (mg) of Metoprolol daily for HTN, beginning 9/19/17. The order documented Resident #9's blood pressure and pulse should be taken prior to administration, and the medication should be held if the resident's pulse was below 60 bpm or systolic blood pressure was less than 100. The order documented staff were to notify the physician if the medication was held.</p> <p>Resident #9's Medication Administration Record (MAR) from 9/1/17 through 10/2/17 documented Metoprolol was administered daily.</p> <p>Resident #9's Vital Summary did not document his blood pressure was taken between 9/1/17 and 9/12/17, 9/14/17 and 9/16/17, and on 9/18/17, 9/19/17, or 10/1/17.</p>	{F 281}		

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{F 281}	Continued From page 13 On 9/20/17 Resident #9's Vital Summary documented his pulse was 54 bpm. The resident's MAR documented he received received Metoprolol that day. There was no documentation the resident's physician was not notified. On 10/4/17 at 9:56 am, the RNC stated the staff should have held the medication when the pulse was below 60 bpm, and should have called the physician for further instructions. She stated the resident's blood pressure should have been taken prior to the administration of the medication.	{F 281}			
{F 309} SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	{F 309}		11/13/17	

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{F 309}	Continued From page 14 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, policy review, and record review, the facility failed to provide the necessary care and services to attain or maintain residents' highest practicable level of physical, mental, and psychosocial well-being, for 1 of 1 residents (#8) reviewed for dialysis services, specifically dressing management of the shunt site (surgically created blood vessel access area) after returning to the facility from dialysis and complete coordination of care with the dialysis provider. Findings include: Resident #8 was readmitted to the facility on 12/9/16 with diagnoses that included end stage renal disease with dialysis. Resident #8's quarterly Minimum Data Set (MDS) assessment, dated 9/11/17, documented she was cognitively intact and dependent on staff for most care needs.	{F 309}	1. Resident #8's Mar updated to reflect care and management necessary to shunt site. Coordination of care to be established between facility Medical Director/ designee and Medical Director/ designee at dialysis site. 2. All residents on dialysis have the potential to be affected. Resident #8 is the only current resident receiving dialysis. 3. Medical director/designee from facility and dialysis clinics will communicate regarding coordination of care, and will follow the plan of care for dialysis patients at the facility. Care plans will be reviewed and revised to reflect conditions of coordination of care. Staff educated on policy and procedure for dialysis care. Hemodialysis audits to be conducted 3x a		

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{F 309}	Continued From page 15 The facility was unable to provide documentation of a coordinated plan of care with the dialysis center regarding Resident #8. Resident #8 had Dialysis Communication Records forms in her clinical record, which contained areas for facility nurses to communicate clinical information to the dialysis center when the resident went for each treatment, and to receive information back from the dialysis center when the resident returned. The Dialysis Communication Records could not be located for Resident #8 for the dialysis treatments completed on 9/13/17, 9/15/17, 9/18/17, 9/20/17, 9/25/17 and 9/29/17. Resident #8's clinical record from 9/11/17 through 10/4/17 did not include management or monitoring of her shunt site. On 10/4/17 at 11:30 am, Licensed Practical Nurse (LPN) #1 stated when Resident #8 returned from dialysis there was a dressing to the shunt site. On 10/4/17 at 9:56 am, the Regional Nurse Consultant (RNC) stated the management of the dressing to the Resident #8's shunt site and monitoring of the site itself should be documented on the resident's MAR . The RNC stated she could not find a coordination of care with the dialysis center.	{F 309}	week x1 week, then weekly x4, then monthly x3 by DON/ designee. 4. Review of audits conducted monthly at QAPI to monitor for compliance.		
{F 312} SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming,	{F 312}		11/13/17	

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{F 312}	<p>Continued From page 16 and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interview, and clinical record review, it was determined the facility failed to provide necessary assistance with bathing. This was true for 3 of 6 residents (#3, #8 and #11) reviewed for hygiene and created the potential for harm from embarrassment or rejection by others due to appearance and/or personal odor. Findings include:</p> <p>The Facility's Bathing Schedule documented all showers were scheduled Monday through Friday, and "Make-up Showers" were scheduled for Wednesdays. There were no scheduled or "Make-up Showers" on the weekends.</p> <p>1. Resident #3 was readmitted to the facility on 8/22/17 with diagnoses that included aspiration pneumonia, muscle spasms, and fibromyalgia.</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 8/29/17, documented Resident #3 had moderate cognitive impairment and was dependent on 2 staff members for transfers and dependent on 1 staff member for bathing.</p> <p>The Facility's Bathing Schedule documented Resident #3 was to receive a shower/bath on Tuesdays and Fridays.</p> <p>An ADL Care Plan, dated 8/15/17, documented Resident #3 required total assistance of 2 staff members for bathing. The care plan did not address the frequency of bathing.</p>	{F 312}	<p>1. Resident #3 no longer resides in facility. Residents #8 and #11 were provided showers.</p> <p>2. All residents have the potential to be affected. Facility reviewed bathing sheets to ensure bathing has been taking place.</p> <p>3. Staff educated on refusals and bathing/showering make ups. C.N.A's will notify the charge nurse when a refusal takes place, and the nurse will re-approach residents and document refusals if they occur. Residents will be offered a make up shower/bath if one is missed. Bathing sheets will be revised and will be reviewed for compliance at clinical meeting in perpetuity by DON/ designee for compliance.</p> <p>4. Review of audits conducted monthly at QAPI to monitor for compliance.</p>		

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{F 312}	Continued From page 17 Resident #3's CNA Bathing Sheets from 9/1/17 through 10/3/17 documented he was not showered/bathed from 9/7/17 to 9/13/17 (6 days), 9/14/17 to 9/19/17 (5 days) and 9/28/17 to 10/3/17 (5 days). Resident #3's record documented he refused a shower on 9/8/17, 9/15/17 and 9/29/17. Three other baths/showers were documented as scheduled but not completed with no explanation. The Bathing Sheets did not document staff re-approached the resident if/when he refused to shower on the above dates. On 10/2/17 at 2:20 pm, Resident #3 stated he did not receive baths as scheduled and he was aware of missed bathing opportunities recently. Resident #3 stated he did not recall refusing showers recently. He stated the times he remembered refusing they offered the shower close to his meal time or during a favorite television show. 2. Resident #8 was readmitted to the facility on 12/9/16 with diagnoses that included end stage renal disease with dialysis. Resident #8's quarterly MDS assessment, dated 9/11/17, documented she was cognitively intact and dependent on staff for bathing needs. The ADL Care Plan, dated 11/4/16, documented Resident #8 required total assistance of 2 staff members for bathing. The care plan did not address the frequency of bathing. The Facility's Bathing Schedule documented Resident #8 was scheduled for a shower/bath on	{F 312}			

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{F 312}	<p>Continued From page 18 Tuesdays and Thursdays.</p> <p>Resident #8's CNA Bathing Sheets from 9/1/17 through 10/3/17 documented she was not showered/bathed from 9/1/17 to 9/7/17 (6 days), 9/8/17 to 9/19/17 (11 days), 9/20/17 to 9/26/17 (5 days), and 9/27/17 to 10/3/17 (6 days). Resident #8's record documented she refused to bathe on 9/14/17, 9/21/17 and 9/29/17. Two other baths/showers were documented as scheduled but not completed with no explanation. The Bathing Sheets did not document staff offered to shower/bathe Resident #8 or whether staff re-approached the resident if/when she refused to shower on the above dates.</p> <p>On 10/3/17 at 4:14 pm, Resident #8 stated she knew the staff was busy and she understood that staff could not "always" get her showers done on Tuesdays and Thursdays. She stated she wanted a shower "at least" once a week.</p> <p>3. Resident #11 was admitted to the facility on 1/13/15 with diagnoses that included dementia.</p> <p>Resident #11's quarterly MDS assessment, dated 7/31/17, documented she was severely cognitive impaired and required physical help of one staff member for bathing needs.</p> <p>Resident #11's CNA Bathing Sheets from 9/1/17 through 10/4/17 documented she was not showered/bathed from 9/19/17 to 9/25/17 (6 days) and 9/26/17 to 10/4/17 (9 days). Resident #11 refused to bathe on 9/5/17, 9/6/17, 9/21/17, 9/28/17 and 9/29/17. Two other baths/showers were documented as scheduled but not completed with no explanation. The Bathing</p>	{F 312}		

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{F 312}	<p>Continued From page 19</p> <p>Sheets did not document staff offered to shower/bathe Resident #8 or whether staff re-approached the resident if/when she refused to shower on the above dates.</p> <p>On 10/4/17 at 11:25 am, Certified Nursing Assistant (CNA) #3 stated when a resident refused to shower on their scheduled shower day she would reapproach later that day and offer an opportunity to bathe again. CNA #3 stated she would reapproach "at least" twice. She stated after her last reapproach she would tell a nurse or social services to see if they could get the resident to agree to shower. CNA #3 stated she did not document the re-approaches and/or continued refusals. CNA #3 stated if a resident refused their shower on Monday or Tuesdays she would attempt to shower them on Wednesdays or the "Make-up Shower" day "if she had time." CNA #3 stated she did not know how a shower was "made up" if a resident refused a shower on Wednesday, Thursday, or Friday. CNA #3 stated she did not know how the facility accommodated a resident who preferred or requested a shower or bath on a weekend. CNA #3 stated from the documentation it appeared showers were "only" occurring on the weekdays while she was working. CNA #3 stated "guessed" the residents who did not get a shower on Thursdays or Fridays would not receive showers until the next week. CNA #3 stated she worked Monday through Fridays and was the only person assigned to bathe residents on Monday through Wednesday each week. CNA #3 stated she had help to perform showers on Thursdays and Fridays from another shower aide. CNA #3 stated residents were assigned different shower days and she did not always have time to complete all</p>	{F 312}			

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{F 312}	Continued From page 20 the showers. She stated when she did not have time to complete the shower she documented the shower did not occur. She stated she knew showers were not always being completed and stated she needed help to complete them.	{F 312}		