



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

TAMARA PRISOCK—ADMINISTRATOR  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

**CORRECTED COPY**

October 31, 2017

Stephen Farnsworth, Administrator  
Gateway Transitional Care Center  
527 Memorial Drive,  
Pocatello, ID 83201-4063

Provider #: 135011

Dear Mr. Farnsworth:

On **October 13, 2017**, a survey was conducted at Gateway Transitional Care Center 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 in your facility to be an isolated deficiency that constitutes immediate jeopardy to resident health or safety, as documented on the enclosed CMS-2567, whereby significant corrections are required.** You were informed of the immediate jeopardy situation(s) in writing on **October 11, 2017**.

On **October 12, 2017**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed effecting **October 12, 2017**. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet,

answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 9, 2017**. Failure to submit an acceptable PoC by **November 9, 2017**, may result in the imposition of additional civil monetary penalties by **December 3, 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*.

- **F0367 -- S/S: J -- 483.60(e)(1)(2) -- Therapeutic Diet Prescribed By Physician**

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

- Civil monetary penalty
- Denial of Payment for New Admissions effective January 13, 2018

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 13, 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 and 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, 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.

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

Stephen Farnsworth, Administrator  
October 31, 2017  
Page 4

This request must be received by **November 9, 2017**. If your request for informal dispute resolution is received after **November 9, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink that reads "Nina Sanderson (L.S.W.)". The signature is written in a cursive style.

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

NS/lj

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

PRINTED: 11/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/13/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE POCATELLO, ID 83201</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from October 10, 2017 to October 13, 2017. Immediate Jeopardy was identified at:</p> <p>*42 CFR 483.60 [F367]</p> <p>Immediate Jeopardy at F367 was removed prior to the exit conference.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Leader Linda Kelly, RN Cecilia Stockdill, RN Sunday Crawford, RN Jackie Miles, LSW</p> <p>Abbreviations:</p> <p>ADL = Activities of Daily Living ADON = Assistant Director of Nursing AIT = Administrator In Training AROM = Active Range of Motion BG = Blood Glucose CBC = Complete Blood Count CCD = Consistent Carbohydrate Diet CDM = Certified Dietary Manager CNA = Certified Nursing Assistant DM = Diabetes Mellitus DNS = Director of Nursing Services DON = Director of Nursing F = Fahrenheit GERD = gastroesophageal reflux disease GI = gastrointestinal HD = hemodialysis</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

11/03/2017

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

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F 000	Continued From page 1 HOB = head of her bed IC = Infection Control IDT = Interdisciplinary Team IJ = immediate jeopardy IP = Infection Preventionist IPCP = infection prevention and control program IV MAR = Intravenous Medication Administration Record LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set mg = milligrams mg/dl = milligrams per deciliter ml = milliliter NPO = nothing by mouth LSW = Licensed Social Worker O2 = oxygen OZ = Ounce PO = By Mouth P&P = Policy and Procedure PRN = As needed PROM = Passive Range of Motion Pt = Patient QA = Quality Assurance RD = Registered Dietitian RN = Registered Nurse RNA = Restorative Nursing Assistant ROM = Range of Motion SLP = Speech Language Pathology s/sx = signs/symptoms ST = Speech Therapy TAR = Treatment Administration Record TF = Tube Feeding UTI = urinary tract infection	F 000			
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		11/3/17	

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F 157	Continued From page 2  (g)(14) Notification of Changes.  (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-  (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;  (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);  (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or  (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).  (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.  (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-  (A) A change in room or roommate assignment	F 157			

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F 157	<p>Continued From page 3 as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). 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 a resident's physician was notified of significant changes in the resident's clinical condition. This was true for 1 of 17 (#2) sample residents and had the potential for more than minimal harm when the facility failed to notify Resident #2's physician of the resident's low blood sugar readings. Findings include:</p> <p>Resident #2 was admitted on 6/7/17 with diagnoses including sepsis (severe infection), UTI (urinary tract infection), and Type II diabetes mellitus.</p> <p>Resident #2's diabetes mellitus care plan documented "Monitor/document/report to MD (Medical Doctor) PRN (as needed) signs and symptoms of hypoglycemia (low blood sugar)."</p> <p>Resident #2's 10/2/17 Order Summary Report documented Humalog (Insulin Lispro): "...If BG (blood glucose) is 70 or below notify MD."</p> <p>Resident #2's 8/1-8/31/17 Medication Administration Record (MAR) documented blood glucose readings as follows: 67 on 8/20/17 at</p>	F 157	<ol style="list-style-type: none"> <li>1. Reviewed and educated nursing staff of the facility P&amp;P of diabetic protocol in particular, physician notification. education was conducted on the following dates: 10/14, 10/17 and 10/25.</li> <li>2. All residents with orders for insulin have the potential to be affected by this deficient practice.</li> <li>3. All current residents with insulin were reviewed and orders were updated in the electronic medical record to prompt nursed to notify the physician when blood sugars are out of range as outlined in the facility P&amp;P.</li> <li>4. DON/Designee will audit the medical records to ensure that the nursing staff is properly notifying the physician when blood sugar readings are out of range 5 days per week for 2 weeks then once per week for 2 months, then periodically thereafter. Audits began on 10/18/17. Report findings to QAPI.</li> <li>5. Date of compliance 11/3/2017.</li> </ol>		

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F 157	Continued From page 4 7:00 am, 61 on 8/28/17 at 7:00 am, 60 on 8/30/17 at 6:30 and 7:00 am, 58 on 8/31/17 at 7:00 am, and 60 on 8/31/17 at 8:00 pm.  Resident #2's 9/1-9/30/17 MAR documented blood glucose readings as follows: 62 on 9/4/17 at 7:00 am, 61 on 9/7/17 at 7:00 am, and 68 on 9/12/17 at 12:00.  Resident #2's 10/1/17-10/31/17 Medication Administration Record (MAR) documented a blood glucose of 52 on 10/3/17 at 8:00 am and a blood sugar of 59 on 10/5/17 at 7:00 am.  On 10/12/17 at 1:05 pm, Resident #2 said he did not notice any symptoms when his blood glucose was low. He did not know if his physician was notified when this occurred.  On 10/13/17 at 9:24 am the DON (Director of Nursing) said there was no documentation Resident #2's physician was notified, he did not recall if the physician was notified. The DON stated the nurse should follow physician's orders.	F 157			
F 164 SS=D	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  (h)(3)The resident has a right to secure and confidential personal and medical records.	F 164		11/3/17	

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F 164	<p>Continued From page 5</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>§483.70</p> <p>(i) Medical records.</p> <p>(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure a resident's privacy during peri care (cleaning between the resident's legs.) This was true for 1 of 17 sample residents (#4). This</p>	F 164	<p>1. Nursing staff was educated on 10/14, 10/17 and 10/25 on residents rights with regards to privacy during cares to include closing the window blinds.</p> <p>2. All residents that receive cares have</p>		

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F 164	Continued From page 6 deficient practice created the potential for harm should Resident #4 become embarrassed if others observed her receiving peri care and her exposed body was seen by others. Findings include:  Resident #4 was admitted to the facility on 6/17/16 and re-admitted on 2/13/17 and 7/3/17 with diagnoses including sepsis (severe infection) and muscle weakness.  On 10/11/17 at 4:55 pm, Resident #4 was lying in bed and CNA (Certified Nursing Assistant) #3 entered the resident's room. CNA #3 told the resident she was going to change her disposable briefs and pulled the privacy curtain between the bed and the door. The window blinds were in the open position on the other side of the resident's bed. It was possible to see through the resident's window into a grassy courtyard with a bench facing towards the resident's window. The Courtyard was an open area for staff, visitors, and residents to walk around and sit on the bench. CNA #3 proceeded to pull down Resident #4's pants to her knees, exposing the abdomen, disposable brief, and upper legs. When asked if the resident's privacy was protected, CNA #3 looked at the window and said she should have closed the blinds.	F 164	the potential to be affected by this deficient practice. 3. Facility P&P was reviewed and updated to ensure that privacy was defined to include, but not limited to: pulling blinds during cares. Facility re-education on the facility P&P for privacy during cares was conducted on the dates outlined above. 4. Lead nurse aide or designee will audit resident care episodes 3 times per week for 4 weeks, then once per week for 2 months to ensure that facility privacy P&P is being followed. Audits began 10/17/2017. Report findings to QAPI. 5. Date of compliance of 11/3/2017.		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY  (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 241		11/3/17	

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F 241	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure residents were treated with dignity and respect during their dining experience when staff stood over a resident while assisting the resident to eat. This was true for 1 of 17 sample residents (#7) and created the potential for harm if residents' sense of self-worth or self-esteem was negatively affected. Findings include:  Resident #7 was admitted on 4/24/14 with diagnoses including Type 2 diabetes mellitus, depression, and dementia.  Resident #7's 9/8/17 quarterly (Minimum Data Set) assessment documented severe cognitive impairment, and supervision was required for eating.  On 10/12/17 at 12:35 pm, CNA (Certified Nursing Assistant) #4 was observed feeding Resident #7 in his room as he sat up in bed. CNA #4 stood on the left side of the resident as she fed him. The resident occasionally opened his eyes to verbal stimuli as CNA #4 fed him a sandwich and potato and assisted him to drink water.  On 10/12/17 at 12:45 pm, when asked about how to ensure the resident is treated with respect and dignity during meals, CNA #4 said she should have been sitting down as she fed the resident and she forgot.	F 241	1. Facility nursing staff was educated on the importance of not standing while assisting residents to eat. This training was completed on 10/14, 10/17 and 10/25. 2. All residents that require eating assistance are at risk with the this deficient practice. 3. The facility P&P on Diners/Assisting dependent was reviewed and updated on 10/14 to reflect that staff are to sit whenever they are assisting a resident to eat. 4. Lead nurse aide or designee will audit that proper assistance with dignity is provided to the residents that need dining assistance from the facility staff 3 times per week for 4 weeks, then once per week for 2 months. Audits began on 10/17. Report findings to QAPI. 5. Date of compliance of 11/3/2017.		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS  483.20	F 279		11/3/17	

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F 279	<p>Continued From page 8</p> <p>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p>	F 279			

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NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE POCATELLO, ID 83201</b>		
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F 279	<p>Continued From page 9</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and revise care plan interventions for 1 of 17 sample residents (Resident #18). This was true when Resident #18's care plan did not address diabetes management. This failure created the potential for harm should residents have unmet care needs or receive inappropriate care due to inaccurate information on the care plan. Findings include:  Resident #18 was admitted to the facility on 8/25/17 with diagnoses that included Diabetes Mellitus.  An Admission MDS assessment, dated 9/1/17, documented Resident #18 was cognitively intact and required insulin injections 7 days a week.</p>	F 279	<ol style="list-style-type: none"> <li>1. Facility updated resident #18 care plan to reflect proper diabetic management on 10/13.</li> <li>2. This deficient practice has the potential to affect the care of all residents.</li> <li>3. The admitting nursing staff were educated to apply all history and physical Dx's that are being actively treated to the resident care plan upon admission on 10/24. All clinical staff were educated on this system change on 10/25. Facility has implemented a care plan update tool (10/25) to be located at each nurses station for clinical staff to note any significant changes in residents plan of care which is then reviewed by nurse administration to ensure that noted changes are being applied to the resident</li> </ol>		

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F 279	Continued From page 10  Resident #18's clinical record did not contain a Diabetes Management Care Plan from 8/25/17 through 10/13/17.  On 10/13/17 at 11:20 am, the Assistant Director of Nursing (ADON) stated she could not locate the Diabetes Care Plan for Resident #18 and would get one added to her record.	F 279	care plan. Education on 10/25. 4. DON/Designee will audit all new admissions and the care plan audit tool to ensure that care plans are updated in a timely manner. 3 times a week for 4 weeks then once per week for 2 months. Audits began on 10/25. Report findings to QAPI. 5. Date of compliance of 11/3/2017.		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:  (i) The right to participate in the planning process, 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 right to participate in his or her treatment and	F 280		11/3/17	

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F 280	<p>Continued From page 11 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 and their resident representative is determined</p>	F 280			

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F 280	<p>Continued From page 12 not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, 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 6 of 20 sample residents (#s 2, 3, 4, 5, 9 &amp; 19). The deficient practice had the potential to cause harm if residents did not receive appropriate care and services due to inaccurate information in their care plans. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 4/10/17 with diagnoses that included cancer of the mouth, malnutrition and dysphagia of the oropharyngeal phase.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 9/1/17, documented Resident #3 was cognitively intact and required nutrition support. The MDS documented he received chemotherapy and radiation therapy.</p> <p>a. Resident #3's Cancer Care Plan, revised 7/7/17, documented he was receiving cancer treatments at a cancer center, initiated 7/7/17</p>	F 280	<p>1. All residents that were identified to be affected were reviewed and care plans/orders were updated to reflect current care needs by 10/31. 2. All residents have the potential to be affected by this deficient practice. 3. Corrective actions accomplished to ensure the deficient practice does not re-occur are: Facility has implemented a Care Plan Update Tool (10/25) to be located at each nurses station for clinical staff to note any significant changes in residents plan of care which is then reviewed by nurse administration to ensure that noted changes are being applied to the resident care plan. Education on 10/25. 4. DON/designee will audit all new admissions and the care plan audit tool to ensure that care plans are updated in a timely manner. 3 times per week for 4 weeks then once per week for 2 months. Audits began on 10/25. Report findings to QAPI. 5. Date of compliance of 11/3/2017.</p>		

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F 280	<p>Continued From page 13 and had a Complete Blood Count (CBC) drawn weekly for 3 weeks, initiated 4/11/17.</p> <p>On 10/12/17 at 3:24 pm, the Assistant Director of Nursing (ADON) stated Resident #3 had finished treatment at the cancer center a few weeks ago and the care plan should have been updated. The ADON stated the labs were drawn back in April of 2017 and these items should have been resolved and removed from the care plan.</p> <p>b. Resident #3's Tube feeding Care Plan, dated 7/7/17, documented he was at risk for complications related to swallowing difficulty and cancer of the tongue. Resident #3's tube feeding care plan did not document:</p> <ul style="list-style-type: none"> <li>* Verification of the feeding tube placement prior to administering the tube feeding.</li> <li>* The need to check residuals prior to the administration of the tube feeding.</li> <li>* The type and placement of Resident #3's feeding tube.</li> <li>* The need to flush water through the feeding tube.</li> <li>* The need to keep the head of Resident #3's bed elevated following a tube feeding.</li> </ul> <p>On 10/12/17 at 3:24 pm, the ADON stated she would correct the concerns brought up on Resident #3's care plan.</p> <p>2. Resident #5 was readmitted to the facility on 12/23/11 with diagnoses that included contractures, anoxic brain injury, aphasia, and convulsions.</p> <p>A Quarterly MDS assessment, dated 8/31/17,</p>	F 280			

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F 280	<p>Continued From page 14</p> <p>documented Resident #5 had a severe cognitive impairment, was totally dependent on 1 to 2 staff members for all cares, received passive range of motion (PROM), utilized a splint, and required nutrition support.</p> <p>a. On 10/12/17 at 12:50 pm, Resident #5 was observed in the common area near the nurses' station and with a splint on both arms. Each splint was placed placed just above the resident's elbow, extended down her arms and stopped at the wrists.</p> <p>A 6/5/13 Activities of Daily Living (ADL) Care Plan documented Resident #5 was to have a splint placed on her right arm, from the elbow to the wrist; and a splint on the left wrist. The care plan was not revised to reflect the bilateral above elbow to wrist splints observed on 10/12/17. Nor did it document when the splints were to be applied or how long the splints were to be in place. In addition, the ADL Care Plan did not document the number of people required to assist Resident #5 with bed mobility, dressing, bathing and hygiene.</p> <p>On 10/12/17 at 2:24 pm the ADON said she was not sure how long Resident #5's bilateral arm splints were to be in place and that she would look into it. The ADON said she knew the resident's current splints were above the elbows to the wrists; and, that 1 - 2 staff were needed to assist with ADLs. The ADON said the resident's care plan needed to be revised in both areas.</p> <p>b. Resident #5's Alteration in Mood Care Plan, revised on 9/8/15, documented she had episodes of agitation and staff were to monitor her</p>	F 280			

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F 280	<p>Continued From page 15 behaviors frequently throughout the day and administer medication as ordered.</p> <p>On 10/12/17 at 3:30 pm, the Licensed Social Worker (LSW) stated Resident #5 was not taking a medication for agitation and this care plan should have been updated to reflect this.</p> <p>c. Resident #5's October 2017 Physician's Orders included:</p> <ul style="list-style-type: none"> <li>* Jevity 1.2 at 52 milliliters (ml) per hour for 20 hours. The tube feeding was to be turned on at 2:00 pm and off at 10:00 am. Staff were to run the tube feeding continuously and were to check the tube placement prior to starting the feeding, initiated 12/7/16.</li> <li>*Staff were to flush the feeding tube with 120 ml of water four times daily, initiated 8/17/16.</li> <li>*Staff were to keep the head of her bed (HOB) elevated up 45 degrees at all times, initiated 2/3/17.</li> </ul> <p>Resident #5's Tube feeding Care Plan, revised 9/10/13, documented she required tube feeding related to dysphagia and anoxic brain injury. Interventions included:</p> <ul style="list-style-type: none"> <li>* Resident #5 was to be elevated at least 30 - 45 degrees at all times.</li> <li>* Staff members were to verify the feeding tube placement prior to administering the tube feeding or medications.</li> <li>*Staff members were to monitor her gastric content and residual volume per facility protocol.</li> <li>* Staff were to provide Jevity 1.2 at 55 ml per hour for 20 hours starting at 2:00 pm and stopping at 10:00 am. Staff were to administer 60</li> </ul>	F 280			

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F 280	<p>Continued From page 16</p> <p>ml of water flushes four times a day.</p> <p>* Staff was to monitor his tube feeding site for s/sx of inflammation and redness.</p> <p>* Staff members were to check residuals prior to the administration of the tube feeding.</p> <p>Resident #5's Tube Feeding Care Plan did not include:</p> <p>*Staff were to flush the tub before and after medications and tube feeding administrations.</p> <p>*The type and placement of the feeding tube Resident #5 had.</p> <p>Resident #5's Tube Feeding Care Plan was inconsistent with her physician orders regarding the tube feeding rate, water flushes required, and HOB elevation.</p> <p>On 10/12/17 at 3:24 pm, the ADON stated she would correct the concerns brought up on Resident #5's care plan.</p> <p>3. Resident #19 was readmitted to the facility on 5/24/16 with diagnoses of Diabetes Mellitus</p> <p>Resident #19's Quarterly MDS assessment, dated 9/21/17, documented he was cognitively intact.</p> <p>A 4/4/17 Physician's Order documented Resident #19 was to receive Novolog as per sliding scale for diabetes.</p> <p>Resident #19's Diabetes Care Plan, dated 8/18/15, documented staff were to monitor for signs and symptoms of hyperglycemia and did not include when to monitor for hypoglycemia or</p>	F 280			

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

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F 280	<p>Continued From page 17</p> <p>when to initiate the hypoglycemic /hyperglycemic protocols as needed.</p> <p>On 10/13/17 at 2:45 pm, the ADON stated she did not see where the care plan documented hypoglycemic signs and symptoms, and she would correct it.</p> <p>On 10/12/17 at 3:00 pm, the ADON stated care plans were reviewed at least quarterly, and she and the Director of Nursing (DON) tried and review care plans as frequently as possible. The ADON stated when a resident had a change in status, the charge nurse was responsible for reviewing the care plan to verify it was appropriate. The nurse would verify those findings with with the ADON, the DON, or LSW as needed. The ADON stated as soon as a change was identified the facility should update the care plan.</p> <p>4. Resident #2 was admitted to the facility on 6/7/17 with diagnoses including sepsis (severe infection), UTI (urinary tract infection), muscle weakness, and Type II diabetes mellitus.</p> <p>Resident #2's 6/14/17 admission MDS (Minimum Data Set) assessment documented he was cognitively intact, always incontinent of bladder, had a diagnosis of renal insufficiency (poor kidney function), and received dialysis.</p> <p>Resident #2's 9/13/17 quarterly MDS assessment documented he was cognitively intact, required intermittent catheterization, was frequently incontinent of urine, and received dialysis.</p> <p>Resident #2's hemodialysis care plan, initiated</p>	F 280			

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F 280	<p>Continued From page 18</p> <p>6/19/17, documented the resident received hemodialysis (HD) and that a catheter for peritoneal dialysis (PD) had been removed. One intervention, initiated 8/30/17, was to monitor the dialysis site. The location of the dialysis site was not specified. There were not further updates documented to Resident #2's dialysis care plan such as avoiding checking the blood pressure in the arm with the HD dialysis access device or to monitor the site for the presence of a thrill (a palpable vibration) and bruit (hearing blood flow through a stethoscope) after the device was placed in the left arm or after the resident returned from dialysis.</p> <p>Resident #2's 10/2/17 Order Summary documented, "After fistula (access site for dialysis) placement monitor incision site for for signs of infection," ordered on 9/26/17.</p> <p>Resident #2's 10/3/17 at 1:00 am Nursing Progress Note documented the resident had a new fistula site on the left arm (for dialysis).</p> <p>Resident #2's 10/6/17 at 5:11 pm Nursing Progress Note documented the resident had an upper left arm dialysis shunt site "from last week" that had decreased swelling and much bruising.</p> <p>On 10/12/17 at 1:25 pm, Resident #2 was observed to have bruising and mild swelling to the left arm fistula site.</p> <p>On 10/12/17 and 3:00 pm, LPN #1 said no designated person does the care plan update or reviews, it's done by "whoever has a chance."</p> <p>On 10/13/17 at 5:22 pm, the Director of Nursing</p>	F 280			

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F 280	Continued From page 19	F 280			
F 309 SS=D	<p>said the care plan should have been updated.</p> <p><b>483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p><b>483.24 Quality of life</b> 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.</p> <p><b>483.25 Quality of care</b> 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:</p> <p>(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.</p> <p>(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</p>	F 309		11/3/17	

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F 309	<p>Continued From page 20 preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and resident and staff interview, it was determined the facility failed to ensure care and services were provided for 3 of 20 (#s 2, 9 &amp; 18) sampled residents reviewed for dialysis, hypoglycemic management and pain management. The failure created the potential for harm if residents experienced complications and/or compromised medical status. Findings include:</p> <p>1. Resident #18 was admitted to the facility on 8/25/17 with diagnoses that included end-stage liver cirrhosis and diabetes mellitus (DM).</p> <p>An Admission Minimum Data Set (MDS) assessment, dated 9/1/17, documented Resident #18 was cognitively intact and required insulin injections 7 days a week.</p> <p>Resident #18's clinical record did not contain a Diabetes Management Care Plan.</p> <p>Resident #18's October 2017 Physician Orders for DM included:</p> <p>* Lantus 40 units subcutaneously at bedtime, ordered 8/25/17.</p> <p>* Novolin R insulin 10 units subcutaneously, four times a day (scheduled), hold if blood glucose (BG) is under 200 and/or if resident does not eat more than 50% of meals, ordered 8/27/17.</p> <p>* Novolin R insulin per sliding scale, subcutaneously before meals and at bed time,</p>	F 309	<p>1. All orders and care plans were updated for all three affected residents to include: A. Resident #18 care plan was updated to include diabetic management on 10/13. #18 insulin orders were reviewed with the resident and the physician to ensure proper management. B. Resident #9 pain orders have been updated to include follow up pain scale as a means of verifying efficacy of pain control. C. Facility reviewed and updated the dialysis communication form to include: prompting the LN for a report from dialysis clinic and to indicate if there were changes to the resident status or care on 10/17.</p> <p>2. All residents who require care in the areas of pain management and dialysis have the potential to be affected by this deficient practice.</p> <p>3. Correct actions: A. Blood glucose policy has been updated and all residents with the potential to be affected orders' and care plans being updated to reflect the facility P&amp;P. Education provided to nursing staff regarding diabetic management and facility P&amp;P on 10/14, 10/17 and 10/25. The admissions process was updated to identify upon admission those with insulin that requires orders to prompt nurses to notify the physician when results are out of range according to P&amp;P. B. Facility pain management P&amp;P has been updated as well as orders to include a follow up pain scale rating post</p>		

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F 309	<p>Continued From page 21 but give insulin after meals and hold insulin if BG is under 200 and/or if resident does not eat more than 50% of meals, ordered 8/27/17.</p> <p>The Sliding Scale order was: BG 100-150 = 2 units BG 151-200 = 4 units BG 201-250 = 6 units BG 251- 300 = 8 units BG 301 -350 = 10 units</p> <p>On 10/6/17, the Novolin R Sliding Scale order was changed to reflect no insulin administration when the BG was less than 200 mg/dl as follows:</p> <p>BG 200 - 249 = 2 units BG250 - 299 = 4 units BG 300 - 349 = 6 units BG 350 - 399 = 8 units</p> <p>The 10/6/17 order the instructions for the BG before meals with insulin administration after meals and to hold the insulin if the BG was under 200 mg/dl and/or she did not eat more than 50% of the meals.</p> <p>Resident #18's September 2017 Medication Administration Record (MAR) documented her BG was less than 200 mg/dl on 72 occasions and that the scheduled Novolin R was administered 45 of those occasions and the sliding scale Novolin R was administered 51 of those occasions.</p> <p>In September 2017, Resident #18's BG was less than 70 on 9/17/17 at 9:00 am (BG was 67), on 9/27/17 at 7:30 am (BG was 54), and on 9/28/17 at 9:00 am (BG was 64).</p>	F 309	<p>pain medication administration to evaluate efficacy. C. LN's will communicate with the dialysis clinic for resident status and report and document on facility dialysis communication form or in resident medical record. Nursing staff have been educated (10/14, 10/17 and 10/25) on the updated dialysis communication form that requires LNs to acquire a report from the dialysis clinic and indicate if there were any changes to the resident status or care. Implementation of this new tool took place 11/1.</p> <p>4. A. DON/designee will audit the medical records to ensure that nursing staff is properly notifying the physician when blood sugar readings are out of range and that all residents upon admission with a diagnosis of diabetes will have an accurate diabetic care plan. 5 days per week for two weeks then once per week for two months, then periodically thereafter. Audits begin on 10/18. Report findings to QAPI. B. DON/designee will audit the facility medical records to ensure that the pain scale is being utilized to help measure post pain medication administration efficacy. 5 days per week for 2 weeks then weekly for 2 months then weekly ongoing. Report findings to QAPI. Audits began 11/1. C. Ward clerk will audit the updated dialysis communication form to ensure that report is being given and updates are being noted as appropriate 5 days per week for two weeks then once per week for 2 months, then weekly ongoing. Audits to</p>		

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

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FORM APPROVED  
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F 309	<p>Continued From page 22</p> <p>Resident #18's clinical record did not contain documentation that the low BG levels on 9/17/17, 9/27/17 and 9/28/17 were reassessed, interventions attempted, and or the physician notified.</p> <p>Resident #18's Meal Record from 9/1/17 through 9/30/17 documented she ate less than or equal to 50% of her meals on 28 occasions. Her 10 units of scheduled Novolin insulin was administered 20 of those occasions and her Sliding Scale Novolin was administered 24 of those occasions.</p> <p>Resident #18's clinical record from 9/1/17 to 9/30/17 documented, her scheduled and or sliding scale insulin were administered when her BG was less than 200 mg/dl and she consumed less than or equal to 50% of her meals on 17 occasions.</p> <p>A 10/12/17 Physician's Order for Resident #18 documented she received 10 units of Novolin subcutaneously four times a day for DM. Staff were to check the resident's BG before meals and give her insulin after meals. Staff were to hold Resident #18's insulin if her BG was under 200 mg/dl and or if she did not eat more than 50% of her meals.</p> <p>Resident #18's MAR from 10/1/17 through 10/12/17 documented, her BG was less than 200 mg/dl on 39 occasions. Her dose of 10 units of scheduled Novolin was administered 15 of those occasion and her Sliding Scale Novolin was administered 9 of those occasions.</p>	F 309	<p>begin 11/1. Report the findings to QAPI. 5. Date of compliance 11/3/2017.</p>		

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F 309	<p>Continued From page 23</p> <p>Resident #18's Meal Record from 10/1/17 through 10/12/17 documented she ate less than or equal to 50% of her meals on 14 occasions. Her 10 units of scheduled Novolin insulin was administered 7 of those occasions and her Sliding Scale Novolin was administered 3 of those occasions.</p> <p>On 10/13/17 at 2:45 pm, the Assistant Director of Nursing (ADON) reviewed Resident #18's MAR and stated the insulin was administered when Resident #18's BG levels was less than 200 mg/dl or she ate less than 50% of her meal. The ADON stated staff was to follow the facility's hypoglycemic and hyperglycemic policy when residents experienced BG levels outside of facility established ranges. The ADON stated the policy directed nurses to notify the physician if residents' BG levels were less than 70 mg/dl or greater than 400 mg/dl.</p> <p>The American Diabetes Association, Standards of Medical Care in Diabetes - 2016, Diabetes Care Journal, Volume 39 Supplement 1, documented BG levels should fall within the 100-180 mg/dl range for those in poor health and with an "end stage chronic illness." The journal documented older adults with diabetes in a Long-Term Care facility were at higher risk of experiencing hypoglycemic episodes, and providers should be called "immediately" in case of hypoglycemic episodes or when BG levels were less than 70 mg/dl.</p> <p>2. Resident #9 was readmitted to the facility on 3/18/17 with diagnoses which included, cirrhosis, fibromyalgia and encephalopathy.</p>	F 309		

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F 309	<p>Continued From page 24</p> <p>An Annual MDS assessment, dated 9/22/17, documented Resident #9 was cognitively intact and required scheduled and as needed (PRN) pain medication.</p> <p>Resident #9's Pain Care Plan, revised 11/23/15, documented she had chronic pain related to neck and back pain. An intervention on the care plan included staff were to follow the pain scale and medicate as ordered.</p> <p>Resident #9's October 2017 Physician Orders included:</p> <ul style="list-style-type: none"> <li>* 5 milligrams (mg) of Oxycodone by mouth every 4 hours PRN for pain on a scale of 0-6, ordered 3/18/17.</li> <li>* 10 mg of Oxycodone by mouth every 4 hours PRN for pain on a scale of 7-10, ordered 3/18/17.</li> <li>* 20 mg of Baclofen by mouth 4 times a day for muscle spasms, ordered 3/18/17.</li> <li>* 900 mg of Gabapentin three times a day for neuropathy, ordered 3/18/17.</li> <li>* Monitor Resident #9's pain every shift and rate her pain on a scale of 0-10. Resident #9's acceptable pain level was a 3, ordered 3/18/17.</li> </ul> <p>On 10/10/17 at 4:05 pm, Resident #9 stated her pain was not being controlled by the facility. Resident #9 stated an acceptable pain level for her pain was a 3. Resident #9 stated she had an appointment in July 2017 to have a Baclofen pump placed for more consistent pain control, but was unable to complete the procedure due to abnormal labs. She stated the facility had not completed an assessment of her labs in the month of September 2017 or as of 10/13/17.</p>	F 309			

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

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F 309	<p>Continued From page 25</p> <p>On 10/13/17 at 5:16 pm, the ADON stated the facility had not received an order to assess Resident #9's lab values since August 2017. She stated she would work on getting an order for follow up labs completed to get the Baclofen pump trial completed.</p> <p>A 7/27/17 Fax from an outside Surgery Center, documented Resident #9's Baclofen pump trial was canceled due to abnormal labs and Resident #9's labs would be need to be normalized prior to a repeat trial.</p> <p>Resident #9's Pain Management Review, dated 9/22/17, documented Resident #9 was interested in getting a Baclofen Pump, however her labs were abnormal and couldn't be completed until the lab normalized.</p> <p>Resident #9's MAR from 9/1/17 through 10/12/17 documented 64 administrations of PRN 10 mg of Oxycodone and 9 administrations of 5 mg of Oxycodone. The facility documented a follow up pain scale with Resident #9 for 5 of these administrations. On 10/11/17 at 11:00 am, Resident #9 stated her PRN pain meds were not always effective and the staff did not always ask her what her pain scale was after administration of the PRN pain medications.</p> <p>On 10/13/17 at 5:16 pm, The ADON stated that her expectation if the as needed pain administration was documented as effective the pain scale was less than a 3 for Resident #9. The ADON stated if Resident #9 reported a pain level of 4 or greater after pain medication administration, her pain should be re-evaluated."</p>	F 309			

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F 309	<p>Continued From page 26</p> <p>3. Resident #2 was admitted to the facility on 6/7/17 with diagnoses including sepsis (severe infection), UTI (urinary tract infection), and Type II diabetes mellitus.</p> <p>a. Resident #2's 6/14/17 admission MDS (Minimum Data Set) and 9/13/17 quarterly assessments documented he was cognitively intact and was receiving dialysis.</p> <p>Resident #2's hemodialysis care plan, initiated 6/19/17, documented the resident received hemodialysis related to renal (kidney) failure.</p> <p>Resident #2's 10/2/17 Order Summary Report documented dialysis on Monday, Wednesday, and Friday was ordered on 9/12/17.</p> <p>Resident #2's Dialysis Communication Forms reviewed from 9/2/17 through 10/4/17 did not consistently document the nurse gave report to the dialysis center, received report from the dialysis center, or assessed the resident's condition before and after dialysis.</p> <p>On 10/11/17 at 7:50 am Resident #2 was observed waiting by the front door of the facility and he said he was waiting to go to dialysis.</p> <p>On 10/11/17 at 5:45 pm Resident #2 was observed in the dining room prior to receiving his meal. He said he "made it through dialysis."</p> <p>On 10/13/17 at 11:40 am, RN #1 said they should complete the Dialysis Communication Form with each dialysis treatment. She said the resident often goes directly to therapy or the dining room when he returns from dialysis so the nurse might</p>	F 309			

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F 309	Continued From page 27 not see him immediately when he returns. She said they don't routinely communicate with the dialysis center other than the Dialysis Communication Forms but they can call if they need to.	F 309		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  (c) Mobility.  (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. 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 received treatment and services to prevent further decrease in range of motion (ROM). This was true for 1 of 3 residents (#5) reviewed for treatment and services related to ROM and created the potential for harm when Resident #5 did not have a splint placed on contracted limbs or appropriate care plan information to prevent deterioration of existing ROM limitations. Findings include:  Resident #5 was readmitted to the facility on 12/23/11 with diagnoses that included contractures, anoxic brain injury, aphasia, and convulsions.	F 318	1. order and care plan were updated to include but not limited to; splint placement location, when to apply the splint and for what duration of time to be worn and when to be removed. updated on 10/31/17. 2. all residents who require splint placement have the potential to be affected by this deficient practice. 3. all appropriate staff who are involved in applying resident splints will follow the resident plan and orders. facility has updated orders and care plans to reflect splint placement location, and duration of time worn, education provided to clinical staff regarding proper splint placement	11/3/17

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F 318	<p>Continued From page 28</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 8/31/17, documented Resident #5 had a severe cognitive impairment, was totally dependent on 1 to 2 staff members for all cares, received passive range of motion (PROM); utilized a splint, and had contractures to all four extremities.</p> <p>A 2/9/17 Physician's Order documented Resident #5 was to receive "Restorative: Splint Placement."</p> <p>A 2/29/16 Physician's Order documented, Staff were to perform skin checks under and around Resident #5's splinted areas every shift and as needed.</p> <p>Resident #5's Physician's Orders did not include:</p> <ul style="list-style-type: none"> <li>* Instruction for staff of where the splint was to be located.</li> <li>* The need for more than one splint.</li> <li>* When to apply and or remove the splint.</li> <li>* How long the splint was to be in place.</li> </ul> <p>Resident #5's Activities of Daily Living (ADL) Care Plan, dated 6/5/13, documented she was to have a splint or brace placed on her right elbow and bilaterally to her hands. The care plan did not include when to apply the splints, when to remove the splints or how long to leave the splints in place.</p> <p>On 10/10/17 at 3:50 pm, Resident #5 was observed being wheeled down the hall in a Broda chair without splint devices on her arms.</p>	F 318	<p>location, and duration of time on 10/14, 10/17 and 10/25.</p> <p>4. Lead nurse aide to monitor all non therapy supervised splint placements 5 times per week for 2 weeks then weekly for 2 months. Audits to begin 11/2. Report findings to QAPI.</p> <p>5. Date of compliance 11/3/2017.</p>		

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F 318	<p>Continued From page 29</p> <p>On 10/11/17 at 8:30 am - 11:00 am, Resident #5 was observed in her bed without splint devices on her arms.</p> <p>On 10/11/17 at 3:09 pm, Resident #5 was observed in her bed without splint devices on her arms.</p> <p>On 10/11/17 at 5:29 pm, Resident #5 was observed in her bed without splint devices on her arms.</p> <p>On 10/12/17 at 8:12 am, Resident #5 was observed in her bed without splint devices on her arms.</p> <p>On 10/12/17 at 12:50 pm, Resident #5 was sitting in the common area near the nurses' station and had a splint on each arm. The splints placements were identical and started just above her elbow and extended down her arm and stopped at her wrist.</p> <p>On 10/12/17 at 5:22 pm, Resident #5 was observed in her bed without splint devices on her arms.</p> <p>On 10/12/17 at 2:24 pm, the Assistant Director of Nursing (ADON) stated she thought the splints were applied during the day but was not sure how long the splints were to be applied, when to put them on or remove them. The ADON stated she knew the splints currently started just above her elbows and extended down her arms and stopped at her wrists.</p> <p>The Restorative Nursing Flowsheet from 9/1/17 through 10/12/17 documented the following:</p>	F 318			

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F 318	Continued From page 30  * On 10/1/17, 10/6/17 and 10/8/17 there was no documentation that restorative Nursing had assisted Resident #5 with her "splint" or performed ROM activities with her. * Assistance with splint or brace - The length of time for assistance was documented as "15" and the time the assistance was provided varied from 9:05 am to 6:59 pm.  On 10/13/17 at 3:25 pm, Certified Nursing Assistant (CNA) #1 stated Restorative CNAs were the only ones who do restorative duties and "they know what to do." CNA #1 stated the splint was placed on Resident #5 during the day and the time it got placed and removed varied depending on the caseload of the Restorative CNAs. CNA #1 stated the "assistance with splint" on the Restorative Nursing Flowsheet meant it took the CNAs 15 minutes to apply the splints and that it did not mean the splints were left on Resident #5 for 15 minutes.	F 318			
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS  (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F 322		11/3/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/13/2017</b>
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F 322	Continued From page 31  (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of clinical records and policies, it was determined the facility failed to ensure adequate care and treatment was provided to 2 of 2 sample residents (#3 and #5) reviewed for feeding tube use, and that the feeding tube policy and procedure met current standards of practice. The failures created the potential for more than minimal harm if complications developed from improper tube feeding practices. Findings include:  1. The facility's Gastrostomy Tube Policy and Procedure (P&P), dated 5/2007, documented staff were to assess and verify the feeding tube position before each use, and if the feeding was continuous staff were to check the tube position several times a day. The facility's policy and procedure documented "the physician may recommend ... to check residuals in the stomach."  When asked to provide its clinical standards of practice related to their Gastrostomy Tube P&P, the facility submitted an undated, untitled, photo copied page from an unknown source. The Director of Nursing (DON) stated it was from the Lippincott Manual of Nursing Practice. The page	F 322	1. Resident #3 and #5 care plans' were updated to include: residual amounts to be checked prior to tube feeding and then documented, placement of tube to be verified before tube feeding, head of bed to be elevated during/after feeding 30-45 degrees, assessment and documentation of PEG tube site and dressing changes. Monitoring and documentation for bowel sounds and abdominal distention. updates completed on 11/1. 2. All residents the require tube feeding have the potential to be affected. 3. Nurse administration has reviewed and updated orders and care plans for all residents identified to be affected by this deficient practice to include: residual amounts to be checked prior to tube feeding and documented, placement of tube to be verified and documented before tube feeding, head of bed to be elevated during/after feeding 30-45 degrees, assessment and documentation of PEG tube site and dressing changes. Monitoring and documentation for bowel sounds and abdominal distention. Changes to the affected residents care plans were updated on 11/2. LNs		

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F 322	<p>Continued From page 32</p> <p>documented it was for "Pediatric Procedures."</p> <p>According to Lippincott Manual of Nursing Practice, Ninth Edition, the definition of a PEG was a tube inserted into the stomach. The manual documented for "Long-Term Nutrition Support" use, education was to be provided regarding the "need to assess tube placement and residual before each feeding (for gastric feedings only)." The manual documented the "procedure" for continuous tube feeding, the bag was to be filled with 4 hours' worth of tube feeding formula. The "procedure" continued to document, "Flush with 30-60 ml of water every 4 hours and after first checking residual." In addition, the "procedure" documented "Nursing action" included a "Follow-up Phase" in which the head of bed (HOB) needed to be elevated for 30 - 60 minutes after non-continuous feedings. The "procedure" documented nurses were to "document type and amount of feeding, amount of water given, and patient tolerance of procedure." In addition, the "procedure documented nursing were to "monitor breathing sounds, bowel sounds, gastric distention, constipation..."</p> <p>The facility's policy and procedure was not consistent with current standards of practice for adult Long-Term Nutrition Support care needs.</p> <p>2. Resident #3 was admitted to the facility on 4/10/17 with diagnoses that included cancer of the mouth, malnutrition and dysphagia of the oropharyngeal phase.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 9/1/17, documented Resident</p>	F 322	<p>educated on the importance of following the resident tube feeding care plan on 10/14, 10/17 and 10/25.</p> <p>4. DON/designee will audit the medical record of residents that have the potential to be affected to ensure that the care plan and orders are followed by LNs. 5 times per week for 2 weeks then once per week for 2 months. Audits to begin 11/2. Report findings to QAPI.</p> <p>5. Date of compliance 11/3/2017.</p>		

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F 322	<p>Continued From page 33</p> <p>#3 was cognitively intact and required nutrition support.</p> <p>Resident #3's October 2017 Physician's Orders for tube feeding included:</p> <ul style="list-style-type: none"> <li>* Jevity 1.5, one can five times a day and one can as needed (PRN) every 6 hours as a bolus or gravity feeding with 60 milliliters (ml) of water flush before and after the feeding.</li> <li>* Jevity 1.5, one can one time a day as a bolus or gravity feeding with 60 ml water flushes before and after feeding. Both of the Jevity orders were started 8/11/17.</li> </ul> <p>Resident #3's Tube feeding (TF) Care Plan, dated 7/7/17, documented he was at risk for complications related to swallowing difficulty and cancer of the tongue.</p> <p>Resident #3's Tube feeding care plan did not include:</p> <ul style="list-style-type: none"> <li>* The need for the head of bed to be elevated after tube feeding administration.</li> <li>* The need to verify the feeding tube placement prior to administering the tube feeding.</li> <li>* The need to check residuals prior to the administration of the tube feeding.</li> </ul> <p>Resident #3's 9/1/17 through 10/12/17 Medication Administration Record (MAR), Treatment Administration Record (TAR) and/or Intravenous Medication Administration Records (IV MAR) did not contain documentation of residual checks being completed, tube placement verification, HOB requirements, dressing changes to the stoma site, and monitoring of</p>	F 322			

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F 322	<p>Continued From page 34 bowel sounds and abdominal distention.</p> <p>On 10/12/17 at 2:24 pm, the Assistant Director of Nursing (ADON) stated Resident #3 changed his own dressing to his stoma site.</p> <p>A Nurse's Note, dated 10/12/17 at 4:58 pm documented Resident #3 was evaluated and educated to perform his dressing changes to his stoma site and performed return demonstration with the dressing changes. The note documented the staff educated him on watching for signs and symptoms of infection and reporting these signs and symptoms if they occurred.</p> <p>3. Resident #5 was readmitted to the facility on 12/23/11 with diagnoses that included contractures, anoxic brain injury, aphasia, and convulsions.</p> <p>Resident #5's October 2017 Physician's Orders included:</p> <p>* Jevity 1.2 at 52 ml per hour for 20 hours. The tube feeding was to be turned on at 2:00 pm and off at 10:00 am. Staff were to run the tube feeding continuously and were to check the tube placement prior to starting the feeding, initiated 12/7/16.</p> <p>*Staff were to provide 120 ml of water flushes four times a day, initiated 8/17/16.</p> <p>Resident #5's Tube Feeding Care Plan, revised 9/10/13, documented she required tube feeding related to dysphagia and anoxic brain injury. There were no interventions documented for the feeding tube to be flushed with water prior to use, or the type and placement of Resident #5's</p>	F 322			

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F 322	<p>Continued From page 35 feeding tube.</p> <p>A 8/1/8/17 Registered Dietitian (RD) Note, documented Resident #5 was tolerating the feeding tube and had "minimal residual noted."</p> <p>An 8/28/17 Physician's Progress note, documented Resident #5 "continues to show signs of reflux of the tube feeding, she again today had white substance drooling from her mouth." The progress note documented the physician asked the dietitian (RD) to re-evaluate Resident #5's tube feeding to try and decrease the reflux.</p> <p>Resident #5's Clinical Record did not contain documentation that the physician requested re-evaluation by the RD had been completed.</p> <p>Nurses Notes, dated 8/25/17 at 8:58 am, 8/26/17 at 1:32 am, 9/1/17 at 9:36 pm, and 9/8/17 at 8:21 am, documented Resident #5's lung sounds were diminished and congestion was noted.</p> <p>A Nurse's Note, dated 10/11/17 at 12:31 pm, documented Resident #5 had increased secretions.</p> <p>A Nurse's Note dated 10/12/17 at 1:27 am, documented Resident #5 had increased amounts of phlegm.</p> <p>Resident #5's MAR/TAR 9/1/17 through 10/11/17 documented her water flushes were administered 4 times a day at 6:00 am, 2:00 pm, 6:00 pm and 10:00 pm. The administration of the water flushes was not consistent with the clinical standard of practice of water flushes every 4 hours.</p>	F 322			

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

PRINTED: 11/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

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F 322	Continued From page 36  Resident #5's 9/1/17 through 10/12/17 MAR/TAR/IV MAR did not contain documentation of residual checks being completed, tube placement verification throughout the continuous feeding, and monitoring of bowel sounds and abdominal distention.  Resident #5 was observed with a creamy foam-like substance coming out of the corner of her mouth on 10/11/17 at 8:30 am to 9:23 am and on 10/11/17 at 10:57 am and 8:16 pm.  On 10/11/17 at 8:20 pm, the DON stated Resident #5 sometimes coughed up phlegm.  On 10/12/17 at 9:00 am, the DON stated it was not facility practice to check residuals on continuous tube feeding residents, however, it was practice to check residuals with bolus feeding residents.  On 10/12/17 at 2:24 pm, the ADON stated it was not the facility practice to routinely check residuals for any tube feeding administrations, but staff would check residuals on a PRN basis. The ADON stated staff followed the facility's policy and procedure for tube feeding administration and for assessing tolerance of tube feeding. The ADON stated Resident #5 had a suction machine in her room for excess secretions. The ADON was unsure if the facility checked bowel sounds and she would look into it.	F 322			
F 364 SS=E	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  (d) Food and drink	F 364		11/3/17	

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F 364	<p>Continued From page 37</p> <p>Each resident receives and the facility provides-</p> <p>(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;</p> <p>(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interview, test tray evaluation, and staff interview, it was determined the facility failed to consistently serve food at palatable temperatures. This was true for 7 of 12 residents in a resident Group Interview and it had the potential to affect other residents who dined in the facility. The failed practice created the potential for a negative effect on the residents' nutritional status and their psychosocial well-being related to unpalatable food. Findings include:</p> <p>On 10/11/17 at 10:00 am, a Group Interview was conducted with 12 residents in attendance. Seven of the residents said hot foods were not hot when they were served to residents in their rooms and sometimes in the dining room. One of the residents said the food was always "lukewarm."</p> <p>On 10/12/17 at 12:32 pm, an evaluation of the main lunch meal and the alternate meat was conducted. The Certified Dietary Manager (CDM) was present. The main lunch meal included an Italian sausage sub sandwich with sauteed peppers and onion, oven fried potatoes, and braised cabbage. The Italian sausage temperature was 109.2 degrees Fahrenheit (F). The CDM said the sausage was "cool." The fried</p>	F 364	<ol style="list-style-type: none"> <li>1. Facility tested all pellet warmers and removed all non functioning pellet warmers on 10/13.</li> <li>2. All residents that eat in their rooms have the potential be affected by this deficient practice.</li> <li>3. All pellet warmers being used will hold proper temps. Facility has removed any faulty pellet warmers to ensure equipment is functioning properly.</li> <li>4. Dietary temp test a random hall tray 5 times per week for 2 weeks then weekly for 2 months. Dietary/designee will test pellet warmers one time per week ongoing. Audits to begin 11/1.. Dietary manager will interview random residents to determine food temps, the same frequency above will apply for this audit, will begin 11/8.</li> <li>5. Date of compliance 11/3/2017.</li> </ol>		

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F 364	Continued From page 38 potato temperature was 97 degrees F. The CDM said the potatoes had good flavor and were tender. The braised cabbage temperature was 103.6 degrees F. The CDM said the cabbage was "cold." The alternate meat was chicken a la orange which had a temperature of 124.5 degrees F. The main lunch meal was on one plate and the alternate meat was on another plate. Both plates were on pellet warmers and were covered until the evaluation was conducted. The CDM said the pellet warmer for the main meal was cool to the touch while the pellet warmer for the alternate meat was warm to the touch. The CDM said the cool pellet warmer was defective and that could be why the main meal foods were cool or cold. He said he would check all of the plate pellet warmers.	F 364			
F 367 SS=J	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN  (e) Therapeutic Diets  (e)(1) Therapeutic diets must be prescribed by the attending physician.  (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure thickened liquids and/or diet texture alterations were provided as ordered when served to residents. This was true for 3 of 6 sample resident (#s 11, 12, and 13) with orders	F 367	1. Facility created a therapeutic diet abatement plan that was shared with the survey team on 10/12. Abatement plan was accepted the same day. Abatement plan is included in 2567 for reference. 2. All residents have the potential to be	11/3/17	

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F 367	<p>Continued From page 39</p> <p>for thickened liquids and/or diet texture alterations. Residents #11, #12 and #13 were in immediate jeopardy (IJ) of serious harm, impairment, or death when: a. Resident #11 received nectar thick rather than honey thickened liquids; b. Resident #12 received regular texture food rather than mechanical soft; and Resident #13 received mechanical soft food with mixed textures and crust on bread rather than no mixed texture foods and no crust. On 10/11/17 at 9:10 pm, the facility's Administrator was notified verbally and in writing of the IJ situation. Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>* Ensure physician orders were followed regarding therapeutic diets, which increased residents' risk of aspiration or choking on beverages or food.</li> <li>* Ensure the food prepared and delivered to residents was consistent with physician's dietary orders prior to residents eating or drinking food and/or beverages.</li> <li>* Ensure thickened liquids were provided at the consistency ordered by the physician.</li> <li>* Identify incorrect mechanical soft diet textures and incorrect mixed diet consistencies before they were served to residents.</li> </ul> <p>The combined effect of the above failed systems placed Residents #11, #12, #13, and all other residents on thickened liquids and/or altered textured diets, at immediate risk for serious harm, impairment, and/or death.</p> <p>Findings include:</p>	F 367	<p>affected by the deficient practice.</p> <p>3. Facility staff that handle or pass food to residents in the facility were educated on the importance of the following the resident dietary care plan and ensure that what is being served matches what is on the resident meal tray ticket and the abatement plan process. Education provided on 10/14, 10/17 and 10/25. System changes outlined in abatement plan referenced in 2567.</p> <p>4. DON/designee will audit 10 random trays for three meals, then 2 times per week for 1 month, then weekly for 4 weeks. Audits began 10/12.</p> <p>5. Date of compliance 10/13/2017.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 367	<p>Continued From page 40</p> <p>The website American Speech Language Hearing Association at <a href="https://www.asha.org/public/speech/swallowing/Swallowing-Disorders-in-Adults/">https://www.asha.org/public/speech/swallowing/Swallowing-Disorders-in-Adults/</a> documented the signs and symptoms of dysphagia (swallowing difficulty) may occur during or right after eating or drinking and may include a wet or gurgly sounding voice during or after eating or drinking, taking extra effort and/or time to chew and/or swallow, food or liquid leaking from the mouth or getting stuck in the mouth, pneumonia or chest congestion after eating, and weight loss or dehydration.</p> <p>The facility's Modified Consistency Diets Nutrition Care Manual, dated 1/2014, referenced The Academy of Nutrition and Dietetics Association, described honey thick fluids as fluids that pour like honey and are too thick to drink through a straw. Examples of honey thick liquids are honey and tomato sauce.</p> <p>The Idaho Diet Manual, 11th Edition, 2015, described honey-thick consistency as a "continuous 'string' when poured" and included examples such as commercial thickener or product to achieve honey-thick consistency. Nectar-thick liquids were described as "discontinuous 'beads' when poured" and included examples such as fruit nectars and vegetable juice. Mechanical soft diet was described as "...designed to provide a texture modification of the regular diet for patients with chewing or swallowing difficulty. Meats are in the ground form..." Regarding mechanical soft diet vegetables, the diet manual documented, "Tender cooked or canned vegetables; vegetable</p>	F 367			

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F 367	<p>Continued From page 41 juice; finely chopped raw vegetables if tolerated." and "All should be 1/2 inch in diameter."</p> <p>1. Resident #11 was admitted to the facility on 5/24/11 with diagnoses including Type II Diabetes Mellitus and gastroesophageal reflux disease (GERD).</p> <p>Resident #11's 11/2/16 annual MDS (Minimum Data Set) assessment documented the resident required supervision while eating and one person physically assisting during meals. There were no signs or symptoms of aspiration and the resident was on a mechanically altered diet. The resident was receiving RNA (Restorative Nursing Assistant) services to help her with eating and/or swallowing.</p> <p>Resident #11's 7/7/17 and 10/4/17 Dietary Quarterly Evaluation documented the resident required tray set-up, divided plate, Consistent Carbohydrate Diet (CCD) puree texture, and honey fluid consistency.</p> <p>Resident #11's 7/9/17 quarterly MDS assessment documented the resident required supervision and set-up help for eating. The MDS documented the resident had signs and symptoms of aspiration such as loss of liquids/solids from the mouth, holding food in the mouth/cheeks or residual food in the mouth, and coughing or choking during meals or when swallowing medication. The MDS documented she continued to receive RNA services for assistance with eating and/or swallowing.</p> <p>Resident #11's nutrition risk care plan documented interventions to provide the diet as</p>	F 367			

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

PRINTED: 11/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/13/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE POCATELLO, ID 83201</b>		
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F 367	<p>Continued From page 42</p> <p>ordered-CCD pureed diet and honey thick liquids, initiated on 5/29/13, and staff to assist resident with eating, initiated on 2/1/16.</p> <p>Resident #11's Order details, dated 7/11/17 at 2:34 pm, documented NPO (nothing by mouth) and pureed diet texture with honey thick fluid consistency. It also documented "All pureed food to be pudding thick to assist swallowing..." On 10/12/17 at 8:10 am, the Administrator stated Resident #11 was as risk of choking on "any" food and the Speech Therapist had recommended the resident to be NPO. The Administrator stated the resident had refused to be NPO and refused tube feeding so they ordered the safest diet possible until the family could be consulted.</p> <p>Resident #11's 7/12/17 IDT (Interdisciplinary Team) Progress Note documented a family meeting was held on 7/12/17 regarding Resident #11's increased aspiration risk with eating and drinking and the recommendation of NPO. The note documented education was provided to the resident and her son regarding the risks verses benefits and the resident decided to continue eating a pureed diet and declined tube feeding. The physician said "that [the] pt (patient) is at risk in both situations (pureed diet or feeding tube.)" Following the IDT meeting, Resident #11's diet order was changed to a CCD pureed texture and honey thick liquid consistency on 7/13/17.</p> <p>Resident #11's 9/15/17 Speech Therapy SLP (Speech Language Pathology) Evaluation and Plan of Treatment documented the resident referred herself for a swallowing evaluation due to increased signs and symptoms of aspiration</p>	F 367			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/13/2017</b>
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F 367	<p>Continued From page 43</p> <p>during meals. The resident exhibited signs of aspiration during trials of honey-thick liquids from a cup, but did not exhibit signs and symptoms of aspiration when honey consistencies were presented with a teaspoon. The evaluation did not contain evidence the staff was educated on providing Resident #11's fluids with a teaspoon.</p> <p>Resident #11's nutrition risk care plan, dated 5/29/13, did not contain documentation the care plan was updated on 9/15/17 with the speech recommendation to provide the honey thick fluids with a teaspoon.</p> <p>Resident #11's 9/26/17 Speech Therapy Encounter Note documented the speech therapist educated staff about thickened liquids and the resident's diet level, and "collaborated with staff to ensure [the] patient receives honey-thick consistencies at meals to decrease [the] risk of aspiration."</p> <p>Resident #11's 10/11/17 Speech Therapy Encounter Note documented the resident received deep pharyngeal neuromuscular stimulation (electrical stimulation to the throat area) to improve her swallowing function. The resident demonstrated signs and symptoms of aspiration with pureed textures during therapy and was instructed to take smaller bites. The resident remained on aspiration precautions, honey thick liquids and a pureed diet.</p> <p>On 10/11/17 at 5:21 pm, Resident #11 was observed in the dining room consuming the evening meal and was gagging on nectar thickened liquids. CNA #1 and CNA #2 were at the table with the resident. CNA #1 used her</p>	F 367			

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

PRINTED: 11/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/13/2017</b>
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F 367	<p>Continued From page 44</p> <p>radio to call for "nurse to dining room." The ADON (Assistant Director of Nursing) arrived in the dining room at 5:24 pm as well as several other staff members.</p> <p>On 10/11/17 at 5:55 pm, Resident #11 was frequently coughing and drooling at the table in the dining room. A glass that contained an amber-colored liquid was on the table in front of the resident. CNA (Certified Nursing Assistant) #2 provided the resident with a second glass that contained a brown liquid. The resident continued to exhibit coughing and drooling as she consumed the drinks. Upon examination, the liquids in front of the resident appeared to readily pour from the cup as Resident #11 brought the cup up to her mouth and the liquid poured into her mouth. Resident #11 was not provided her fluids with a teaspoon. The resident's meal ticket on the table next to her documented CCD-Pureed, Honey Thick, and drinks in a mug. Resident #11's meal ticket did not specify she was to receive her fluids with a teaspoon. CNA #2 said the resident preferred to drink from a glass instead of a mug. When asked if the resident's drinks were honey thick, CNA #2 said the drinks were not honey thick and they should be. CNA #2 said he should have made sure the drinks were honey thick before they were provided to the resident. CNA #2 removed Resident #11's drinks from the table to add additional thickener and returned once he had completed this task. The resident left the table a short time after that.</p> <p>On 10/12/17 at 8:05 am, Resident #11 was observed in the dining room consuming breakfast. The resident's meal ticket documented</p>	F 367			

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F 367	<p>Continued From page 45</p> <p>CCD-Pureed, Honey Thick, Drinks in a mug. The resident was lifting a mug of white liquid to her mouth and coughed. Resident #11 was not provided her fluids with a teaspoon. The white liquid consistency appeared thickened to a honey consistency and more readily adherent to the mug, and CNA #1 confirmed it was honey thick. A container of commercially packaged honey thick water was near the resident's table and the contents resembled the liquid in the resident's mug. The resident said she preferred to have her drinks in a glass because a mug can be hard to hold. CNA #2 told the resident her drink has to be in a mug because "it's on the order."</p> <p>On 10/12/17 at 8:50 am, CNA #1 asked the resident if she wanted her drink to be in a glass, and the resident said she would like her drink to be in a glass.</p> <p>On 10/12/17 at 8:52 am, the Clinical Resource Nurse provided Resident #11 with a glass of white liquid, which she poured from a container of commercially prepared honey-thick water. The resident took a drink of the white liquid in the glass and coughed. The resident did not exhibit any overt distress and exhibited less coughing and less drooling than at dinner the previous night. The white liquid appeared to be the appropriate consistency for honey-thick.</p> <p>2. Resident #12 was admitted to the facility in 2011 and readmitted in 2013 with multiple diagnoses including Alzheimer's type dementia.</p> <p>A 9/19/17 quarterly MDS assessment further documented the resident had dysphagia, moderately impaired cognition but able to</p>	F 367			

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

PRINTED: 11/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/13/2017</b>
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F 367	<p>Continued From page 46</p> <p>understand others and was understood by others, and supervision and set up help only with eating was needed.</p> <p>The resident's care plan included the following focus areas and their associated interventions:                      * At "nutrition risk," revised 1/14/16 - Provide and serve diet as ordered, mechanical soft texture.                      * "Alteration in chewing and swallowing ability as demonstrated by occasional pocketing food and sometimes spitting food out that is partially chewed up...", initiated and revised 6/27/13                      * "Diet to be followed as prescribed mechanically chopped meats to puree with gravy. Monitor for need to change diet."</p> <p>The resident's 10/2/17 Order Summary Report of "Active" orders included mechanical soft diet, dated 5/6/15.</p> <p>At 5:35 pm on 10/11/17, during the evening meal in the main dining room, Resident #12 was served a whole slice of roast turkey, approximately 1/2 to 3/4 inches thick, placed on bread and covered with gravy. In addition, the plate contained cooked whole broccoli florets with stems, each about 3 inches long and 2 inches wide. Resident #12 was sitting at the table and pushing the food around on his plate, he attempted to pick up a piece of the meat and bread and the food fell onto his plate. The resident's meal ticket documented mechanical soft diet with "ground" roast turkey for open-faced sandwich and "sliced broccoli cuts." At 5:40 pm, when asked if the texture of Resident #12's food was correct, the DON said he did not know. The DON directed the surveyor to ask CNA #1, who was "in charge" of ensuring residents' meals</p>	F 367			

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

PRINTED: 11/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE POCATELLO, ID 83201</b>		
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F 367	<p>Continued From page 47</p> <p>were served at the appropriate texture and consistency. At 5:45 pm, CNA #1 cut the roast turkey with gravy on bread into 3/4 inch by 1/2 inch pieces but left the broccoli florets whole. The CNA said the turkey was "okay" because it was processed. CNA #1 and a surveyor went to where the facility's 2014 Diet Manual was stored and reviewed its contents regarding mechanical soft diets. The manual documented mechanical soft diets "consists of ground meats, with soft fruits and vegetables, and most bread products." The manual did not mention processed meats. The manual documented that naturally large vegetables, such as broccoli or cauliflower florets, "should be sliced or chopped." CNA #1 was observed speaking to the Clinical Resource RN about the content of the diet manual. CNA #1 left the meal tray in front of Resident #12 and stated she thought he could eat the food "just" fine.</p> <p>At 6:05 pm on 10/11/17, the CDM said Resident #12's meat should be ground but that it was not ground. The CDM removed the plate and took it to the kitchen. Moments later, the CDM returned with a plate of ground roast turkey with gravy on bread and whole broccoli florets/stems which he placed in front of the resident. The resident began eating the open face sandwich right away. When asked about the whole broccoli florets/stems, the CDM said it was "okay" because the broccoli was soft enough. At 6:10 pm, the CDM, who was in the kitchen, was informed the resident's broccoli needed to be sliced. Resident #12 ate the whole broccoli floret/stems. Resident #12 consumed all the open-faced turkey sandwich after the consistency was corrected.</p>	F 367			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/13/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE POCATELLO, ID 83201</b>		
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F 367	<p>Continued From page 48</p> <p>3. Resident #13 was admitted to the facility on 9/3/09 with diagnoses including dysphagia of the oropharyngeal phase.</p> <p>The 6/1/17 quarterly MDS assessment documented Resident #13 had a moderate cognitive impairment, had a communication language barrier and required a mechanically-altered diet.</p> <p>Resident #13's Physician's orders included a "Mechanical Soft texture diet, Thin Liquids... No mixed consistencies. No crust on bread," dated 3/1/17.</p> <p>Resident #13's Nutrition Care Plan, dated 5/29/13, documented the risk for nutritional decline related to difficulty chewing. Interventions included staff monitoring/ documenting/ and reporting to the physician any signs and symptoms of dysphagia and her need for a mechanical soft diet. The care plan did not identify the specific physician ordered restrictions Resident #13 required.</p> <p>Resident #13's 10/11/17 Dinner Meal Ticket documented she was to receive a "Mechanical Soft" diet with "No Crust on the Bread." The meal ticket included ground roast turkey for open faced sandwich, mashed potatoes- no gravy, sliced broccoli cuts and raspberry yogurt. The meal ticket did not identify the need for the "no mixed consistencies."</p> <p>On 10/11/17 at 6:15 pm, Resident #14's dinner plate included a ground turkey open faced sandwich. The sandwich consisted of ground</p>	F 367			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/13/2017</b>
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F 367	<p>Continued From page 49</p> <p>turkey was on top of a slice of wheat bread, which had crust on the bread, no gravy and was a mixed consistency with the bread and the meat. The broccoli florets were whole and included the stems. The stems measured to approximately 3 inches long and the florets were approximately 2 inches wide in diameter. The broccoli was not sliced or cut. The resident's dinner tray also included raspberry yogurt contained chunks of fruit in the yogurt, which was a mixed consistency. Resident #13 was observed consuming two bites of a bread/meat mixture but had stopped eating the meat and bread.</p> <p>On 10/11/17 at 6:20 pm, the CDM observed Resident #13's dinner meal plate and stated she did not like gravy. The CDM did not identify the improper mixed consistencies of the meat on top of the bread, the crust on the bread, or large pieces of broccoli as identified in her physicians orders.</p> <p>On 10/11/17 at 6:25 pm, Resident #13 was observed pushing food around on her plate and was observed consuming a couple more bites of yogurt and mashed potatoes. Resident #13 did not consume the meat or bread mixed consistency and left the dining room without consuming the majority of her dinner meal.</p> <p>On 10/11/17 at 6:25 pm, the Clinical Resource RN stated the food for Resident #13 was not appropriate for her diet order. She stated whoever delivers the tray was to verify the meal was consistent with the physician orders. She stated the meal ticket did not identify that the meal was not to include mixed consistencies. The Clinical Resource RN stated the meal ticket</p>	F 367			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/13/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE POCATELLO, ID 83201</b>		
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F 367	<p>Continued From page 50</p> <p>had mixed consistencies, crust on the bread and the broccoli was not cut up.</p> <p>On 10/11/17 at 6:30 pm, the CDM stated the bread should have been crust free and the meal ticket did not document "no mixed consistencies." The CDM stated the meat on top of the bread was a mixed consistency. He stated the broccoli was soft and did not need to be cut or chopped.</p> <p>On 10/11/17 at 6:40 pm, CNA #1 stated the process of meal verification started in the kitchen with the cook and the assistant who helped the cook. She stated after they plated the food and verified the meal; the person passing the tray would verify the accuracy of the food. She stated any staff member could pass a tray which could include nursing staff, administrative staff, business office, activities, and others. She stated the meal tray for Resident #13 was not how the physician had ordered it.</p> <p>Resident #13's 10/12/17 Breakfast Meal Ticket documented she was to receive a "Mechanical Soft" diet with "No Crust on the Bread," and "no mixed consistencies." The food listed on the meal ticket included ground sausage patty and raspberry or peach yogurt</p> <p>On 10/12/17 at 8:20 am, Resident #13's breakfast meal tray was delivered by CNA #2 and it included ground sausage patty with gravy over the top of the ground meat, which created a mixed consistency. The tray contained raspberry yogurt with chunks of fruit in the yogurt which was a mixed consistency.</p> <p>On 10/12/17 at 8:21 am, the ADON examined the</p>	F 367			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/13/2017</b>
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F 367	<p>Continued From page 51</p> <p>breakfast meal tray for Resident #13 and told CNA #2 to remove the yogurt from Resident #13's tray because it contained pieces of fruit in the yogurt. CNA #2 removed the yogurt and the ADON and CNA #2 left Resident #13 to consume her meal without identifying the meat and gravy as a mixed consistency. Resident #13 ate approximately 2 bites of the meat with gravy mixture. Resident #13 ate approximately 25% of her oatmeal and drank her milk.</p> <p>On 10/12/17 at 8:35 am, the ADON removed Resident #13's plate of ground sausage and gravy and stated she pulled the plate due to its mixed consistency. This was 15 minutes after the plate was delivered and she had taken two bites of the food.</p> <p>4. The facility identified 15 other residents with orders for mechanically altered diet textures and or thickened liquids which included sampled residents (#3, #8, #10, and #17).</p> <p>The facility failed to ensure the health and safety of residents whose nourishment included mechanically altered diet textures, mixed consistencies and/or thickened liquids, were not in imminent risk of serious harm, impairment, or death from choking or aspiration.</p> <p><b>NOTIFICATION AND REMOVAL OF IMMEDIATE JEOPARDY:</b></p> <p>On 10/11/17 at 9:10 pm, the facility Administrator, DON (Director of Nursing), and ADON (Assistant Director of Nursing), Clinical Resource Nurse, and the Administrator in Training were notified verbally and in writing of the IJ and of the need to</p>	F 367			

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

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OMB NO. 0938-0391

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F 367	<p>Continued From page 52</p> <p>develop and implement a plan to remove the immediacy.</p> <p>On 10/12/17 at 1:00 pm, the facility provided evidence that an acceptable plan to remove the immediacy had been developed and implemented.</p> <p>The facility reviewed its Practice Guidelines on Therapeutic Diets/consistencies with members of the IDT to include the Certified Dietary Manager (CDM) to incorporate prompt monitoring to begin on 10/12/17 for the breakfast meal and all meals thereafter to ensure that proper therapeutic diets/consistencies were being served. This review was completed on 10/11/17 at 9:30 pm.</p> <p>Food was prepared to match all therapeutic diets/consistencies. The cook read the ticket while plating the items then passed the plate to the aide who placed the ticket on the tray.</p> <p>The aide double checked the items the cook placed on the plate and compared to the ticket. If there were any discrepancies the aide returned the plate to the cook for correction.</p> <p>The dietary aide passed the tray to an assigned clinical staff member who verified that it matched the ticket and food that has been plated for therapeutic diet consistency. After verification, the tray was passed to a co-worker for delivery to the resident. This process was also followed for the hall carts.</p> <p>Dietary staff prepared pre-thickened beverages located in the dining room and hall carts as needed in designated bins labeled with the</p>	F 367			

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NAME OF PROVIDER OR SUPPLIER  <b>GATEWAY TRANSITIONAL CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE POCATELLO, ID 83201</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 367	Continued From page 53 consistencies.  The DON was educated by the speech therapist on 10/12/17 at 7:10 am on recognizing the differences in textured diets and liquid consistencies.  The above actions were verified and the Immediate Jeopardy removed prior to the survey exit conference completed on October 13, 2017.	F 367			
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS  (a) Infection prevention and control program.  The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);  (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:  (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441		11/3/17	

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F 441	<p>Continued From page 54</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 actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p>	F 441			

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F 441	<p>Continued From page 55</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish an adequate infection prevention and control program (IPCP) that included a system for collecting and analyzing data to detect potential clusters and trends of infections occurring within the facility, and failed to ensure staff consistently performed hand hygiene to reduce the risk for infection. This was true for 1 sampled resident (#5) and had the potential to effect any resident in the facility. The deficient practice created the potential for harm if residents were exposed to infections from sources not identified by the facility, or developed infections from cross-contamination. Findings include:</p> <p>1. The facility's infection Surveillance Information Logs for June, July, August, and September 2017 did not document a response to "Culture Taken Yes/No" for any of the documented infections.</p> <p>The facility's Surveillance Information Logs for June, July, August, and September 2017 did not document a response to "Organism Type" for any of the documented infections.</p> <p>The facility's Surveillance Information Logs for June, July, August, and September 2017 documented no response to "Infection Cleared Date" for all of the documented infections.</p> <p>On 10/13/17 at 4:01 pm, the DON (Director of Nursing) said the facility tracks infections through antibiotic reports, reviewing orders and cultures, and the facility downloaded culture results for</p>	F 441	<p>1. Corrective actions accomplished for those affected were: A. staff educated on hand washing after peri care on 10/14, 10/17 and 10/25. B. infection prevention manger and staff were educated (10/14, 10/17 and 10/25) to include in the infection control tracking log, an indication if a culture was obtained, organism identification and infection resolve date. Facility also reviewed months june--September to identify organisms of in house infection which shed no cross contamination, this was provided to the survey team on 10/16.</p> <p>2. All residents have the potential to be affected.</p> <p>3. Measures applied to ensure the deficient practice does not occur are: A. P&amp;P updated for peri care to include hand washing and application of gloves. All staff educated on this P&amp;P on dates outlined above. B. The infection prevention manger and staff were educated on documenting if a culture was taken, organism identified, and infection resolve date.</p> <p>4. A. Lead nurse aide/designee to monitor peri care 3 times per week for 4 weeks then weekly for 2 months. B. DON/designee to monitor the infection tracking weekly for 3 weeks, then monthly thereafter.</p> <p>5. Date of compliance of 11/3/2017.</p>		

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

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F 441	<p>Continued From page 56</p> <p>each resident into the facility's computer system. He said the organism type is not recorded on the Surveillance Information Log and the facility was not tracking the specific organism. The DON said if a resident came to the facility from the hospital and had an infection, the facility would request lab data and should map the organism to look for the same organism throughout the facility; however, the facility's infection tracking and mapping system did not document the causative organism for any infections listed on the Surveillance Information Log.</p> <p>The facility's Surveillance and Infections-IC (Infection Control) Tracking Policy documented "...there will be a system in place whereby the tracking and trending of potential/actual infections will be monitored to ensure that measures are taken to prevent any potential outbreak" and "IP (Infection Preventionist)/DNS (Director of Nursing Services)/Designee will review the log...to ensure all potential/actual infections/outbreaks are being identified."</p> <p>The facility's Policy/Procedure for Perineal Care (cleaning the area between the resident's legs) did not document the use of gloves. The Policy/Procedure documented in order to complete the perineal care procedure, wash hands "properly."</p> <p>On 10/13/17 at 4:05 pm, when asked about the facility's Policy/Procedure for Perineal Care, the DON (Director of Nursing) said gloves should be worn when performing perineal care. The DON said handwashing should be performed for 40-60 seconds and staff members have received training in proper hand hygiene.</p>	F 441			

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F 441	<p>Continued From page 57</p> <p>2. Resident #5 was readmitted to the facility on 12/23/11 with diagnoses that included contractures, anoxic brain injury, and convulsions.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 8/31/17, documented Resident #5 had a severe cognitive impairment and was totally dependent on 1 to 2 staff members for all cares.</p> <p>On 10/11/17 at 9:23 am, CNA #3 was in Resident #5's room removing her incontinence briefs. At 9:25 CNA #3 asked for another CNA to come assist her with changing Resident #5 and CNA #3 started providing pericare while waiting for assistance. At 9:29 am, CNA #1 entered the room to assist CNA #3. At 9:33 am, CNAs #1 and #3 completed the pericare and applied a new brief. Then, both CNAs removed their gloves and repositioned the resident. CNA #3 was asked if she changed her gloves and performed hand hygiene after moving from providing pericare. CNA #3 stated she changed her gloves but forgot to perform hand hygiene.</p>	F 441		