



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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November 22, 2017

Remick "Micky" Clark, Administrator
Good Samaritan Society - Idaho Falls Village
840 East Elva Street
Idaho Falls, ID 83401-2899

Provider #: 135092

Dear Mr. Clark:

On **October 27, 2017**, a survey was conducted at Good Samaritan Society - Idaho Falls Village by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 4, 2017**. Failure to submit an acceptable PoC by **December 4, 2017**, may result in the imposition of penalties by **December 27, 2017**.

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

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

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

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

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

- Civil Monetary Penalty

The remedy, which will be recommended if substantial compliance has not been achieved by **January 27, 2018** includes the following:

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- Denial of payment for new admissions effective **January 27, 2018**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 27, 2018**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 27, 2018** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

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- BFS Letters (06/30/11)

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

This request must be received by **December 4, 2017**. If your request for informal dispute resolution is received after **December 4, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson LSW".

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj
Enclosures

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

PRINTED: 12/13/2017
FORM APPROVED
OMB NO. 0938-0391

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|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2017 |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 000 | <p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from October 23, 2017 to October 27, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Cecilia Stockdill, RN</p> <p>Definitions include:</p> <p>ADL = Activities of Daily Living ADON = Assistant Director of Nursing cc = cubic centimeter CDC = Center for Disease Control CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DM = Dietary Manager DNS = Director of Nursing Services GERD = Gastroesophageal Reflux Disease HS = bedtime LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams MRSA = Methicillin Resistant Staphylococcus Aureus MS = Multiple Sclerosis NPO = Nothing by mouth PEG = percutaneous endoscopic gastrostomy RD = Registered Dietician RN = Registered Nurse WBAT = weight bearing as tolerated W/C = wheelchair</p> | F 000 | | | |
| F 157 SS=D | <p>NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> | F 157 | | 12/29/17 | |

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

TITLE

(X6) DATE

Electronically Signed

12/01/2017

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 157 | <p>Continued From page 1 CFR(s): 483.10(g)(14)</p> <p>(g)(14) Notification of Changes.</p> <p>(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-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(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);</p> <p>(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</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(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.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> | F 157 | | | |

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| F 157 | <p>Continued From page 2</p> <p>(A) A change in room or roommate assignment 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 staff interview and resident record review, it was determined the facility failed to ensure residents' physicians were promptly notified of a resident's fall with potential for injury and a resident's elevated blood pressure readings. This was true for 2 of 11 sample residents (#3 and #6) and had the potential for harm if physicians were not provided with information necessary to initiate and/or alter interventions to meet residents' changing needs. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 8/11/10 with diagnoses including Parkinson's disease, dementia, and osteoporosis.</p> <p>On Saturday, 5/13/17 at 9:33 am, an Incident Progress Note documented Resident #3 was being transferred from the bed to wheelchair, her pants were pulled up and her legs "gave out." The resident was assisted to the floor and no injuries were noted.</p> <p>On 5/15/17, an Investigation Interview documented the LPN assessed Resident #3's feet later in the day after the fall because the</p> | F 157 | <p>#1. Resident #3 has had her care plan updated and doctor is aware of her current condition. Resident #6's orders for her blood pressure medication were updated 11/30/17 so that the LN's will be aware of when the physician should be notified of low or high blood pressures.</p> <p>#2. All residents with changes in condition, falls, or pertinent information regarding cares will be called to physician and families in a timely manner.</p> <p>#3. The DNS and SDC will provide education to all nursing service staff on the importance of timely notification with changes in condition, abnormal vital signs, falls with potential injuries. Physicians were notified on 11/27/17 requesting parameters for hypertension for residents with diagnosis of hypertension and medications to treat hypertension. Nurses are to call physician and report concerns, incidents or change in condition. Additional information or details</p> | | |

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| F 157 | <p>Continued From page 3</p> <p>resident complained of some pain in her left foot. The resident's feet were "a little swollen at that time but nothing that was abnormal for her..." No bruising was present; however, there was a "line on the great toe of her left foot."</p> <p>On 5/13/17 at 9:30 am, a fax notification to Resident #3's physician documented the resident was "assisted to the floor when being transferred...Knees buckled. No injury." A response fax from the physician, dated 5/15/17, documented "Noted. I subsequently heard she injured her ankle/legs...x-rays ordered [and] awaiting reading." There was no documentation the facility spoke to the physician until 10:00 pm the day after the fall.</p> <p>On 10/26/17 at 9:35 am, the Director of Nursing Services said the facility should have called Resident #3's physician to verify he received the fax notification regarding the resident's fall on 5/13/17.</p> <p>2. Resident #6 was admitted to the facility on 1/9/09 and readmitted on 10/3/16 with multiple diagnoses including essential hypertension.</p> <p>Resident #6's annual MDS, dated 9/22/17, documented Resident #6 was cognitively intact.</p> <p>Resident #6's hypertension Care Plan, dated 10/13/16, directed staff to assess for shortness of breath and cyanosis, assess and observe fingers and toes for warmth and color and report changes to nurse.</p> <p>Resident #6's October 2017 Physician Orders documented:</p> | F 157 | <p>of incident or other concerns can be faxed but calls must be initiated at the time of the incident or concern. A review of the INTERACT-Change in Condition Evaluation will be included in this education. A reminder of the Care Paths and Change in Condition File Cards are available within the eINTERACT Change of Condition Evaluation for a quick reference. This education will be held on 12/06/17.</p> <p>#4. The SDC or designee will audit Alerts on PCC and other parts of the medical record to ensure proper and timely notification to physicians was done. This audit will be done weekly X4 and then monthly X3. The SDC or designee will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p> | | |

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| F 157 | Continued From page 4 * Carvedilol 3.125 mg by mouth two times daily related to essential hypertension, hold if systolic blood pressure is less than 100 or diastolic blood pressure is less than 60. * Clonidine 0.1 mg by mouth two times a day related to essential hypertension, hold if systolic is less than 100 or 90. There was no physician direction for hypertensive episodes. The facility Procedure titled Vital Signs- Blood Pressure and Orthostatic, dated 9/12 and revised 10/17, did not provide direction for management of hypertensive episodes. The Centers for Disease Control and Prevention has classified high blood pressure as systolic was 140 mmHg or higher and diastolic was 90 or higher. (The first number, called systolic blood pressure, measures the pressure in your blood vessels when your heart beats. The second number, called diastolic blood pressure, measures the pressure in your blood vessels when your heart rests between beats.) Between 10/1/17 and 10/26/17, 38 blood pressures ranging from 149/77 to 221/77 were documented on Resident #6's blood pressure log. No documentation could be located of Physician notification. On 10/26/17 at 3:05 pm, the DNS stated the physician should have been notified. | F 157 | | | |
| F 272 SS=D | COMPREHENSIVE ASSESSMENTS CFR(s): 483.20(b)(1) (b) Comprehensive Assessments | F 272 | | 12/29/17 | |

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| F 272 | Continued From page 5 (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. | F 272 | | | |

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| F 272 | <p>Continued From page 6</p> <p>The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and resident, family, and staff interviews, it was determined the facility failed to ensure residents' MDS assessments accurately assessed and identified issues related to communication devices. This was true for 1 of 11 residents, (Resident #5) whose MDS assessments were reviewed. The deficient practice resulted in an MDS assessment of Resident #5 which did not accurately reflect his hearing and vision deficits. Findings include:</p> <p>Resident #5 was admitted to the facility on 8/1/12 with multiple diagnoses, including diabetes mellitus type 2.</p> <p>Resident #5's 4/10/17 annual, 7/7/17 quarterly and 10/5/17 quarterly MDS assessments documented his hearing was adequate and a hearing aid or other device was not used.</p> <p>Resident #5's Communication Problem Care Plan documented the resident was hard of hearing and wore a hearing aid. The intervention directed staff to ensure Resident #5's hearing aid (right) is available for the resident to place when he desired.</p> <p>Resident #5's 4/10/17 annual and 7/7/17 quarterly MDS assessments documented his use of corrective lenses or visual aids.</p> | F 272 | <p>#1. The care plan for resident #5 was updated on 10/26/17 to reflect his communication needs. All of resident #5's MDS's from 1/27/16 to current were modified to reflect the resident's vision and hearing needs on 12/08/17.</p> <p>#2. All residents will be assessed to assure their communication needs are met, staff will see this reflected on the care plan and Kardex. The MDSs will be coded correctly regarding communication needs.</p> <p>#3. The DNS will provide education on 12/14/17 to the care team on assessment, proper coding of the MDS and care plan follow-up related to communication needs.</p> <p>#4. The DNS or designee will audit care plans and MDSs to assure residents with communication needs to assure these needs are reflected on the MDS and the care plan. The audit will also include whether the resident has the items needed, if communication needs have changed, and if CNA staff are providing the needed items. This audit will be done weekly X4 and then monthly X3 with the DNS or designee reporting the findings to</p> | | |

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| F 272 | Continued From page 7 Resident #5's quarterly MDS, dated 10/5/17, documented Resident #5 did not use corrective lenses or visual aids. Resident #5's Care Plan, dated 12/3/13 and revised on 4/21/17, documented impaired visual function and the need for assistive device (magnifying glasses) to read large print. The interventions direct staff to provide Resident #5 with large print books and magnifying glasses. On 10/24/17 at 10:00 am, Resident #5 was in bed reading a book. Resident had magnifying goggles over corrective glasses. While conversing, Resident #5 placed his right hand to his right ear and said, "you will have to speak louder." Resident #5 did not have a hearing aide in his ear. On 10/26/17 at 4:00 pm, MDS RN stated the resident does not always utilize the hearing aid or the magnifying glasses. She stated they should be available to him. | F 272 | the QAPI committee monthly. The committee will determine if further auditing is needed. | | |
| F 279 SS=D | DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (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. 483.21 (b) Comprehensive Care Plans | F 279 | | 12/29/17 | |

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| F 279 | Continued From page 8 (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 - (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 (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). (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. (iv) In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the | F 279 | | | |

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| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401 | | |
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| F 279 | <p>Continued From page 9</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure care plans were appropriately developed and implemented based on residents' comprehensive assessments. This was true for 1 of 11 sample residents (#3.) This deficient practice created the potential for residents to receive inappropriate or inadequate care. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 8/11/10 with diagnoses including Parkinson's disease, dementia, and osteoporosis.</p> <p>Resident #3's 4/4/17 annual MDS (Minimum Data Set) assessment documented she was cognitively intact and required extensive assistance with transfers/two plus person physical assist. When moving from seated to a standing position, the resident was not steady and required human assistance to stabilize. The triggered care areas included ADL (Activities of Daily Living)/functional rehabilitation potential and falls.</p> <p>Resident #3's ADL (Activities of Daily Living) care plan interventions, initiated 7/12/16, documented she was unable to ambulate and required the</p> | F 279 | <p>#1. Resident # 3's care plan was updated on 11/28/17 to reflect the current ADL assist needed.</p> <p>#2. All residents will have assessments done to assure that the care plan will reflect their current and actual needs of that resident.</p> <p>#3. The DNS or designee will educate the care team and licensed nurses as to how the assessments should be done and how to use the information from those assessments to promote and maintain the highest well-being of each resident. This education will be done on 12/14/17.</p> <p>#4. The DNS or designee will audit care plans to assess that current needs for ADL assistance are reflected on the care plan based on the assessments. This audit will also include observation of cares and any changes in the resident's abilities that could potentiate significant changes resulting in updates made to the care plan. This audit will be done weekly X4 and then monthly X3 with the DNS or designee reporting the findings to the</p> | | |

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| F 279 | Continued From page 10 assistance of one staff when transferring between surfaces. | F 279 | QAPI committee monthly. The committee will determine if further auditing is needed. | | |
| F 280 SS=D | <p>On 10/26/17 at 10:10 am, the Director of Nursing Services stated Resident #3's level of assistance was not accurately reflected on the care plan.</p> <p>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)</p> <p>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:</p> <p>(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.</p> <p>(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.</p> <p>(iv) The right to receive the services and/or items included in the plan of care.</p> <p>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.</p> <p>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--</p> | F 280 | | 12/29/17 | |

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

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| F 280 | <p>Continued From page 12</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 3 of 11 (#2, #3, and #7) sample residents. The deficient practice had the potential to cause harm if residents did not receive appropriate care and interventions due to inaccurate information on their care plans. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 8/11/10 with diagnoses including Parkinson's, dementia, and osteoporosis.</p> <p>Resident #3's 5/25/17 significant change in status and 8/25/17 quarterly MDS assessments documented she was cognitively intact and was totally dependent with transfers/two plus persons physical assist.</p> <p>Resident #3's physical mobility care plan documented the following interventions were initiated on 5/19/17: "Non-weight bearing on left leg, right foot pivot transfers," and "Resident requires staff total lift with mobility by nursing staff."</p> | F 280 | <p>#1. Resident # 3's care plan was updated on 11/28/17 to reflect their current assistance needs. Resident # 2's care plan was updated on 11/28/17 to reflect the use of the feeding tube. Resident # 7's care plan was updated on 10/26/17 to reflect the need for a sack lunch to go with him when he attends dialysis.</p> <p>#2. All residents will have updated and correct care plans to reflect all of their current needs.</p> <p>#3. The DNS or designee will provide education to the care team, including the RD; reviewing the Care Plan P/P with the need to have current needs for each resident on the care plan, this education will be done on 12/14/17.</p> <p>#4. The DNS or designee will audit care plans to assure all areas are based on the resident's current needs and also based on new physician orders, new assessments, and any changes in</p> | | |

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| F 280 | <p>Continued From page 13</p> <p>Resident #3's 10/24/17 Medication Review Report documented "OK to WBAT (weight bearing as tolerated) on left leg at this point in her cast boot. Cast boot can come off to sleep." No care plan updates were documented in response to this order.</p> <p>On 10/23/17 at 12:12 pm, Resident #3 was observed in the dining room with a black boot on her left lower leg.</p> <p>On 10/25/17 at 3:35 pm, the Director of Nursing Services (DNS) said the non-weightbearing status should have been taken off the care plan and they would update the care plan.</p> <p>2. Resident #2 was admitted on 6/10/11 and re-admitted on 10/18/17 with diagnoses including GERD (Gastroesophageal Reflux Disease-a stomach acid problem) and MS (Multiple Sclerosis).</p> <p>Resident #2's 3/14/17 annual and 8/1/17 quarterly MDS (Minimum Data Set) assessments documented she was cognitively intact.</p> <p>Resident #2's 8/1/17 quarterly MDS assessment documented she was totally dependent with eating and received tube feeding while a resident.</p> <p>Resident #2's nutritional problem care plan documented the following interventions were initiated on 4/26/17 and revised on 10/13/17: "... NPO (nothing by mouth) with tube feeding as ordered." The care plan did not document a focus area or interventions regarding the resident's</p> | F 280 | <p>conditions. This audit will be done weekly X4 and then monthly X3 and reported to the QAPI committee by the DNS or designee monthly. The committee will determine if further auditing is needed.</p> | | |

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| F 280 | <p>Continued From page 14 feeding tube site.</p> <p>On 10/26/17 at 11:41 pm, a Progress Note documented Resident #2 had a PEG (Percutaneous Endoscopic Gastrostomy-a feeding tube in the stomach) for feeding and medication.</p> <p>Resident #2's 10/1-10/31/17 Treatment Record documented "If pus type drainage at PEG tube site or fever over 101 degrees F[ahrenheit], notify [the] doctor. Apply ice pack to affected area every day and every night shift for PEG tube care..."</p> <p>On 10/25/17 at 11:25 am, LPN #2 was observed administering medication through Resident #2's PEG tube. LPN #2 said the PEG tube site was cared for each shift and she would wipe the site with a sterile saline wipe.</p> <p>On 10/25/17 at 2:45 pm, the DNS said she would look at putting information regarding the PEG tube on the care plan. The DNS said the care plan was not accurate or complete.</p> <p>3. Resident #7 was admitted to the facility on 9/15/16 with diagnoses including end-stage renal disease and diabetes mellitus.</p> <p>Resident #7's annual MDS dated 9/14/17, documented resident was cognitively intact.</p> <p>Resident #7's hemodialysis care plan, dated 9/16/16, directed staff of scheduled appointments at the dialysis center 3 times each week. The interventions did not direct the facility to ensure Resident #7 was provided a sack lunch on the days of dialysis treatment.</p> | F 280 | | | |

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

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| F 280 | Continued From page 15 Resident #7's nutritional problem care plan, dated 9/21/16, did not provide interventions to direct staff to prepare or provide a sack lunch for resident on the days of dialysis treatment. On 10/26/17 at 10:00 am, the Dietary Manager (DM) stated a sack lunch is prepared for Resident #7 on his dialysis days. "We know what he wants and we make his usual unless he wants something different." The DM could not identify where this direction would be documented. On 10/26/17, at 10:15 am, LPN #3 stated the facility provided a lunch for Resident #7 on his dialysis days. "I have worked here for 2 years so I just know." She stated she did not know about any order to provide Resident #7 with a lunch on dialysis days and she would have to look at the care plan to see if it was there. For new staff, LPN #3 stated "We would have to train them." On 10/26/17 at 10:30 am, the Registered Dietician (RD) stated the nursing staff would not let Resident #7 get on the bus without a lunch. The RD stated there was not a physician order and it was not in the care plan. "Sorry, I will get that in the care plan." | F 280 | | | |
| F 281 SS=G | SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- | F 281 | | 12/29/17 | |

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| F 281 | <p>Continued From page 16</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to:</p> <p>*Adequately assess residents for injuries immediately following falls and monitor for latent signs of injuries after falls. This was true when a resident experienced a fall and was not assessed or monitored appropriately after the fall. This failed practice resulted in harm to 1 of 11 sample residents (#3) when the resident was subsequently diagnosed with multiple fractures and was hospitalized related to the fractures.</p> <p>*Assess residents blood pressure using an accurate and appropriate blood pressure measuring device. This was true when a resident (#11) was found to have an elevated blood pressure reading when checked using a blood pressure measuring device that was not provided by the facility. This failed practice created the potential for harm if residents received inappropriate medical treatment due to inaccurate blood pressure readings.</p> <p>*Follow physician orders consistently regarding monitoring residents pulse and lung sounds before and after administering medication via nebulizer to a resident (#10). This failed practice created the potential for harm if abnormal oxygen saturation and lung sounds remained undetected and untreated.</p> <p>Findings include:</p> <p>1. Resident #3 was admitted to the facility on</p> | F 281 | <p>#1. Resident #3 has been assessed and appropriately care planned for her current needed assistance with transfers. Resident #11's blood pressures are now being taken with manual cuff that is appropriate and accurate. Resident #10's nebulizer treatments are now being completed with the appropriate before and after pulse and lung sounds.</p> <p>#2. All residents will be assessed thoroughly after a fall with physician notification immediately. Nursing staff will automatically re-check vital signs when abnormal readings. Blood pressure readings will be done manually at this time with equipment provided by facility. Automated vital sign machines have been ordered and facility will calibrate these machines per manufactures recommendations for accuracy. Physician orders regarding medication monitoring with administration of medications will be followed.</p> <p>#3. The DNS or SDC will provide education to nursing staff on 12/14/17 regarding assessments after injuries, re-checking vital signs with abnormal findings, the need to follow manufacturer guidelines with any equipment, and the need to properly administer medications following physician orders and parameters or nursing orders.</p> | | |

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| F 281 | <p>Continued From page 17 8/11/10 with diagnoses including Parkinson's, dementia, and osteoporosis.</p> <p>The United States Department of Health and Human Services Agency for Healthcare Research and Quality in October 2014 (http://www.arhq.gov/professionals/systems/long-term-care/resources/injuries/fallspx/fallspsm2.html), documented the nursing standard of practice following a resident fall at a nursing home included an evaluation of resident injuries immediately post-fall and monitoring the resident for the next 72 hours.</p> <p>Resident #3's 4/4/17 annual MDS (Minimum Data Set) assessment documented she was cognitively intact and required extensive assistance with transfers/two plus persons physical assist. When moving from seated to a standing position, the resident was not steady and required human assistance to stabilize.</p> <p>Resident #3's 5/25/17 significant change in status and 8/25/17 quarterly MDS assessments documented she was cognitively intact and was totally dependent with transfers/two plus persons physical assist.</p> <p>On Saturday, 5/13/17 at 9:30 am, a fax documented Resident #3's physician was notified that the resident was "assisted to the floor when being transferred...Knees buckled. No injury." A response fax from the physician, dated 5/15/17, documented "Noted. I subsequently heard she injured her ankle/legs...x-rays ordered [and] awaiting reading."</p> <p>On 5/13/17 at 9:33 am, an Incident Progress</p> | F 281 | #4. The DNS or SDC will audit assessments done after injuries and when the physician was notified. The audit will include monitoring of abnormal vital signs to assure they we re-checked immediately. All equipment used in the nursing department will have manufacturer guidelines available for nursing to refer to when the equipment or findings are questionable. Audit will include medication passes to include observation of assessments needed before/after med administration, if vital signs were done in accordance to orders or specific to the medication. Audit will also include overall nursing practice in the administration of medications. These audits will be done weekly X3 and then monthly X4 with the DNS or SDC reporting the findings to the QAPI committee monthly, the committee will determine if further auditing is needed. | | |

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| F 281 | <p>Continued From page 18</p> <p>Note documented Resident #3 was being transferred from the bed to wheelchair, her pants were pulled up and her legs "gave out." The resident was assisted to the floor.</p> <p>On 5/14/17 at 1:26 pm, an eAdmin Record Progress Note documented Resident #3's "Acetaminophen Tablet "Give 1000 mg (milligrams) by mouth every 6 hours as needed for pain... PRN (as needed) Administration was: Effective [the resident] stated pain is better." The note did not document the location or severity of Resident #3's pain.</p> <p>On 5/13/17 at 1:33 pm, an eAdmin Record Progress Note documented Resident #3's "Acetaminophen Tablet 500 mg Give 1000 mg by mouth every 6 hours as needed for pain..." The note did not document the location or severity of Resident #3's pain, or whether the medication was effective at alleviating the pain.</p> <p>On 5/13/17 at 1:36 pm, Progress Note documented Resident #3's "Late Entry: When assisting resident to wheelchair from floor leg[s] where [were] placed under resident and assisted up without any pain."</p> <p>No other nursing assessments were documented between 1:36 pm 5/13/17 and 10:00 pm on 5/14/17.</p> <p>On 5/14/17 at 10:00 pm, a Health Status Progress Note documented Resident #3 refused to get out of bed due to pain in her left leg, right leg and ankle, and her right great toe was bruised and swollen. The physician was contacted by phone and x-rays were ordered of</p> | F 281 | | | |

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| F 281 | <p>Continued From page 19 the left leg, right leg, and right great toe.</p> <p>On 5/15/17, an X-ray report documented Resident #3's had fractures of the left proximal and distal fibula and distal tibia (lower leg), right proximal fibula, base of the first proximal phalanx (great toe) on the left foot, and base of the first proximal phalanx on the right foot.</p> <p>On 5/15/17 at 2:55 pm, a Progress Note documented Resident #3 was transferred to the hospital for treatment of fractures.</p> <p>On 5/15/17 at 5:45 pm, a hospital note documented Resident #3's fractures of the left tibia and fibula, right tibia, base of the left great toe, possible subacute or healing fracture of the left fifth metatarsal (bone in the foot), possible non-displaced fracture involving the base of the right great toe, and "probable subacute healing fractures" of the right third and fourth metatarsals. It was documented the resident had a "Nursing home fall resulting in multiple fractures bilaterally of the lower extremities." The resident was admitted to the hospital for management of the fractures.</p> <p>On 5/15/17, an Investigation Interview documented the LPN "observed" Resident #3's feet later [on 5/13/17] after the fall because the resident complained of some pain in her left foot. The resident's feet were "a little swollen at that time but nothing that was abnormal for her..." No bruising was present; however, there was a "line on the great toe of her left foot." The resident was given Tylenol for pain and the LPN said the resident "might be a better candidate for a two person assist rather than a one person assist..."</p> | F 281 | | | |

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| F 281 | <p>Continued From page 20</p> <p>The investigation did not document any further assessment or interventions for Resident #3's pain complaints, swelling, or skin discoloration.</p> <p>There was no documentation that Resident #3's range of motion was assessed immediately after the fall, that she was monitored for further signs of injury in the hours subsequent to the fall, or the physician was contacted by phone until the resident refused to get out of bed due to pain at 10:00 pm the next day.</p> <p>On 10/23/17 at 4:53 pm, LPN #1 said she evaluated the resident after the fall on 5/13/17. LPN #1 said the resident was found on the floor, a skin assessment and vital signs were performed with no abnormal findings, and the resident was transferred to a chair and "monitored." LPN #1 did not remember how the fall happened, and said two people would have been better rather than a one person assist.</p> <p>Resident #3 was harmed when she had an assisted fall on 5/13/17 at 9:33 am, and was not assessed for injury per professional standards of practice for over 36 hours following the fall. There was no documentation the physician was aware of the faxed notification of Resident #3's fall until two days after the fall, and the resident's legs and feet were not assessed for changes in her range of motion or by x-ray during that time. Resident #3 was diagnosed with multiple fractures related to the fall which were not identified until two days after she experienced a fall. Resident #3 required admission to the hospital for management of the fractures two days after she fell.</p> | F 281 | | | |

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| F 281 | <p>Continued From page 21</p> <p>2. Resident #11 was admitted on 3/26/15 with diagnoses including hemiplegia (weakness on one side of the body), atrial fibrillation (irregular heart rhythm), heart failure, history of stroke, and hypertension (high blood pressure).</p> <p>Resident #11's 10/27/17 Medication Review Report documented Amlodipine Besylate Tablet (blood pressure medication) 10 mg (milligrams) once a day and hold if blood pressure less than 110 systolic (top number) or less than 60 diastolic (bottom number).</p> <p>On 10/24/17 at 9:35 am, RN (Registered Nurse) #1 checked Resident #11's blood pressure using a small white automatic blood pressure device on the resident's left wrist. The blood pressure reading was 243/100. RN #1 re-checked Resident #11's blood pressure on his right wrist using the same blood pressure device. The blood pressure reading on the right wrist was 209/96. RN #1 said she would re-check the resident's blood pressure manually (with a stethoscope and blood pressure cuff that is inflated by hand).</p> <p>On 10/24/17 at 10:17 am, RN #1 said she should notify the physician of Resident #11's blood pressure reading.</p> <p>On 10/24/17 at 10:20 am, RN #1 called Resident #11's physician and left a message for the nurse or physician to call back regarding the resident's elevated blood pressure.</p> <p>On 10/24/17 at 10:25 am, RN #1 re-checked Resident #11's blood pressure manually on the resident's right arm and said the blood pressure reading was 140/82. RN #1 said she did not</p> | F 281 | | | |

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| F 281 | <p>Continued From page 22</p> <p>believe the blood pressure reading from the automatic blood pressure device was accurate.</p> <p>On 10/24/17 at 10:32 am, RN #1 said she would check the battery in the small white blood pressure device and re-check a blood pressure on another individual to make sure the machine was working correctly. She said if the machine was working "erroneously" she would not notify the physician of the initial blood pressure readings for Resident #11.</p> <p>On 10/24/17 at 2:25 pm, the Director of Nursing Services (DNS) said if the blood pressure reading was high when the nurse used the automated blood pressure machine, she would expect the nurse to re-check the blood pressure manually. She said the automated blood pressure machine reading seemed inaccurate and she would not expect the nurse to report the results obtained from the automated blood pressure machine; however, she would expect the nurse to report to the physician if the resident's blood pressure medication was not effective.</p> <p>On 10/24/17 at 3:47 pm, the DNS said it is best practice to check blood pressure manually but "our policy says it's okay to use a machine." She said she would look for the manufacturer's instructions for the blood pressure machine that was used on Resident #11.</p> <p>On 10/24/17 at 3:00 pm, the DNS said the nurse used her personal blood pressure machine to check the resident's blood pressure and the manufacturer's instructions were not available. The DNS said the facility does not supply</p> | F 281 | | |

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| F 281 | <p>Continued From page 23</p> <p>automated blood pressure machines and each medication cart has manual blood pressure equipment. The DNS said the nurses are expected to use manual blood pressure equipment and would no longer be allowed to use their own automated blood pressure machines.</p> <p>3. Resident #10 was admitted on 10/5/17 with diagnoses including diastolic heart failure, COPD (Chronic Obstructive Pulmonary Disease), and hypertension (high blood pressure).</p> <p>Resident #10's 10/26/17 Medication Review Report documented Albuterol Sulfate Nebulization Solution (a liquid breathing medication that is inhaled as a mist) "1 [One] dose inhale orally via nebulizer three times a day...Document pulse and lung sounds pre & post administration and record the total time (min) nursing spent with resident on treatment."</p> <p>Resident #10's 10/26/17 Medication Record documented the Albuterol Sulfate Nebulization Solution was administered each day from 10/6 - 10/25/17. Documentation of the minutes, heart rate, and lung sounds before and after Albuterol was either not done or was incomplete for 37 of 54 administrations.</p> <p>On 10/26/17 at 4:00 pm, LPN #3 was observed administering the Albuterol Sulfate Nebulization Solution to Resident #10 without checking the resident's pulse or lung sounds prior to the medication. When asked about the order to monitor the resident's pulse and lung sounds prior to and after the Albuterol, LPN #3 said the order was not followed and it should be.</p> | F 281 | | | |

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| F 281 | Continued From page 24 | F 281 | | | |
| F 309 SS=D | <p>On 10/26/17 at 4:05 pm, Resident #10 said the Albuterol administration was done about 15 minutes ago and her breathing was fine. She said the nurse did not check her lungs or pulse oximetry (a device that shows the resident's pulse and oxygen level).</p> <p>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l)</p> <p>483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.</p> <p>483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:</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</p> | F 309 | | 12/29/17 | |

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| F 309 | <p>Continued From page 25 preferences.</p> <p>(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to ensure residents diagnosed with diabetes mellitus (#1, #5 and #9) received care consistent with their needs, care plans, current standards of practice, and facility policy. This was true for 3 of 3 residents reviewed for diabetic management. As a result:</p> <ul style="list-style-type: none"> * Residents did not have blood glucose (BG) monitoring orders * The facility did not have a policy addressing overall diabetic care <p>This deficient practice placed residents with diabetes at risk of further health complications because of inadequate diabetic management. Findings include:</p> <ol style="list-style-type: none"> 1. Resident #1 was admitted to the facility on 6/13/14 with multiple diagnoses, including diabetes mellitus type 2. <p>The significant change of condition Minimum Data Set (MDS) assessment, dated 9/27/17, documented Resident #1 was cognitively intact and received insulin 7 days a week.</p> | F 309 | <p>#1. Physician orders requested on 12/01/17 to include parameters on the use of long-acting insulin and notification of high blood glucose levels for resident #1. Physician orders were requested on 12/01/17 to include parameters on when to notify physician with low blood glucose levels for resident #5. Physician orders were requested on 12/01/17 including parameters on when to hold long-acting insulin and when to notify the physician of high or low blood glucose levels for resident #9.</p> <p>#2. All residents with physician orders for insulin will include parameters on when to notify the physician of high or low blood glucose levels and when to hold insulin.</p> <p>#3. The SDC will educate all nurses of the need for complete physician orders regarding insulin orders. These orders will include parameters for both high and low blood glucose levels, what to do in the event of very low or very high blood glucose levels, and when to hold long-acting insulin. This education will be</p> | | |

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| F 309 | <p>Continued From page 26</p> <p>Resident #1's Diabetic Care Plan, dated 6/26/14 and revised on 7/1/14, directed staff to monitor/document/report to the health care provider, as needed signs/symptoms of hypoglycemia per the facility's Hypoglycemic Incidents Procedure. The care plan did not direct staff regarding hyperglycemic events.</p> <p>Resident #1's October 2017 Physician Orders documented Lantus 5 units subcutaneously at bedtime daily, beginning. 6/13/17.</p> <p>The physician orders also documented NovoLog insulin per sliding scale, dated 8/31/16:</p> <ul style="list-style-type: none"> * If 201-250 = 3 units; * 251-300 = 4 units; * 301-350 = 6 units; * 351-400 = 8 units; * 401-500 = 10 units subcutaneously before meals and at bedtime for diabetes mellitus per MD's written instruction. <p>*If blood glucose was under 70, refer to Hypoglycemic Incidents Procedure.</p> <p>Resident #1's Physician order, dated 4/15/16, documented to check blood glucose pm, (as needed) and refer to Hypoglycemic Incidents Procedure if under 70.</p> <p>Physician Orders did not include parameters directing staff when to hold long acting insulin, parameters or when staff were to notify the physician of elevated BGs levels.</p> <p>2. Resident #5 was admitted to the facility on 8/1/12 with multiple diagnoses, including diabetes mellitus type 2.</p> | F 309 | <p>done on 12/14/17.</p> <p>#4. The SDC or designee will audit all physician orders regarding insulin orders to assure parameters for high and low blood glucose levels are included and information regarding when to hold long-acting insulin. This audit will also include monitoring the eMAR to assure that nursing is following these parameters. These audits will be done weekly X4 and then monthly X3 with the SDC or designee reporting findings to the QAPI committee. The committee will determine if further auditing is needed.</p> | | |

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| F 309 | <p>Continued From page 27</p> <p>Resident #5's quarterly MDS, dated 10/5/17, documented moderately impaired cognition and he received insulin 7 days a week.</p> <p>Resident #5's Diabetic Care Plan, dated 12/3/13 and revised 3/6/14, directed staff to monitor/document/report for and report to Nurse signs and symptoms of hyperglycemia and monitor/document/report for and report to Nurse signs and symptoms of hyperglycemia.</p> <p>Resident #5's Physician Orders documented NovoLog insulin per sliding scale, dated 8/31/16:</p> <ul style="list-style-type: none"> * If 151-200 = 2 units; * 201-250 = 4 units; * 251-300 = 6 units; * 301-350 =8 units; * 351-400 = 10, call MD if greater than 400, subcutaneously 4 times a day. * If blood glucose is less than 45, follow Hypoglycemic Incident Procedure. <p>Resident #5's Physician order, dated 3/27/15, documented to check blood glucose as needed. Monitor if blood glucose is less than 70, follow Hypoglycemic Incidents Procedure, notify physician if greater than 400 or symptomatic of hyperglycemia. The Physician orders did not provide parameters for when staff were to notify the physician of low BG levels.</p> <p>3. Resident #9 was admitted to the facility on 9/26/16 and readmitted on 4/30/17 with multiple diagnoses including diabetes mellitus.</p> <p>Resident #9's quarterly MDS, dated 8/16/17,</p> | F 309 | | | |

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| F 309 | <p>Continued From page 28</p> <p>documented Resident #9 was cognitively intact and received insulin 7 days a week.</p> <p>Resident #9's Diabetic Care Plan, dated 2/24/17, directed staff to assist with the visual function of managing diabetes and provide foot care.</p> <p>Resident #9's October 2017 Physician Orders directed staff to administer Lantus, 32 units subcutaneously in the morning, dated 10/13/17.</p> <p>The Physician orders also documented to administer HumaLog insulin per sliding scale, dated 2/22/17:</p> <ul style="list-style-type: none"> * If 151-200 = 2 units; * 201-250 = 4 units; * 251-300 = 6 units; * 301-350 = 8 units; * 351-400 = 10 units; * 401-450 = 12 units subcutaneously before meals and at bedtime. <p>The Physician orders for Resident #9 did not provide parameters directing staff when to hold long acting insulin or when staff were to notify the physician of elevated or low BG levels.</p> <p>On 10/25/2017 at 1:30 pm, the Administrator provided facility policies for diabetic management. The Procedure for Hypoglycemic Incidents, last revised 12/15, and Blood Glucose Monitoring, Disinfecting and Cleaning, last revised 10/17.</p> <p>The Procedure for hypoglycemic incidents directed staff to immediately call the practitioner when the blood glucose value is less than 70</p> | F 309 | | | |

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| F 309 | Continued From page 29 mg/dL. The Policy and Procedure for Blood Glucose Monitoring, Disinfecting and Cleaning, directed staff to verify that the physician's orders include blood glucose high and low parameters and when to notify the resident's physician. On 10/26/17 at 3:00 pm, the Director of Nursing Services (DNS) stated the facility did not have a policy for diabetic management. The DNS stated the resident's physicians ordered the management of diabetes on an individual basis. | F 309 | | | |
| F 323 SS=G | FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain | F 323 | | 12/29/17 | |

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| F 323 | <p>Continued From page 30 informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and record review, it was determined the facility failed to ensure adequate supervision and assistance, as assessed, was provided during transfers for residents at risk for falls. This was true for 1 of 11 sample residents (#3) and resulted in harm to Resident #3, who sustained fractures to both lower extremities from a fall during a transfer in her room. Findings include:</p> <p>Resident #3 was admitted to the facility on 8/11/10 with diagnoses including Parkinson's, dementia, and osteoporosis.</p> <p>Resident #3's 4/4/17 annual MDS (Minimum Data Set) assessment documented she was cognitively intact and required extensive assistance with transfers/two plus persons physical assist. When moving from seated to a standing position, the resident was not steady and required human assistance to stabilize. The triggered care areas included ADL (Activities of Daily Living)/functional rehabilitation potential and falls.</p> <p>Resident #3's ADL care plan interventions, initiated 7/12/16, documented she was unable to ambulate and required 1 staff limited support for transferring between surfaces.</p> <p>Resident #3's risk for falls care plan interventions, initiated 11/14/13, documented the</p> | F 323 | <p>#1. Resident #3's care plans have been updated with current assessments and to meet current needs of the resident.</p> <p>#2. All residents will be assessed for mobility limitations and the assistance needed will be reflected on the care plan and Kardex.</p> <p>#3. All nursing staff will be educated on 12/14/17 by the SDC and the DNS on assessments upon admission, changes in condition, and how the assistance for residents will be communicated to staff. The staff will also be educated on the importance of checking the care plan and Kardex prior to providing cares for a resident. Assessments after injuries will be reviewed as well as the notification to the physician. Staff will review the importance of following the care plan and Kardex for transfers and not ever vary from what is on the care plan. Care plan interventions will be updated as soon as changes are seen or new physician orders to reflect the current needs of the resident.</p> <p>#4. The SDC or designee will audit care plans to assure the most recent assessments and physician orders are reflected on the care plan and Kardex.</p> | | |

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| F 323 | <p>Continued From page 31</p> <p>resident was to wear non-skid footwear when transferring or "mobilizing in W/C (wheelchair)" and had a raised edge mattress on her bed.</p> <p>Resident #3's physical device care plan interventions, initiated 5/4/16, documented the resident used anti-lock/roll brakes, bed against the wall, bilateral assist bars on bed, and a scooped mattress due to her risk for falls.</p> <p>On 5/13/17 at 9:33 am Incident Progress Note documented Resident #3 was being transferred by one staff person from the bed to wheelchair, her pants were pulled up and her legs "gave out." The resident was assisted to the floor and no injuries were noted.</p> <p>A 5/15/17 Investigation Interview of the CNA (Certified Nursing Assistant) documented Resident #3 was "lowered to the ground during a transfer" on 5/13/17 at approximately 8:45 am. As the CNA assisted Resident #3 to get up for breakfast, she assisted the resident to stand up and the resident held onto the CNA with her hands around the CNA's neck. During the transfer, the CNA pulled up the resident's briefs and pants, the resident's "knees gave out," and she was lowered to the floor. The CNA called for assistance on the walkie-talkie, received no response, and left the resident unattended as she went to the dining room to summon the nurse. The resident was assessed by the nurse and assisted to a chair. The CNA did not think the care plan documented the resident was a two-person assist, but "it would have been nice" to have a second person. The CNA thought the resident's legs "just got too tired to stand any longer" and "knew that she has been kinda iffy</p> | F 323 | <p>Observations of cares will be done to assure the care plan and Kardex are being followed. These audits will be done weekly X4 and then monthly X3 with the SDC or designee reporting the findings to the QAPI committee monthly. The committee will determine if further auditing is needed.</p> | | |

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| F 323 | <p>Continued From page 32</p> <p>while standing." The CNA said she should have had a second person to assist her during the transfer.</p> <p>A 5/15/17 Investigation Interview of the LPN documented she assessed Resident #3's feet later in the day after the fall because the resident complained of some pain in her left foot. The resident's feet were "a little swollen at that time but nothing that was abnormal for her..." No bruising was present; however, there was a "line on the great toe of her left foot." The resident was given Tylenol for pain and the LPN said the resident "might be a better candidate for a 2 person assist rather than a 1 person assist..."</p> <p>A 5/14/17 at 10:00 pm Health Status Progress Note documented Resident #3 refused to get out of bed due to pain in the left lower extremity, right lower extremity and ankle, and the right great toe was bruised and swollen. The physician was notified and x-rays were ordered of the lower extremities and right great toe.</p> <p>A 5/15/17 X-ray report documented Resident #3 had fractures of the left proximal and distal fibula and distal tibia (lower leg), right proximal fibula, base of the first proximal phalanx (great toe) on the left foot, and base of the first proximal phalanx on the right foot.</p> <p>A 5/15/17 at 11:41 am Communication/Visit with Physician Progress Note documented Resident #3's physician called "to report x-ray results [of] both legs. [The] Resident will be non-weight bearing for now..."</p> <p>A 5/15/17 at 1:34 pm Communication/Visit with</p> | F 323 | | | |

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| F 323 | <p>Continued From page 33</p> <p>Physician Progress Note documented Resident #3's physician called back and the resident was to be transferred to the emergency room for evaluation by an orthopedic [physician].</p> <p>A 5/15/17 at 2:55 pm Other Progress Note documented Resident #3 was transferred to the hospital for treatment of fractures.</p> <p>A 5/15/17 at 5:45 pm hospital note documented Resident #3's fractures of the left tibia and fibula, right tibia, base of the left great toe, possible subacute or healing fracture of the left fifth metatarsal (bone in the foot), possible non-displaced fracture involving the base of the right great toe, and "probable subacute healing fractures" of the right third and fourth metatarsals. It was documented the resident had a "Nursing home fall resulting in multiple fractures bilaterally of the lower extremities."</p> <p>On 5/19/17 at 1:47 am, an Admission/Readmission-Other Progress Note documented Resident #3 returned from the hospital with both lower extremities splinted and wrapped, and she had a walking boot. The resident was hospitalized from 5/15-5/18/17 and sustained multiple fractures to both lower extremities. The resident required a total lift for transfers, was non-weight bearing on her left leg and was able to pivot transfer on the right leg.</p> <p>Resident #3's physical mobility care plan interventions, initiated 5/19/17, documented non-weight bearing on the left leg with right foot pivot transfers and the resident required total lift assistance for mobility.</p> | F 323 | | | |

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| F 323 | Continued From page 34 Resident #3's care plan was updated on 6/27/17 related to multiple fractures of the bilateral lower extremities and weight bearing as tolerated with walking boot on the left lower extremity when out of bed. The care plan documented an intervention, initiated on 6/27/17, that the resident required 2 staff/total lift for transfers. On 10/23/17 at 12:12 pm, Resident #3 was observed in the dining room with a black boot on her left lower leg. On 10/23/17 at 4:53 pm, LPN #1 said she evaluated the resident after the fall on 5/13/17. LPN #1 said the Resident #3 was found on the floor, a skin assessment and vital signs were performed with no abnormal findings, and the resident was transferred to a chair and "monitored." LPN #1 did not remember how the fall happened, and said 2 people would have been better rather than a 1 person assist. Resident #3 was harmed when the facility failed to provide two-person assistance for transfers as assessed in her MDS. There resident was lowered to the floor during a one-person transfer and sustained multiple fractures which required hospitalization and resulted in a decline in her ADLs. | F 323 | | | |
| F 334 SS=F | INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS CFR(s): 483.80(d)(1)(2) (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- | F 334 | | 12/29/17 | |

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| F 334 | <p>Continued From page 35</p> <p>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal</p> | F 334 | | | |

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| F 334 | <p>Continued From page 36</p> <p>immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's Infection Control Procedure, it was determined the facility failed to develop and implement processes to minimize the risk of residents acquiring, transmitting, or experiencing complications from pneumococcal pneumonia for 4 of 11 residents (#'s 1, 6, 7, and 9) sampled for the pneumococcal vaccination, and could effect any resident over the age of 65 residing in the facility.</p> <p>The facility did not implement an immunization program to ensure residents' pneumococcal vaccine status were tracked so immunizations could be offered or provided, as indicated. This failed practice increased residents' risk for</p> | F 334 | <p>#1. Residents #1,6,7, and 9 have up to date pneumococcal vaccinations.</p> <p>#2. All residents will have vaccinations reviewed and the medical record will reflect when the vaccines were given. The center now has a pneumococcal immunization process in place to ensure all residents are safely vaccinated per the CDC guidelines.</p> <p>#3. The SDC and ICP will educate nursing staff on 12/14/17 regarding the need for a complete review of resident immunizations upon admission. A list of residents requiring the vaccines will be</p> | | |

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| F 334 | <p>Continued From page 37</p> <p>contracting pneumonia with its associated complications. Findings include:</p> <p>The Centers for Disease Control and Prevention (CDC) website, updated 11/22/16, documented recommendations for pneumococcal vaccination (PCV13 or Prevnar13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older:</p> <p>"Adults 65 years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23."</p> <p>"If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most recent dose of PPSV23."</p> <p>The Infection Control Procedure titled "Immunizations for Residents," dated 6/12 and revised 11/16, directed the staff to provide the pneumococcal vaccinations per the CDC guidelines. The procedure also directed staff to review the immunization record for all residents each year and report the number of vaccinations and types annually to the quality assurance performance improvement committee.</p> <p>On 10/26/17 at 4:30 pm, the Infection Control Nurse and the Director of Nursing Services stated the facility followed the CDC guidelines for pneumococcal vaccinations. When asked how the facility ensured the resident's immunizations were completed to the CDC guidelines, the Director of Nursing Services stated they had not yet started the program.</p> | F 334 | <p>monitored with physician orders received when a vaccine is needed. The process to assure compliance with immunizations will be explained to the nursing staff, nursing will use a calendar to identify if/when a resident is due for a second pneumococcal vaccine. The immunizations will be charted in the medical record per protocol.</p> <p>#4. The ICP or designee will audit all resident medical records to assure vaccinations are up to date. The audit will include a physician order review, a list of residents requiring the pneumococcal vaccination, and if a second vaccine is needed per physician order. When a second vaccine is needed the date will be entered on the EMR and a calendar to alert the nursing staff as to when it is due, these will also be audited to assure compliance. The ICP will audit all resident charts initially and then a monthly review will be done to assure residents needing the vaccine received it. The audit will include a monthly review of all newly admitted residents to assure immunizations are complete. This audit will continue for 4 months and findings will be reported to the QAPI committee by the ICP, the committee will determine if further auditing is needed.</p> | | |

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| F 334 | <p>Continued From page 38</p> <p>Resident #1 was admitted to the facility on 6/13/14 with multiple diagnoses, including diabetes mellitus.</p> <p>Resident #1's significant change in condition Minimum Data Set (MDS) assessment, dated 9/27/17, documented her pneumococcal vaccination was up to date. Resident #1's clinical record did not identify which pneumococcal vaccine had been received.</p> <p>Resident #6 was admitted to the facility on 1/9/09 and readmitted on 10/3/16 with multiple diagnoses including essential hypertension.</p> <p>Resident #6's annual MDS, dated 9/22/17, documented her pneumococcal vaccination was up to date. The resident's clinical record documented the PCV13 had been given on 10/20/10. The was no documentation found for the PPSV23.</p> <p>Resident #7 was admitted to the facility on 9/15/16 with multiple diagnoses including end-stage renal disease and diabetes.</p> <p>Resident #7's annual MDS, dated 9/14/17, documented the Resident #7's pneumococcal vaccine was not up to date because it was not offered.</p> <p>Resident #9 was readmitted to the facility on 4/30/17 with multiple diagnoses including Diabetes Mellitus.</p> <p>Resident #9's quarterly MDS, dated 8/16/17, documented the resident's pneumococcal vaccination was up to date, however, no</p> | F 334 | | | |

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| F 334 | Continued From page 39 documentation was found as to the date it was provided. The facility's pneumococcal immunization process did not reflect current CDC recommendations or the facility's Infection Control Procedure. | F 334 | | | |
| F 431 SS=E | DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. | F 431 | | 12/29/17 | |

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| F 431 | <p>Continued From page 40</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. 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' medications were stored under proper temperature controls and medication refrigerator temperatures were monitored adequately. This was true when the refrigerator temperature was monitored three times in 23 days for 1 of 1 medication refrigerators. This failed practice created the potential for residents to receive medications with decreased efficacy. Findings include: The medication refrigerator was inspected on</p> | F 431 | <p>#1. All medication refrigerators will have a temperature checked twice per day to assure medications are stored at a safe temperature.</p> <p>#2. If a medication refrigerator has a temp that is not within the safe zone (36-46 degrees) the nurse will check the temperature setting in the refrigerator, move the medications to a safe refrigerated area, and notify maintenance if the temperature does not adjust to the correct setting.</p> | | |

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| F 431 | <p>Continued From page 41 10/27/17 at 8:57 am. Medications stored in the refrigerator included Fluzone (influenza vaccine), Afluria (influenza vaccine), Lantus (insulin), Humulin N (insulin), and Humulin R (insulin).</p> <p>The Temperature Log for Vaccines (Fahrenheit) documented the following temperatures: 38 degrees on 10/8/17 pm, 35 degrees and 10/11/17 pm, and 36 degrees on 10/23/17 am. There were no other documented refrigerator temperature readings during the month of October.</p> <p>The manufacturer's information regarding Afluria, Lantus, and Humulin R document the medication should be stored at 36-46 degrees Fahrenheit.</p> <p>According to the CDC (Center for Disease Control), it is recommended to review and record temperatures in the medication freezer and refrigerator at least 2 times each work day.</p> <p>The facility's Vaccine Handling and Storage Parameters policy, issued 10/13 and revised 12/15 and 9/16, documented "The storage unit temperatures should be read using a calibrated thermometer twice each day-once in the morning and once in the evening."</p> <p>On 10/27/17 at 8:57 am, the DNS (Director of Nursing Services) said the medication refrigerator temperature should be checked weekly and acknowledged it had not been checked consistently.</p> | F 431 | <p>#3. The DNS will provide education to the nursing staff on 12/14/17 informing them of the need to check the medication refrigerators twice a day and what needs to be done if a temp is outside the safe zone. A review of Procedure Acquisition, Receiving, Dispensing, and Storage of Medications will be used for this education.</p> <p>#4. The DNS or designee will audit the medication room refrigerator temperature sheets to assure medications are kept within 36-46 degrees. If noted that the refrigerator has not been kept in the safe zone the audit will include what the nurse did to improve the temperature. This audit will be done weekly X4 and then monthly X3 with the DNS or designee reporting the findings to the QAPI committee. The committee will determine if further auditing is needed.</p> | | |
| F 441 SS=E | <p>INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>(a) Infection prevention and control program.</p> | F 441 | | 12/29/17 | |

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| F 441 | Continued From page 42 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; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and | F 441 | | | |

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| F 441 | <p>Continued From page 43</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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff appropriately implemented contact precautions and performed appropriate hand hygiene measures to reduce the risk of infection. This was true when:</p> <p>* There was no signage to indicate contact precautions were in effect for Resident #2 who had Methicillin Resistant Staphylococcus Aureus (MRSA- a bacterial infection.)</p> | F 441 | <p>#1. Resident #2 no longer has MRSA. A warning sign was placed on her door while survey was here and has since been removed with the resolution of the infection.</p> <p>#2. . All residents will be assured that staff are educated, understand the importance of proper hand hygiene, and are compliant with these standards, including isolation techniques when needed.</p> | | |

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| F 441 | <p>Continued From page 44</p> <p>* A staff member did not perform appropriate hand hygiene while preparing to administer medication to Resident #2.</p> <p>* A staff member failed to perform appropriate hand hygiene before and after having direct contact with residents in the dining room. Findings include:</p> <p>1. Resident #2 was admitted on 6/10/11 and re-admitted on 10/18/17 with diagnoses including Type II diabetes mellitus, MRSA, and Multiple Sclerosis (MS).</p> <p>The CDC (Center for Disease Control) website https://www.cdc.gov/mrsa/healthcare/clinicians/precautions.html documented Standard Precautions and Contact Precautions to prevent the spread of MRSA.</p> <p>Resident #2's 8/1/17 quarterly MDS (Minimum Data Set) assessment documented she was cognitively intact, had no infections, and had an open lesion.</p> <p>Resident #2's impairment to skin integrity care plan documented abscesses in the right shoulder and knee.</p> <p>There were no focus areas or interventions documented in Resident #2's care plan related to infection.</p> <p>Resident #2's 10/24/17 Medication Review Report documented wound care was ordered at the wound clinic and Ceftaroline Fosamil (an antibiotic) "600 mg (milligrams) intravenously (IV) two times a day for [o]steomyelitis (infection in</p> | F 441 | <p>#3. The ICP will provide education on 12/06/17 to all staff regarding proper hand hygiene, isolation techniques, and overall infection control practices. The policy on hand hygiene will be reviewed and specific information will be shared regarding isolation for MRSA, c-diff, and other types of isolation needs. Education will include how staff, families, and visitors will be informed of resident who may be on isolation.</p> <p>#4. The ICP will audit staff in all departments on proper hand hygiene as they are providing cares, preparing food, handling linens, etc. Audit will include observation of cares for the resident in isolation. General observation audits will be done with staff during activities, in the dining room, during medication passes, hands on cares to residents, and how staff manages their own hygiene. These audits will be done weekly X4 and them monthly X3 with the ICP reporting findings to the QAPI committee monthly, the committee will determine if further auditing is needed.</p> | | |

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| F 441 | <p>Continued From page 45 the bone) related to UNSPECIFIED INFECTIOUS DISEASE..."</p> <p>Resident #2's 10/1/-10/31/17 Medication Record documented she received Vancomycin (an antibiotic) 1 gram intravenously for MRSA on 10/11/17.</p> <p>A 10/19/17 at 11:45 am Nutritional Status Note documented Resident #2's "Right knee dressing is clean, dry and intact with MRSA present."</p> <p>A 10/22/17 at 3:36 pm Daily Skilled Note documented Resident #2 "Remains on MRSA isolation."</p> <p>A 10/24/17 at 9:55 pm Daily Skilled Note documented Resident #2 "... has wounds with MRSA."</p> <p>On 10/23/17 at 1:00 pm, Resident #2's door was closed and an isolation cart (a clear plastic storage container with drawers containing gowns, gloves, and masks and other items) was outside the resident's room. There was no sign near the resident's door or room indicating the resident required isolation or special precautions.</p> <p>On 10/24/17 at 9:20 am, Resident #2 said she had a wound on her right knee and right shoulder and had MRSA.</p> <p>On 10/24/17 at 11:13 am, LPN #2 said Resident #2 had MRSA in her right knee and right upper arm, that it was covered with an occlusive dressing and "standard precautions are fine." LPN #2 said if drainage from the resident's wounds was being dealt with, then protective</p> | F 441 | | | |

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| F 441 | <p>Continued From page 46</p> <p>equipment should be used. LPN #2 said there should be a sign on the resident's door regarding infection precautions, but "they said a sign would violate privacy." When asked how a visitor or unfamiliar staff member would know about the precautions needed when in the resident's room, LPN #2 said "a visitor shouldn't mess with the [resident's wound] drainage."</p> <p>On 10/26/17 at 8:17 am, the Infection Control Nurse said Resident #2 did not have a sign outside her door for contact precautions due to privacy but they would put a sign that would alert visitors to check with the nurse before entering the resident's room.</p> <p>2. On 10/25/17 at 11:50 am, LPN #2 was gathering supplies to administer a medication. LPN #2 was observed with blood from a scab on her left upper arm moving toward her elbow. She had the following in her arms: IV tubing, a 100 cc bag of IV fluid, a vial of antibiotic powder, oxygen tubing, and a bottle of sterile water.</p> <p>When the blood on her arm was pointed out to LPN #2, she placed the supplies on the counter and washed her left arm in the sink using only water as there was no soap in the soap dispenser. After turning the water off, LPN #2 dried her arm and wiped the remaining blood out of the sink with her right hand using a paper towel.</p> <p>LPN #2 then picked up the supplies from the counter using her left hand and ultimately touched the supplies with her right hand as well. She walked towards the door as if to exit the supply room. When the breach in hand hygiene</p> | F 441 | | | |

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| F 441 | <p>Continued From page 47</p> <p>and the possibility of cross contamination was brought to her attention, LPN #2 discarded the supplies, washed her hands appropriately, placed a Band-Aid over the bleeding area, washed her hands appropriately, and gathered new supplies.</p> <p>On 10/25/17 at 11:55 am, LPN #2 walked down the hall with the supplies. She stopped at the medication cart near the medication supply room, LPN #2 knocked a box of tissue onto the floor. LPN #2 picked up the box of tissue off the floor and placed it on top of the trash receptacle on the side of the medication cart. LPN #2 then dropped her keys onto the floor, bent over, and picked the keys up off the floor.</p> <p>LPN #2 then picked up the supplies off the medication cart and carried the supplies into Resident #2's room. LPN #2 placed the supplies on Resident #2's bed and applied gloves. She did not perform hand hygiene until reminded by the surveyor.</p> <p>LPN #2 then removed the gloves, placed the gloves inside her pocket, and washed her hands. LPN #2 then pulled the gloves out of her pocket and began applying the same gloves. When asked if she should re-apply the same gloves after touching the floor and not sanitizing her hands prior to applying the gloves, LPN #2 removed the gloves, washed her hands and applied new gloves.</p> <p>2. During the lunch meal observation on 10/24/17, between 12:15 pm and 12:45 pm, the Registered Dietician (RD) was observed as she assisted a resident using a spoon also handled</p> | F 441 | | | |

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| F 441 | Continued From page 48 by the resident. The RD then assisted another resident to butter her roll. When asked if she would normally sanitize her hands after handling utensils residents use, she stated "yes, I normally would." The RD then obtained a plate guard and placed it on a resident's plate. The plate guard fell to the floor, the RD picked it up and placed it in the dish bin. The RD obtained another plate guard and placed it on the plate. She did not perform hand hygiene. The RD then got a clean fork and knife out of a divided utensil tray and assisted another resident cut meat. She interacted with residents, touched their shoulders, moved their plates closer, and blew kisses. The RD was not observed performing hand hygiene. The facility's Procedure for Hand Hygiene and Handwashing, dated June 2012 and revised March 2016, directed staff to use alcohol based hand rub before having direct contact with residents; after having contact with another person's skin and after touching equipment or furniture near the resident. On 10/26/17 at 4:30 pm, the DNS provided a 2017 June Skills Lab form which documented the RD received training for hand hygiene, signed on 6/26/17. The DON stated the expectation is for all staff to complete hand hygiene at appropriate times. | F 441 | | | |
| F 514 SS=D | RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. | F 514 | | 12/29/17 | |

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| F 514 | <p>Continued From page 49</p> <p>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure complete and accurate clinical records were maintained for 1 of 11 sample residents (#2). This deficient practice increased the risk for</p> | F 514 | <p>#1. Resident #2's Gabapentin order was changed on 10/26/17.</p> <p>#2. All resident medication orders will include the correct route.</p> | | |

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| F 514 | <p>Continued From page 50</p> <p>care decisions to be based on inaccurate information and increased the risk for complications due to inappropriate care or interventions. Findings include:</p> <p>Resident #2 was admitted on 6/10/11 and re-admitted on 10/18/17 with diagnoses including Type II diabetes mellitus, GERD (Gastroesophageal Reflux Disease-a stomach acid problem), Methicillin Resistant Staph Aureus (MRSA-a bacterial infection), and Multiple Sclerosis (MS).</p> <p>Resident #2's 10/24/17 Medication Review Report documented "Gabapentin Capsule (a nerve pain medication) Give 100 mg by mouth three times a day...". Thirteen additional medications and an enteral feeding (tube feeding) were ordered to be given via feeding tube.</p> <p>Resident #2's 10/1/17-10/31/17 Medication Administration Record (MAR) documented "Gabapentin Capsule Give 100 mg by mouth three times a day..." and documented the Gabapentin was administered as written on 10/18-10/24/17.</p> <p>On 10/25/17 at 10:46 am, LPN #2 said the Gabapentin is given through the feeding tube and the order should say, "give by feeding tube."</p> <p>On 10/25/17 at 11:25 am, LPN #2 was observed administering the Gabapentin through Resident #2's feeding tube.</p> <p>On 10/25/17 at 2:45 pm, the DNS (Director of Nursing Services) said Resident #2 took all</p> | F 514 | <p>#3. The ADON will provide education on 12/14/17 to the nursing staff as to what is needed for a complete medication order. She will also review the importance of checking the medication against the MAR to assure the instructions match the label to the eMAR and that the med is then given correctly. If a part of that order is incorrect or missing the nurse will immediately validate the order with the physician and correct the error.</p> <p>#4. The ADON or designee will audit medication passes to assure nurses are checking the med against the MAR and giving the med as ordered. Audit will include a review of current medications to assure all of the components of a medication order are in place. The audit will be done weekly X4 and then monthly X3 with the ADON reporting the findings monthly to the QAPI committee, the committee will determine if further auditing is needed.</p> | | |

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

PRINTED: 12/13/2017
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135092 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2017 |
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| F 514 | Continued From page 51 medications through her feeding tube and the DNS was not sure why the Gabapentin was ordered by mouth. On 10/25/17 at 2:45 pm, the Assistant Director of Nursing (ADON) said Resident #2 was in the hospital, returned to the facility, and the Gabapentin order did not get changed. The ADON said she would change the Gabapentin order to be given through the resident's feeding tube. | F 514 | | | |

Bureau of Facility Standards

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| C 000 | <p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey of your facility from October 23, 2017 to October 27, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Cecelia Stockdill, RN</p> | C 000 | | |
| C 099 | <p>02.009 CRIMINAL HISTORY AND BACKGROUND CHECK REQUIRE</p> <p>01. Criminal History and Background Check. A skilled nursing and intermediate care facility must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the skilled nursing and intermediate care facility. A Department check conducted under IDAPA 16.05.06, " Criminal History and Background Checks, " satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. (3-26-08)</p> <p>02. Scope of a Criminal History and Background Check. The criminal history and background check must, at a minimum, be a fingerprint-based criminal history and background check that includes a search of the following record sources: (3-26-08)</p> <p>a. Federal Bureau of Investigation (FBI); (3-26-08)</p> | C 099 | | 12/29/17 |

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| Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed | TITLE | (X6) DATE 12/01/17 |
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| C 099 | <p>Continued From page 1</p> <p>b. Idaho State Police Bureau of Criminal Identification; (3-26-08)</p> <p>c. Sexual Offender Registry; (3-26-08)</p> <p>d. Office of Inspector General List of Excluded Individuals and Entities; and (3-26-08)</p> <p>e. Nurse Aide Registry. (3-26-08)</p> <p>03. Availability to Work. Any direct patient access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, " Criminal History and Background Checks, " is disclosed, the individual cannot have access to any resident. (3-26-08)</p> <p>04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of his date of hire. (3-26-08)</p> <p>05. New Criminal History and Background Check. An individual must have a criminal history and background check when: (3-26-08)</p> <p>a. Accepting employment with a new employer; and (3-26-08)</p> <p>b. His last criminal history and background check was completed more than three (3) years prior to his date of hire. (3-26-08)</p> <p>06. Use of Criminal History Check Within Three Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: (3-26-08)</p> <p>a. The individual has received a criminal history</p> | C 099 | | |

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| C 099 | <p>Continued From page 2</p> <p>and background check within three (3) years of his date of hire; (3-26-08)</p> <p>b. The employer has documentation of the criminal history and background check findings; (3-26-08)</p> <p>c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification, and (3-26-08)</p> <p>d. No disqualifying crimes are found. (3-26-08)</p> <p>07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of his date of hire. (3-26-08)</p> <p>This Rule is not met as evidenced by: Based on personnel files, staff interview and review of employee time punches, it was determined the facility failed to ensure 1 of 5 employees (C) had completed criminal history background checks that included fingerprinting within 21 days of hire. This had the potential for harm if newly-hired staff with a history of abuse and/or neglect were put into direct contact with the facility's residents. Findings include:</p> <p>Employee C's employee file documented she was hired on 9/27/17 and signed an Authorization of Background Investigation" form on 9/20/17.</p> <p>An Authorization and Acknowledgement to obtain background and criminal history information and</p> | C 099 | <p>#1. Employee C was placed on general leave on 10/26/17 and was not allowed to return to work until her criminal background check had come back clear.</p> <p>#2. All residents have the potential to be affected by this practice.</p> <p>#3. The HR coordinator and all hiring managers will review the policy on hiring new staff and will sign off that they have understood the policy on new staff being fingerprinted and had a state background check performed within the first 21 days of employment. This will be done on 12/5/17.</p> | |
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Bureau of Facility Standards

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001310 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 10/27/2017 |
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| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - IDAHO FALLS \ | STREET ADDRESS, CITY, STATE, ZIP CODE 840 EAST ELVA STREET IDAHO FALLS, ID 83401 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|---|---------------|--|--------------------|
| C 099 | <p>Continued From page 3</p> <p>Affidavit was signed by Employee C and notarized on 10/25/17.</p> <p>There were no results of a criminal history background check including fingerprinting in the employee file.</p> <p>On 10/26/17 at 10:55 a.m., the Human Resources Director said there were no results yet of Employee C's criminal history background check as the employee just went in for fingerprinting the previous day. The Human Resources Director said there were no earlier appointments available and it is difficult to get appointments for fingerprinting. The Human Resources Director said she thought they have 21 days from the date the application for fingerprinting was notarized to obtain the background check. She acknowledged it was greater than 21 days since the employee was hired.</p> <p>On 10/26/17 at 10:55 a.m., the Administrator said they do extensive background checks prior to the employee starting work but it did not happen this time. The Administrator said they would make sure the employee was removed from duty until results of the background check were received.</p> <p>Employee C's Punch Detail Report documented she worked on 9/27, 9/28, 9/29, 10/3, 10/4/, 10/5, 10/11, 10/13, 10/14, 10/18/, 10/19, 10/20, 10/25, and 10/26/17.</p> | C 099 | <p>#4. The Administrator or designee will audit personnel files of new hires to assure they are getting fingerprinted and having the state background check performed within the 21 days after hire. The audit will be done weekly X4 and then monthly X6 with the Administrator reporting the findings monthly to the QAPI committee, the committee will determine if further auditing is needed.</p> | |