



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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November 17, 2017

Darrin Radeke, Administrator  
Mini-Cassia Care Center  
PO Box 1224  
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **October 27, 2017**, a survey was conducted at Mini-Cassia Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes immediate jeopardy to resident health or safety, as documented on the enclosed CMS-2567, whereby significant corrections are required.** You were informed of the immediate jeopardy situation(s) verbally and in writing on **October 25, 2017**.

On **October 27, 2017**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

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

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 27, 2017** . Failure to submit an acceptable PoC by **November 27, 2017** , may result in the imposition of additional civil monetary penalties by **December 20, 2017**.

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

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

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

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

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

Based on the immediate jeopardy cited during this survey:

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**F0323 -- S/S: J -- 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/supervision/devices**

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

- Civil money penalty,
- Denial of Payment for new admissions no later than January 27, 2018

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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

Your facility's noncompliance with the following:

**F0323 -- S/S: J -- 483.25(d)(1)(2)(n)(1)-(3) -- Free Of Accident Hazards/supervision/devices;  
F0334 -- S/S: F -- 483.80(d)(1)(2) -- Influenza And Pneumococcal Immunizations**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **#1, #2, #3, #4, #5, #6, and #7** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder

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Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **November 27, 2017**. If your request for informal dispute resolution is received after **November 27, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

DS/lj  
Enclosures



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

PRINTED: 12/08/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135081</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/27/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>MINI-CASSIA CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1729 MILLER AVENUE BURLEY, ID 83318</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint investigation survey conducted October 23, 2017 to October 27, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Debra Parker, RN Suzi Devereaux, RN</p> <p>Abbreviations:</p> <p>AOC = Allegation of Compliance ASA = Aspirin BIMS = Brief Interview Mental Status CDC = Centers for Disease Control and Prevention cm = centimeter CNA = Certified Nursing Assistant/Certified Nurse Aide COPD = Chronic Obstructive Pulmonary Disease DNS = Director of Nursing DTI = Deep Tissue Injury ER = Emergency Room L = Left LN = Licensed Nurse LWOA = Leave Without Assistance MAR = Medication Administration Record MDS = Minimum Data Set NPUAP = National Pressure Ulcer Advisory Panel PCV13 = Pneumococcal Conjugate Vaccine 13-valent PPSV23 = Pneumococcal Polysaccharide Vaccine 23-valent PRN = As needed</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

11/22/2017

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

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F 000	Continued From page 1 Q = every QAA = Quality Assurance and Assessment Improvement QAPI = Quality Assurance Performance Improvement r/t = related to RCD = Regional Clinical Director RNA = Restorative Nurse Aide TAR = Treatment Administration Record	F 000			
F 253 SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2)  (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure resident equipment was maintained in good repair for 1 of 12 residents reviewed during the survey (Resident # 6). The deficient practice created the potential for harm should a resident become embarrassed or sustain a skin tear from a torn armrest on her wheelchair. Findings include:  On 10/23/17 at 3:25 am Resident #6 was in bed, with her large wheeled Carefoam two-piece chair (a foam chair designed to assist with positioning and/or fall management) in the room with a sheepskin liner. The arms of the chair were ripped with the foam padding exposed.  On 10/25/17 at 9:15 am, Resident #6 was in the Carefoam chair in the common area by the nurse's station, and the foam of the chair arms was exposed.	F 253	The facility will ensure that all residents have equipment that is in good condition. Resident #6 had a new Carefoam chair ordered on 10/30/17 A protective barrier was placed between the resident and the chair to prevent possible adverse exposure. The new chair was given to the resident on 11/16/17. All residents will be protected by the deficient practice by adding a review of seating to the weekly Maintenance Rounds Sheet. In-service training occurred on 11/10/17 on ensuring facility covered items used by residents for their day to day use are in good repair for all staff. This training will be conducted monthly X 3, then q quarterly X 2. The Maintenance Round Sheets will be brought to the Quality Assurance Meeting for review monthly X 3, then quarterly X2. The Administrator will be responsible for ensuring the plan of correction is	10/30/17	

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F 253	Continued From page 2 On 10/26/17 at 9:30 am, Resident #6 was in the chair in the common area, with foam exposed.  On 10/26/17 at 2:40 pm, E #12 stated if resident equipment was in disrepair, "I let (Maintenance Director's name) know. I fill out the paper for maintenance, I filled one out today for (Resident #6's) chair. I had noticed it prior to today, but usually the sheepskin covers the (torn) arms."  On 10/27/17 at 9:50 a.m. the Maintenance Director measured the rips in the Carefoam chair arms. The left arm measured 9" (inches) long x 3" wide and the right arm measured 8" long x 3" wide. The Maintenance Director stated that pictures of the chair's damage had been sent to the corporate office to see if they wanted to repair or replace the chair.	F 253	completed.		
F 314 SS=G	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1)  (b) Skin Integrity -  (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-  (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and  (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 314		12/9/17	

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F 314	<p>Continued From page 3 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to accurately assess for pressure ulcers and implement timely interventions to prevent deterioration of pressure ulcers for one of 1 (Resident #4) residents sampled for pressure ulcers. Resident #4 was harmed when she developed an unstageable pressure ulcer on her left ankle. Findings included:</p> <p>The facility's undated "Pressure Ulcers Treatment" policy documented, "...Definitions and Descriptions: Suspected Deep Tissue Injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear ...General Guidelines: ...6. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician and family and addressed."</p> <p>Resident #4 was admitted to the facility on 1/29/14 with diagnoses which included stroke, hemiplegia, hemiparesis, and aphasia.</p> <p>On 11/13/14, Resident #4's care plan documented the resident was at high risk of skin impairment due to poor mobility, bowel incontinence, diabetes, and the use of a feeding tube to meet her nutritional needs. The care plan documented a weekly skin assessment from a licensed nurse beginning 5/12/15, and the addition of a "chronic" scab to her left ankle on</p>	F 314	<p>On 10/30/17 resident #4 had physician review of the discoloration on her ankle and determined it to be a chronic discoloration and not attributed a deep tissue injury. She will have skin assessments performed by licensed staff and reviewed for accuracy, appropriate care planning, and implementation of orders interventions 2X weekly X4 weeks then monthly X 2, then quarterly X2. All residents will be protected by the deficient practice by adding a full skin assessment to be flagged automatically on the TAR and are completed by the licensed nurse. In-service training on head to toe skin assessments done weekly by the licensed Nurse occurred on 10/27/17. This training was given to licensed nurses and CNAs. This training will be conducted monthly X 3, then q quarterly X 2.</p> <p>The facility will ensure that residents <input type="checkbox"/> skin is assessed by a licensed nurse weekly. In addition, a random audit of 10% of the resident population will be done to ensure the accuracy of the skin assessments, the appropriateness of the care plan, and the appropriate implementation of the interventions. This audit will be done weekly X 4, then monthly X 2, then quarterly X2. Audits will be completed by the DNS or designee on the Skin Assessment Audit form. Continuation of verification of the accuracy of the skin assessments, the</p>		

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F 314	<p>Continued From page 4</p> <p>8/9/16. Interventions included a Podus boot (plastic boots lined with soft material to protect the skin) to the left foot at all times. There were no further updates to Resident #4's care plan.</p> <p>Resident #4's quarterly "Minimum Data Set" (MDS), (a standardized screening and assessment tool) dated 7/19/17 documented the resident was at risk for developing pressure ulcers but did not have any unhealed pressures ulcer.</p> <p>Resident #4's physician's orders for October 2017 documented: *Weekly skin checks every Tuesday, beginning 8/11/15. **"Monitor black scab to the lateral aspect of the left ankle area. 1 cm (centimeter) x 1 cm. Check Q (every) day till resolved, use dressing of choice if condition of area changes or is indicated PRN (as needed) every shift for check till resolved," beginning 5/16/17.</p> <p>Resident #4's clinical record contained no additional details or documentation regarding the appearance or characteristics of the "black scab" discovered to her ankle on 5/16/17.</p> <p>Resident #4's Nurse's Notes (NN) between 6/6/17 and 6/29/17 documented the resident's skin was intact, with no new issues noted. There were no further entries in Resident #4's NN regarding the condition of her skin until 10/23/17.</p> <p>Resident #4's physician's progress note dated 8/29/17 documented her skin was intact.</p> <p>On 10/23/17 at 10:31 am, Resident #4's NN</p>	F 314	<p>appropriateness of the care plan, and the appropriate implementation of the interventions will be done in concert with the quarterly Care Planning Meeting. The audits will be brought to the Quality Assurance Meeting for review monthly X 3, then quarterly X2. The Director of Nursing will be responsible to ensure the plan of correction is complete.</p>		

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

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F 314	<p>Continued From page 5</p> <p>documented, "...socks on and scab to left lower ankle no redness."</p> <p>Resident #4's "Treatment Administration Record" (TAR) for October 2017, was blank in the area to document the resident's skin check on 10/17/17, as was the area to monitor her left ankle.</p> <p>Resident #4's clinical record documented an untitled form completed by the Certified Nurse Aides (CNAs) when the resident had a shower. The forms from 5/12/17 to 10/20/17 documented there were no skin issues on Resident #4's left ankle.</p> <p>On 10/23/17 at 2:45 pm, Resident #4 was in a chair in the common area. Resident #4 was not wearing a Podus boot on her left foot.</p> <p>On 10/24/17 at 8:38 am, Resident #4 was lying in bed. She was not wearing a Podus boot.</p> <p>On 10/24/17 at 9:45 am, Resident #4 was observed with 6 discolored areas to the left ankle. The resident was not wearing a Podus boot.</p> <p>On 10/24/17 at 2:35 pm, Resident #4 was in the common area. The resident was not wearing a Podus boot on her left foot.</p> <p>On 10/24/17 at 4:15 pm, Resident #4 was in the common area. There was no Podus boot on her left foot.</p> <p>On 10/24/17 at 3:30 pm, the Director of Nursing Services (DNS), the Regional Clinical Director (RCD), and surveyor observed Resident #4's left</p>	F 314			

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F 314	<p>Continued From page 6</p> <p>ankle. The observation included:</p> <ul style="list-style-type: none"> <li>- One 1.5 x 1.5 cm round purple spot to the ankle bone.</li> <li>- Four 0.1 x 0.1 cm brownish black areas on left foot, just below the ankle.</li> <li>-One 2 x 3 cm black area on left foot, just below the ankle.</li> </ul> <p>The RCD stated the purple area was not a scab, but a deep tissue injury.</p> <p>On 10/24/17 at 9:45 am CNA #17 (a CNA) said she did not know Resident #4 was to have a Podus boot on her left foot to prevent pressure ulcers. CNA #17 was not aware Resident #4 had wounds on her ankle.</p> <p>On 10/24/17 at 2:35 pm, LPN #6 said she did not know where Resident #4's Podus boot was. She stated, "She won't leave it on." The LPN could not find the boot in the room.</p> <p>On 10/24/17 at 5:25 pm, the DNS stated the facility's skin assessment process was, "The CNA looks at the resident's skin during the resident's shower and fills out the skin form and gives it to the nurse. The nurse then signs the form." The DNS said the LN does not look at the resident's skin unless the CNA indicated the resident had a skin issue found during the resident's shower. She said if a pressure ulcer was found, an incident report had to be completed and the treatment would be put on the TAR.</p> <p>On 10/26/17 at 12:15 am, RN #1 stated he did not know that Resident #4 had wounds to the left</p>	F 314			

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F 314	Continued From page 7 ankle or that she was supposed to have a Podus boot on the left foot.  On 10/26/17 at 2:40 pm, Resident #4's physician said he did not know Resident #4 had wounds to her left ankle and foot.  On 10/26/17, Resident #4's NN documented, "...Chronic/re-occurring wound on L (left) lateral malleolus, small round less than 1.5 cm x 1.5 cm dark purple in color, eschar covered." A care plan update for that date documented, "... chronic wound suspect DTI (deep tissue injury) L lateral malleolus."	F 314			
F 323 SS=J	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	F 323		12/9/17	

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F 323	<p>Continued From page 8</p> <p>the resident or resident representative and obtain 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:</p> <p>Based on observation, interview, facility policy review, and record review, it was determined the facility failed to provide adequate supervision for 1 of 12 (#7) sampled residents. The failure to prevent elopement placed Resident #7 in Immediate Jeopardy of serious impairment or death. It also resulted in harm to Resident #7.</p> <p>The Immediate Jeopardy was identified to have existed since 9/9/17, when the facility failed provide necessary supervision to prevent the resident from eloping. Resident #7 eloped through the window in his room on 9/9/17 and was missing for approximately 10 hours when the facility was notified by a local establishment of his whereabouts. On 9/26/17 Resident #7 broke his window and eloped through the broken window receiving a severe laceration to the left hand which required 43 sutures. The facility was not aware Resident #7 had eloped until law enforcement contacted the facility and notified them Resident #7 had been transported to the hospital for treatment.</p> <p>The Administrator, Director of Nursing Services (DNS) and the Regional Clinical Director (RCD) were notified of the Immediate Jeopardy on 10/25/17 at 5:30 p.m.</p> <p>The immediate jeopardy was removed on 10/27/17 at 11:15 a.m.</p>	F 323	<p>The facility will ensure that residents remain safe in the facility.</p> <p>Resident #7- Resident will have a one to one staff member with him 24 hours a day for the duration of his stay at the facility. All residents will be evaluated on a newly implemented elopement risk assessment and reassessed quarterly. This assessment will be tracked on an Elopement Risk Assessment Audit Form to ensure accuracy, timely completion and timely reassessment. The facility will install a Wander Guard system and all residents that are high risk for elopement will have a wander guard device applied to them. All new elopements that occur from exiting through a window will have a 1:1 staff member 24 hours a day assigned to them until they are no longer considered at risk for elopement as indicated by the assessment form. All residents will be assessed initially for elopement risk and nurses will complete the Elopement Risk Assessment on a quarterly basis. As the assessment is completed it will automatically trigger as a resident becomes newly considered high risk. The nurse will complete an Incident and Accident form to ensure physician and responsible party are notified and appropriate measures are taken. All</p>		

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F 323	Continued From page 9  Findings include:  Resident #7 was admitted to the facility on 3/16/17 with diagnoses including Alzheimer's disease, dementia, psychosis, and epilepsy.  Resident #7's quarterly MDS (Minimum Data Set) dated 9/13/17 documented facility staff assessed the resident needed assistance for daily decisions in new or unfamiliar situations and wandered one to three days out of the previous 7 days.  Resident #7's care plan, initiated 3/27/17, documented the resident had the potential to wander. There were no interventions specific to Resident #7's wandering, and there was no care plan for elopement potential, prior to 9/9/17.  Resident #7's "Behavior Monthly Report" documented for August 2017, Resident #7 had 63 episodes of wandering. The behavior report had the total number of times Resident #7 had wandered but it did not detail each event (i.e., time of day, whether the resident had been trying to elope, etc.)  a. Elopement #1 on 9/9/17:  On 9/6/17, Resident #7's "Wander" assessment documented the resident had risk factors for elopement of Alzheimer's disease, dementia with behavioral disturbances, major depression, restlessness and agitation; and was independently mobile without a wheelchair. The assessment documented the responses on the form placed the resident at "High Risk" of	F 323	newly assessed high elopement risk residents will have a Wander Guard device applied. Training of nursing staff will occur on 12/01/17 on how to appropriately complete the Elopement Risk Assessments and will continue monthly X 3, then Quarterly X2. The IDT will also be educated on the Elopement Risk Assessment tool and when to apply the Wander Guard devices on 12/1/17. The Administrator or designee will complete an Elopement Assessment Audit Tool and the education of staff which will be reviewed weekly X4, monthly X 2, then Quarterly X2 and brought to the QA Committee monthly X 3, then Quarterly X2. The Administrator will be responsible for ensuring the plan of correction is completed.		

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F 323	<p>Continued From page 10</p> <p>elopement, and "elopement precautions" should be addressed in the resident's care plan. The area of the form to document the care plan interventions implemented was blank.</p> <p>An undated "Mini-Cassia Care Center Investigation Report" documented that between 3:45 pm and 5:15 pm on 9/9/17, Resident #7 opened the window in his room, pushed out the screen, and climbed out the window. The report documented Resident #7 had severe cognitive impairment at the time of the elopement, but had not been considered an elopement risk. The report documented an employee at a local gas station, located approximately one mile from the facility on a busy highway, contacted the facility to inform them Resident #7 was at that location, but did not document what time the resident was located.</p> <p>A "Cassia Co (County) Sheriff Case Report" dated 9/9/17 at 5:34 pm documented Resident #7 was reported missing by the facility.</p> <p>Resident #7's "Elopement" report on 9/10/17 at 6:39 pm documented, "[Resident] had left the lobby area between [3:30 and 4:00 pm]. I did have meds to give the resident so myself and the aide did begin to look for [him]. We looked into each room and bathroom in the building and we could not find the resident. Staff did state the window in his room was open and it appeared the screen was hanging open. Myself and several [staff] members did get into our cars and began to look for this resident. I covered north and south streets. Began to get dark and we returned to the facility." It was unclear what time the facility discovered that Resident #7 was</p>	F 323			

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F 323	<p>Continued From page 11 missing.</p> <p>The facility's "North and South Assignment Sheet" for nursing staff dated 9/9/17, documented there were two LPN's, two CNA's and one float (helped on both wings of the facility) CNA caring for 51 residents during the evening shift on 9/9/17 when Resident #7 eloped.</p> <p>On 9/10/17, Resident #7's "Wander" assessment documented he was at High Risk for elopement. The assessment documented the resident's care plan would be updated to include routine monitoring of Resident #7's whereabouts, and the resident would be involved in activity programs during times of restlessness.</p> <p>Resident #7's interdisciplinary team note dated 9/11/17 at 10:27 am documented, "Resident stated the facility was trying to poison him and he eloped from the facility by opening his window and knocking out his screen. Police and staff were called to provide needed support to search for the resident. He stated he hid under a tree until it was dark ...The facility has secured his window and is providing frequent visual checks to ensure his safety."</p> <p>On 9/9/17, Resident #7's dementia care plan was updated to include, "Actual elopement from the facility." An intervention of, "encourage to attend supervised outdoor activities, frequent visual checks, Spanish speaking staff as much as possible, medication review, and psych consult," was added on 9/11/17. Resident #7's clinical record did not include documentation the frequency of "visual checks" following his 9/9/17 elopement. An intervention of, "I may at times</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>believe that I am being poisoned and refuse my medications," was added on 9/21/17.</p> <p>On 9/12/17, Resident #7's "Doctor's Progress Notes" documented, " ...quite agitated lately [and] threatening to elope ..."</p> <p>There was no documentation in Resident #7's clinical record that Activities staff was made aware the resident was to be encouraged to attend supervised outdoor activities.</p> <p>b. Elopement #2 on 9/26/17</p> <p>On 9/26/17 at an undocumented time (later confirmed through staff interview to be prior to his elopement on evening shift), Resident #7's psychiatric progress notes documented, " ...Nursing reported that the patient eloped for about 7.5 hours a few weeks ago. He still continues to make a lot of decisions that put his own safety and health at serious risk. The patient has mood symptoms manifesting as aimless wandering, physical and verbal assault to staff."</p> <p>Resident #7's "Cassia County Sheriff's Case Report" dated 9/26/17 at 7:32 pm documented, "On September 26, 2017 ...was dispatched to a call ...Upon walking upon the victim I observed it was an elderly man with a severe laceration to his left hand. The victim spoke no English but upon communicating through a translator, I established he had escaped from Mini-Cassia Care Center. He stated that he cut his hand when he broke the window with his hand and arm...Mini-Cassia Care Center was notified and they stated he was a resident but was [sic] unaware he was missing. They then confirmed</p>	F 323			

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F 323	<p>Continued From page 13 he was missing."</p> <p>On 9/26/17 at 11:24 pm, Resident #7's progress notes documented, "Res (resident) was in bed resting and was checked on 30 min (minutes) prior and was content. Between [7:00 and 7:30 pm] res broke out window by bed with fist and climbed out window. At approx. (approximately) [7:30 pm] Cassia County Dispatch called and asked if we had a resident by the name of [Resident #7] was confirmed that he was from here and that they would bring him back to us. Dispatch called back and said that they were taking him to [the hospital] because he had cuts on his hand from breaking the window to escape. Has been in the ER [emergency room] since approx. [7:45 pm]. Facility staff ...went to transfer resident back to the facility via company van."</p> <p>On 9/26/17 at 11:35 pm, Resident #7's History and Physical from the emergency room documented the resident had multiple lacerations to his hand after he broke his window at the facility and eloped. The History and Physical documented the resident required 43 sutures, which took over 2 hours to complete.</p> <p>On 9/26/17, Resident #7's dementia care plan was updated to include, "Actual elopement from facility." On 9/27/17, a new intervention documented, "room change to room with window that opens to a secure courtyard. 1:1 staff [at all times] - needs to be Spanish speaking aide."</p> <p>On 9/27/17 at 1:10 am, Resident #7's progress notes documented, "Resident eloped from the facility after breaking a window to exit. He has serious lacerations on his hand for which he was</p>	F 323			

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F 323	<p>Continued From page 14 treated at [the hospital] ...will provide very close monitoring until [psychiatric inpatient] placement can be achieved."</p> <p>On 9/27/17 at 1:58 am, Resident #7's progress notes documented, "Res arrived back from (hospital) via facility van with staff van driver and another aide. Resident was escorted back to facility and taken to a new room assignment by staff that remained with resident...Administrator and DNS was [sic] notified and was assisting in decision how to treat..."</p> <p>On 9/27/17 at 10:47 am, Resident #7's progress notes documented, "Resident was relocated to a bed not next to a window. He has a 24 hour 1:1 [attendant]."</p> <p>Resident #7's "Wander" assessment, dated 9/27/17, documented he was at high risk for elopement from the facility. The form documented the resident's demographic and emergency contact information was added to the facility's "Elopement Binder."</p> <p>The facility's 9/26/17 "North and South Assignment Sheet" for nursing staff documented there were two LPN's and three CNA's caring for 50 residents on the evening shift. The assignment sheets for 9/27/17 and 9/28/17 documented Resident #7 did not have 1:1 staff assignment as documented in his progress notes and care plan.</p> <p>c. Observations and resident interview</p> <p>Resident #1 was observed with a 1:1 attendant on 10/24/17, 10/25/17, and 10/26/17, on all</p>	F 323			

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F 323	<p>Continued From page 15</p> <p>shifts. Through an interpreter, Resident #7 declined an interview, or to have observations made of the injury to his hand.</p> <p>d. Staff interviews</p> <p>On 10/24/17 at 12:15 pm the DNS stated, "The first time he eloped, he was gone about 9 hours. He (Resident #7) walked into (local business) and he didn't have any injuries. The second time he was gone about 1 to 1½ hours and the police recognized him and his hand was bleeding so they called us and took him to the hospital." She said the facility did not know he was missing the second time until the police contacted them. When asked why he did not have a 1:1 CNA on 9/27/17 and 9/28/17 per the care plan and investigation documentation, she stated, "we probably had him in the lobby with a hall monitor or other people watching him. We were probably short on staff and that's why he wasn't 1:1."</p> <p>On 10/25/17 at 9:15 am, the RSD said she had tried to get Resident #7 into a psychiatric unit but they would not take him because he did not have a payor source. She said the psychiatrist that comes to the facility had last seen Resident #7 sometime in September 2017. She said she and the IDT (Interdisciplinary team) met on 9/27/17 to discuss Resident #7 and they decided to put the resident on 1:1 supervision with a Spanish speaking CNA 24/7 (24 hours a day, 7 days a week).</p> <p>During an interview on 10/26/17 at 12:20 am, E #2 (one of the CNA's assigned to Resident #7 for 1:1 supervision) said she had been pulled away from her duties "2 to 3 times (8 hour shifts)" when</p>	F 323			

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F 323	<p>Continued From page 16</p> <p>she was supposed to be 1:1 with Resident #7 because the facility was short of CNA's on the floor. She said that when she was "pulled," Resident #7 was not assigned another 1:1 attendant for the rest of that shift.</p> <p>On 10/26 /17 at 12:45 am, LPN #3, the charge nurse on the night shift, said s/he had to pull the CNA's who are providing 1:1 care to Resident #7, 1 to 2 times a week, if not more, because "we work so short of staff." S/he stated, "no one" stayed with residents who required 1:1, including Resident #7, when he had to pull CNAs to work the floor. LPN #3 stated s/he was working when Resident #7 eloped on 9/26/17 and, "we were short 4 people." S/he said s/he was in another room caring for another resident at the time it was thought Resident #7 broke the window and eloped. S/he said s/he did not know the resident was missing until the police called said they found him. LPN #3 stated, "[Resident #7] had a previous elopement. He kept saying you guys can't keep me here. I'll get out again."</p> <p>e. Policy and procedures</p> <p>The facility's undated "Elopement, Risk, Prevention, and Management of Missing Residents" policy and procedure documented, "...Elopement is the ability of a resident who is not capable of protecting himself or herself from harm to successfully leave the facility unsupervised and unnoticed and who may enter into harm's way... About 80 percent of elopements involve residents known to be chronic wanderers with prior elopements... An elopement risk assessment is completed by the nursing staff on all residents on admission,</p>	F 323			

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F 323	<p>Continued From page 17</p> <p>quarterly, and upon change of condition ...If the resident has not been found after a period of ten minutes, the Administrator or Director of Nursing calls the police and reports the resident missing..."</p> <p>There was no elopement risk assessment found in Resident #7's clinical record.</p> <p>f. Immediate Jeopardy notification and removal plan</p> <p>The Administrator, Director of Nursing Services (DNS) and the Regional Clinical Director (RCD) were notified of the Immediate Jeopardy on 9/25/17 at 5:30 pm. An acceptable plan alleging removal of the Immediate Jeopardy was received on 7/27/17 at 9:03 am. After verifying the implementation of the plan, the immediate jeopardy was removed on 10/27/17 at 11:15 am.</p> <p>The plan to remove the Immediate Jeopardy documented in full: "42 CFR: 485.25 (D) (2) Supervision: The facility will ensure adequate supervision to prevent elopement from those identified as potential elopement risks by:</p> <p>1) Completing elopement tool for those identified as elopement risk. All residents will have elopement tool completed on 10/26/17. All residents will be evaluated quarterly and as appropriate.</p> <p>2) Restore hall monitor on North side to help implement 15-minute check for those residents identified as potential elopement risks.</p> <p>3) MAR (Medication Administration Record) to be</p>	F 323			

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F 323	<p>Continued From page 18</p> <p>updated for all identified as potential elopement risks and nurse to follow up with Q (every) 4-hour checks (in addition to the staff 15 minute checks).</p> <p>4) Care plans of residents identified as potential elopement risks have been updated to include 15 minute checks.</p> <p>5) All new elopement episodes will have 1:1 assigned to the resident until all the above interventions have been implemented and there is a psychiatric medication review. If there is not an extra, available CNA staff to act as 1:1, on call management is contacted to provide or find needed support for floor staff. Resident #7 will not be without a 1:1 during his stay at the facility.</p> <p>6) Inservice-service training on the elopement policy for all employees to be reviewed and signed prior to working with residents as of 10/26/17 2 pm shift."</p> <p>The removal was confirmed by:</p> <p>-RN #12 and LPN's #6 and #13 said they had been in-serviced on the new hall monitor job description that requires them to perform 15-minute checks when needed, the policy and procedure on elopement, who was on-call in administration so they can be called if a 1:1 CNA needs to be pulled to the floor and that 1:1 is not to be pulled unless the administrator, DNS or administration on-call is contacted first.</p> <p>-CNA's #7, #8, #14, #15 and #16 said they had been in-serviced on the new hall monitor job description that requires them to perform 15-minute checks when needed, the policy and</p>	F 323			

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F 323	Continued From page 19 procedure on elopement and 1:1 is not to be pulled unless the administrator, DNS or administration on-call is contacted first.  On 10/27/17 at 1:30 p.m., a review of the in-services and sign-in sheets confirmed staff had received the in-service training regarding elopement prior to their shifts starting.  Resident #7 was placed in immediate jeopardy of serious harm, impairment, or death when the facility failed to recognize the resident was at high risk for elopement, as evidenced by their policy and a "Wander" assessment completed on 9/6/17. The facility failed to develop and implement care plan interventions based on that assessment. Resident #7 first eloped on 9/9/17 by opening the window in his room and exiting the facility, the facility failed to provide a safe environment or increased supervision to prevent a second elopement. On 9/26/17, Resident #7 used his hand to break the window to his room and eloped through the broken glass, which resulted in the resident receiving 43 sutures. The facility updated the resident's care plan to require 1:1 supervision after the second elopement, but that intervention was not consistently implemented.	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-  (i) Before offering the influenza immunization,	F 334		11/22/17	

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F 334	<p>Continued From page 20</p> <p>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 immunization, unless the immunization is</p>	F 334			

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F 334	<p>Continued From page 21</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, the facility failed to develop and implement policies and processes to minimize the risk of residents acquiring, transmitting, or experiencing complications from pneumococcal pneumonia. Specifically,</p> <p>1) The facility failed to ensure residents who were offered the pneumococcal vaccine received information and education consistent with current CDC [Centers for Disease Control and Prevention] recommendations for pneumococcal immunization for 7 of 7 residents (Residents #1-7) reviewed for the pneumococcal vaccination.</p> <p>2) The facility's pneumococcal immunization</p>	F 334	<p>The facility will ensure that residents are appropriately educated and immunized per CDC guidelines.</p> <p>Resident #1 has current documentation on being educated on CDC recommendations of vaccinations in the clinical record 11/22/17 and has received the vaccination on 2/4/16 and will have follow up vaccination on 11/23/17.</p> <p>Resident #2- Documentation that was not accessible to surveyors was located to show the following: as to receiving the vaccination on 4/15/17.</p> <p>Resident #3- Documentation that was not accessible to surveyors was located to show the following: was noted to have received the pneumonia vaccination on</p>		

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F 334	<p>Continued From page 22</p> <p>process and pneumococcal immunization consent form did not reflect current CDC recommendations.</p> <p>3) The facility did not implement an immunization program to ensure residents' pneumococcal vaccines were being tracked with receiving or declining the pneumococcal vaccines PCV13 the first year, followed by the PPSV23 one year later. Findings include:</p> <p>The 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 facility's policy for Pneumococcal Vaccine, revised September 2014, documented, "All residents will be offered the Pneumovax (pneumococcal vaccine) to aid in preventing pneumococcal infections (e.g., pneumonia). Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax (pneumococcal vaccine) .... Before receiving the Pneumovax, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the</p>	F 334	<p>8/17/17 and the CDC's recommendations on vaccinations on 8/17/17.</p> <p>Resident #4 received the CDC recommendations and once again declined the vaccination on 11/22/17.</p> <p>Resident #5 received the CDC recommendations and once again declined the vaccination on 11/11/16 but will have vaccination on 11/23/17.</p> <p>Resident #6 Documentation that was not accessible to surveyors was located to show the following:received the vaccination on 4/8/2009 and will not require another for 11 years.</p> <p>Resident #7 Documentation that was not accessible to surveyors was located to show the following: Resident was educated on CDC recommendations of vaccinations in the clinical record 9/26/17 and has refused the vaccination. Updated information from the CDC with updated Consent forms will be give and vaccinations will be offered and administered within the guidelines set by the CDC. The Policy and Procedure has been updated to include newer regulations on Pneumonia Vaccinations. All residents will be audited to ensure that updated information and pneumonia vaccinations are current per CDC guidelines as residents allow, on the Resident Pneumonia Immunization Tool. Medical Director, DNS, and Infection Control Nurse have reviewed all residents pneumonia vaccination needs 11/22/17. The Quality Assurance Committee will review the Resident Pneumonia</p>		

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F 334	<p>Continued From page 23</p> <p>pneumococcal vaccine. (See current vaccine information statements at <a href="http://www.cdc.gov/vaccines/hcp/vis/index.html">www.cdc.gov/vaccines/hcp/vis/index.html</a>) for educational materials."</p> <p>The facility's policy for "Following Current CDC Recommendations", revised September 2014, documented, "administration of the pneumococcal vaccination or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination."</p> <p>The facility's policy for "Tracking Immunizations", revised September 2014, documented, "The Director of Nursing Services or designee is responsible for tracking all immunizations on the facility immunization log."</p> <p>The facility's Pneumococcal Vaccine Consent Form documented if the resident was unsure if they had the pneumococcal vaccine, the facility will administer the vaccine once as per the facility's policy. The resident or responsible party was to mark on the consent form as follows:</p> <p>* "I hereby agree to receive the pneumococcal vaccine which is to be given once as per facility policy."</p> <p>* "I hereby request that the pneumococcal vaccine be given once as per facility policy to the resident named for who I am authorized to make this request."</p> <p>* "The resident named below has had the pneumococcal vaccine and was older than 59 years old at the time of the vaccination (if vaccine</p>	F 334	<p>Immunization Tool monthly X 3, then quarterly X2. As part of each regular infection control review during QAPI a check for updates on the CDC website will occur and a statement will be part of the infection control meeting documentation.</p> <p>The director of nursing is responsible to ensure compliance with the plan of correction.</p>		

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F 334	<p>Continued From page 24</p> <p>was administered prior to age 59, we will revaccinate as per Center for Disease Control guidelines)."</p> <p>* "I decline/refuse to give consent for the pneumococcal vaccine."</p> <p>The facility's policy stated administration of the pneumococcal vaccine would be made in accordance with current CDC recommendations, however the information and education provided to residents, as documented by the facility's pneumococcal vaccine policy, was not consistent with CDC recommendations. For adults older than 65 years old, CDC recommended vaccination of both PCV13 and PPSV23, at least a year apart. The facility's pneumococcal policy only referenced one (1) vaccine; Pneumovax. The facility's consent form did not provide information for the PCV13 and PPSV23.</p> <p>1. Resident #1 was admitted to the facility on 8/17/16 with multiple diagnoses including COPD [Chronic Obstructive Pulmonary Disease] and sleep apnea.</p> <p>Resident #1's annual MDS [Minimum Data Set] assessment, dated 8/8/17, documented Resident #1 was "up to date" with the Pneumococcal Vaccination.</p> <p>On 10/24/17 at 5:10 pm, the Infection Control Nurse was unable to provide the Pneumococcal Vaccine Consent Form or provide tracking documentation if Resident #1 received or declined the pneumococcal vaccine in Resident #1's clinical record.</p>	F 334			

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F 334	<p>Continued From page 25</p> <p>2. Resident #2 was readmitted to the facility on 3/1/17 with multiple diagnoses, including COPD and heart failure.</p> <p>Resident #2's quarterly MDS assessment, dated 8/23/17, documented Resident #2 was "up to date" with the Pneumococcal Vaccination.</p> <p>Resident #2's April 2017 MAR [Medication Administration Record] documented Resident #2 received the pneumonia vaccine on 4/15/17.</p> <p>On 10/24/17 at 5:10 pm, the Infection Control Nurse provided Resident #2's Pneumococcal Vaccine Consent Form, dated 3/3/17, documented Resident #2 agreed to receive the pneumococcal vaccine once per the facility's policy. The consent form did not document if the vaccine was the PCV13 vaccine or the PPSV23 vaccine.</p> <p>3. Resident #3 was admitted to the facility on 2/1/17 with multiple diagnoses, including hypertension.</p> <p>Resident #3's quarterly MDS assessment, dated 8/1/17, documented Resident #3 was "up to date" with the Pneumococcal Vaccination.</p> <p>On 10/24/17 at 5:10 pm, the Infection Control Nurse provided Resident #3's Pneumococcal Vaccine Consent Form, dated 8/17/17, documented Resident #3 agreed to receive the pneumococcal vaccine once per the facility's policy. The Infection Control Nurse was unable to provide documentation when Resident #3 received the pneumococcal vaccine and if Resident #3 received information and education</p>	F 334			

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F 334	<p>Continued From page 26 consistent with the current CDC recommendations.</p> <p>4. Resident #4 was admitted to the facility on 10/29/14 with multiple diagnoses, including cerebrovascular accident and diabetes mellitus.</p> <p>Resident #4's quarterly MDS assessment, dated 7/19/17, documented Resident #4 was offered and declined the Pneumococcal Vaccine.</p> <p>On 10/24/17 at 5:10 pm, the Infection Control Nurse provided Resident #4's Pneumococcal Vaccine Consent Form, dated 10/31/14, documented Resident #4 declined to give consent for the pneumococcal vaccine. The Infection Control Nurse was unable to provide documentation if Resident #4 received information and education consistent with the current CDC recommendations.</p> <p>5. Resident #5 was admitted to the facility on 11/9/16 with multiple diagnoses, including dementia with behaviors and chronic pain.</p> <p>Resident #5's quarterly MDS assessment, dated 8/15/17, documented Resident #5 was offered and declined the Pneumococcal Vaccine.</p> <p>On 10/24/17 at 5:10 pm, the Infection Control Nurse provided Resident #5's Pneumococcal Vaccine Consent Form, dated 11/11/16, documented Resident #5 declined to give consent for the pneumococcal vaccine. The Infection Control Nurse was unable to provide documentation if Resident #5 or the responsible party received information and education consistent with the current CDC</p>	F 334			

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

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F 334	<p>Continued From page 27 recommendations.</p> <p>6. Resident #6 was admitted to the facility on 4/20/13 with multiple diagnoses, including dementia and hemiplegia.</p> <p>Resident #6's quarterly MDS assessment, dated 10/3/17, documented Resident #6 was "up to date" with the Pneumococcal Vaccine.</p> <p>On 10/24/17 at 5:10 pm, the Infection Control Nurse was unable to provide Resident #6's Pneumococcal Vaccine Consent Form, information and education consistent with current CDC recommendations for the pneumococcal immunization, or provide tracking documentation with the current CDC if Resident #6 received or declined the pneumococcal vaccine.</p> <p>7. Resident #7 was admitted to the facility on 3/16/17 with multiple diagnoses, including dementia with behaviors and epilepsy.</p> <p>Resident #7's quarterly MDS assessment, dated 9/13/17, documented Resident #7 was offered and declined the pneumococcal vaccine.</p> <p>On 10/24/17 at 5:10 pm, the Infection Control Nurse was waiting for Resident #7's guardian to give or decline consent for the pneumococcal vaccine. The infection Control Nurse was unable to provide information and education consistent with current CDC recommendations to Resident #7.</p> <p>On 10/26/17 at 2:45 pm, the Infection Control Nurse was unaware of the most current CDC recommendations for the pneumococcal</p>	F 334			

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F 334	Continued From page 28 vaccination PCV13 and PPSV23, which included to provide information and education to all residents' and tracking all the residents' receiving the pneumococcal vaccination PCV13 dose first, followed by the PPSV23 one year later.  These failed practices represented a systemic failure which increased residents' risk for contracting pneumonia with its associated complications of infection of the blood and covering of the brain and spinal cord which could cause death or brain damage.	F 334			
F 353 SS=G	SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS CFR(s): 483.35(a)(1)-(4)  483.35 Nursing Services  The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]  (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with	F 353		12/9/17	

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F 353	<p>Continued From page 29 resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of residents. This failed practice had a direct negative impact on the level of supervision and/or services provided to 1 of 11 sampled residents (#7) and placed the health and safety of all 48 residents in the facility at risk of harm should the staffing shortage result in the failure to deliver care as physician ordered, as included in their care plans, or otherwise needed. Resident #7 was harmed when the facility's lack of sufficient staff to provide</p>	F 353	<p>Facility will ensure sufficient staffing with the appropriate skills and competencies to provide related nursing services. 1.2.3. Resident #7 has 1:1 staff member 24hours/7 days a week for safety. On 11/10/2017 staff was educated to sign the assignment sheets to properly show staffing areas are being filled. The facility provided training on time management on 11/22/2017 to help staff to prioritize time in order to ensure resident are safe in their environment. The training included working on</p>		

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F 353	<p>Continued From page 30</p> <p>supervision allowed the resident to break a window with his hand, which resulted in the resident receiving 43 sutures. Findings include:</p> <p>The Facility's Hall Monitor job description documented the primary purpose of this assignment was to monitor activity of residents attempting to leave the building in the common area near the front entrance. Duties and Responsibilities included:</p> <ul style="list-style-type: none"> <li>* Stay at their station at all times.</li> <li>* Monitor residents for LWOA [leave without assistance] and falls.</li> <li>* Engage residents in simple activities - ball throw, trivia, reading the newspaper...</li> <li>* Not to act in the capacity of one to one assistance.</li> </ul> <p>1. On 9/9/17, the facility's census was 51. Daily Assignment Sheet documented for North Hall per shift as follows:</p> <p>Day Shift:</p> <ul style="list-style-type: none"> <li>* One hall monitor, four residents required 1:1 supervision, two floor CNA's and one CNA assigned as a "Breaker" [CNA that relieves another CNA for a 15-minute break or lunch break]. There was one LN working from 5:00 am to 5:00 pm and one LN working 7:00 am to 1:00 am.</li> </ul> <p>Evening Shift:</p> <ul style="list-style-type: none"> <li>* One hall monitor, four residents required 1:1 supervision, one floor CNA, and one CNA assigned as a "float" between both the North and</li> </ul>	F 353	<p>competencies for Licensed Nurses and CNAs. Monitoring of 15 minute checks occurs standard week days and are tracked in the 15 Minute Check Audit Tool. Training of staff is tracked on Staff Competency Audit Tool.</p> <p>Upon approval and finish for the tag F323 the door monitor will be added to the schedule of staff working on the North hall to assist with supervision.</p> <p>The facility continues offering a sign-on bonus for CNAs, Conducting a job fair on 11/2/17, placing advertising on the following websites: indeed, craigslist, idahoworks.gov, and careers.csi.edu; and continuing to attempt to use agency CNAs. The facility has halted new admissions in order to better care for existing residents in the facility. The acceptance of new admissions will be run through the Lead CNA in concert with the IDT.</p> <p>An audit of staff satisfaction with staffing will be given weekly X3 weeks, then monthly X2, then quarterly X2. An audit has been implemented to evaluate shift coverage and all related audits will be brought to the QA monthly X 3, then quarterly X2.</p> <p>The IDT will review the staffing schedule 5 days a week X4 weeks, then monthly X2, then quarterly X2.</p> <p>Facility staffing audits will be completed by the Facility Lead CNA to ensure adequate staffing. The administrator will be responsible for compliance.</p>		

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F 353	<p>Continued From page 31</p> <p>South halls. There was one LN working 5:00 pm to 5:00 am, and one LN working 3:00 pm to 7:00 pm.</p> <p>Night Shift:</p> <p>* One hall monitor, and four residents required 1:1 supervision, one floor CNA, and one LN. One of the four 1:1 assignments was vacant for that shift.</p> <p>On 9/9/17, the facility's Daily Assignment Sheet documented for South Hall per shift as follows:</p> <p>Day Shift:</p> <p>* One hall monitor, two floor CNAs, one Restorative Nurse Aide (RNA), and one LN. A "Breaker" was scheduled, but called in sick and was not replaced. The assignment sheet called for a Bath Aide, but that assignment was vacant.</p> <p>Evening Shift:</p> <p>* One hall monitor, one floor CNA, one CNA float between both halls, and one LN. One CNA was assigned to provide 1:1 care.</p> <p>Night Shift:</p> <p>*One hall monitor, one floor CNA, and one LN. One resident was scheduled to have 1:1 supervision, but that assignment was vacant.</p> <p>Resident #7 was admitted to the facility's north hall on 3/16/17 with diagnoses, including Alzheimer's Disease, dementia with behaviors, psychosis, and epilepsy.</p>	F 353			

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F 353	<p>Continued From page 32</p> <p>Resident #7's quarterly MDS [Minimum Data Set] assessment, dated 9/13/17, documented Resident #7 had minimal behavioral symptoms and wandering.</p> <p>A Nurse's Note, dated 9/9/17 at 10:18 am, documented Resident #7 was compliant and cooperative with staff.</p> <p>A Cassia County Sheriff Case Report, dated 9/9/17 at 5:34 pm, documented Resident #7 left the facility through his window, and the facility was not sure how long he was missing. The facility told the Sheriff's Department they believed Resident #7 had been missing for about 2 hours.</p> <p>The Cassia County Sheriff Case Report, dated 9/9/17 at 11:26 pm, documented Resident #7 had been returned to the facility, and Resident #7 stated to the officer, "he would get out again."</p> <p>A Nurse's Note, dated 9/10/17 at 1:57 am, documented Resident #7 was found at a gas station, which was one mile away from the facility, and returned to the facility with no injuries.</p> <p>A Interdisciplinary Team Note, dated 9/11/17 at 10:27 am, documented the facility has secured his window and is providing "frequent checks" to ensure his safety.</p> <p>The facility was unable to provide documentation Resident #7 received "frequent checks."</p> <p>2. On 9/26/17, the facility's census was 50. Daily Assignment Sheet documented for North Hall per</p>	F 353			

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F 353	<p>Continued From page 33 shift as follows:</p> <p>Day Shift:</p> <p>* One hall monitor and two floor CNA's. One LN was working from 5:00 am to 5:00 pm and one LN 7:00 am to 11:00 am. Four residents required 1:1 supervision. The assignment for the "Breaker" was vacant.</p> <p>Evening Shift:</p> <p>* One hall monitor, one floor CNA, one CNA assigned to "float" between both the North and the South halls from 2:00 pm to 6:00 pm. One LN was working from 5:00 pm to 5:00 am, and one LN from 3:00 pm to 7:00 pm. Four residents required 1:1 supervision</p> <p>Night Shift:</p> <p>* One hall monitor, one floor CNA, and one LN. Four residents required 1:1 supervision. One of the four 1:1 assignments was vacant for that shift.</p> <p>On 9/26/17, the facility's Daily Assignment Sheet documented for South Hall per shift as follows:</p> <p>Day Shift:</p> <p>* One hall monitor, two floor CNAs, a bath aide, and one RNA. A "Breaker" was assigned from 10:00 am to 6:00 pm. One resident required 1:1 supervision. There was one LN working.</p> <p>Evening Shift:</p>	F 353			

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F 353	<p>Continued From page 34</p> <p>* One hall monitor, one floor CNA, and one LN. There was one CNA to float between the North and South halls between 2:00 pm and 6:00 pm. One CNA had called in sick, and the assignment was left vacant.</p> <p>Night Shift:</p> <p>* One hall monitor, two floor CNAs, and one LN. One resident was assigned 1:1 supervision. The assignment for a third CNA was left vacant.</p> <p>A Cassia County Sheriff Case Report, dated 9/26/17 at 7:32 pm, documented an officer was dispatched to a location with an elderly man, who had a severe laceration to his left hand. The officer was able to establish that Resident #7 eloped from the facility. The officer contacted the facility and the staff was unaware Resident #7 was missing. Resident #7 returned to the facility after receiving 43 sutures to his left hand.</p> <p>A Nurse's Note, dated 9/27/17 at 1:58 am, documented Resident #7 returned from the hospital and a staff member was assigned to provide 1:1 supervision.</p> <p>The facility's Daily Assignment Sheet for North Hall, dated 9/27/17, documented Resident #7 as a 1:1, but was left blank for the day shift and evening shift.</p> <p>3. Staff interviews and observations:</p> <p>* On 10/24/17 at 12:30 pm, the DNS stated to be "fully staffed" for the census of 48 and the acuity of residents that the facility had, it would have been one hall monitor, two floor CNA's and one</p>	F 353			

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F 353	<p>Continued From page 35</p> <p>"Breaker" for each hall, along with the six residents that required 1:1 supervision. The DNS stated after Resident #7 eloped on 9/26/17, the facility did not have enough staff to assign 1:1 supervision until 9/28/17.</p> <p>On 10/25/17 at 10:00 am, E #11 stated after the survey team left on 10/24/17 at 6:00 pm, the other CNA was sent home and she was left as the only floor CNA for the North Hall. The census for North Hall was 32 residents.</p> <p>On 10/25/17 at 11:15 am, E #10 stated her position was the CNA scheduler since August 2017. E #10 stated when she was unable to fill vacancies on the schedule, she would work the floor, work as a 1:1, or work as a hall monitor. E #10 stated she was not informed that Resident #7 required 1:1 supervision until 9/28/17. E #10 stated to be "fully staffed" the day and evening shifts would need two CNA's per hall, one hall monitor per hall, five residents assigned as 1:1 supervision on the North Hall, one resident assigned as a 1:1 supervision on the South Hall, and one breaker to give breaks between the two halls. E # 10 stated the night shift required the same as day and evening shift, except four residents required 1:1 supervision on the North Hall.</p> <p>On 10/26/17 at 12:00 am, one hall monitor was observed on the South Hall, one licensed nurse, and one resident had 1:1 supervision. The licensed nurse stated the floor CNA was providing cares at this time. On the North Hall, one floor CNA was observed walking quickly to answer a call light down the hallway. The licensed nurse was administering medications,</p>	F 353			

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F 353	<p>Continued From page 36</p> <p>and one CNA walking with a resident to the common area to watch television. E #9 stated she was scheduled as an extra CNA and both nurses asked her to stay and help with monitoring the residents who are 15-minute checks. E #1 stated the North Hall had eight residents required 15-minute checks. E #1 stated by the time the assigned staff member was completed with the 15-minute checks, it was time to check on the residents again.</p> <p>On 10/26/17 at 12:20 am, Resident #7's call light went on, E #17 answered the light, came back out to get the nurse, and they both went back to Resident #7's room. Resident #7's had punched his 1:1 in the face, and E #17 was reassigned by the nurse to stay with Resident #7 as a 1:1. The nurse assigned E #9 to the floor and the nurse was documenting the 15-minute checks. The nurse stated the facility did not have enough staff to both monitor and assist residents, which compromised safety.</p> <p>On 10/26/17 at 12:20 am, E #2 said she had been "pulled" to work as a floor CNA 2 to 3 times when she was assigned to be the 1:1 supervision for Resident #7 because the facility was short of CNA's on the floor. E #2 said when she was reassigned to work the floor, Resident #7 did not have 1:1 supervision for the rest of that shift.</p> <p>On 10/26 /17 at 12:45 a.m., E #3 said he has had to pull the CNA's who are providing 1:1 care to Resident #7, 1 to 2 times a week, if not more, because "we work so short of staff." He stated, "no one" sits with the 1:1 residents when he has to pull a CNA to work the floor. When asked if he was working the night of 9/26/17 when Resident</p>	F 353			

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F 353	Continued From page 37 #7 eloped, he said "yes." He stated, "we were short 4 people." He said none of the staff "heard anything" and he "was in room 32" when he thought Resident #7 broke the window and eloped. He said he did not know the resident was missing until the police called him and told him they had found him. E #3 stated Resident #7, "Had a previous elopement. He kept saying you guys can't keep me here. I'll get out again."  The facility failed to ensure sufficient nursing staff were available to meet the needs of the residents.	F 353			
F 490 SS=F	EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING CFR(s): 483.70  483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, it was determined the facility failed to administer its resources in a manner that ensured sufficient nursing staff; current standard of practice consistent with the Centers for Disease Control and Prevention (CDC) guidelines; policies were followed regarding residents at risk for elopement and for skin assessments; and to ensure these issues were reviewed in the Quality Assurance (QA) program for 2 of 12 sampled residents (Residents #4 and #7). The deficient practice placed all residents in the facility at risk of harm should they have unmet	F 490	The facility will administer in a manner that enables it to use its resources effectively and efficiently to attain and maintain the highest practicable physical, mental and psychosocial well-being of each resident. 1. Supervision Resident #7 has current 24/7 1:1 staff member. Staff has been educated on the need to provide adequate supervision of residents and prioritizing their time to ensure important supervision is paramount.	12/9/17	

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F 490	<p>Continued From page 38</p> <p>care needs which were unaddressed by facility leadership. Findings include:</p> <p>1. Supervision</p> <p>Resident #7 was placed in immediate jeopardy of serious harm, impairment, or death when the facility failed to recognize the resident was at high risk for elopement, as evidenced by their elopement policy and a "Wander" assessment completed on 9/6/17. The facility failed to develop and implement care plan interventions based on that risk. After Resident #7 first eloped on 9/9/17 by opening the window in his room and exiting the facility, the facility failed to provide a safe environment or increased supervision to prevent a second elopement. On 9/26/17, Resident #7 used his hand to break the window to his room and eloped through the broken glass, which resulted in the resident receiving 43 sutures. The facility updated the resident's care plan to require 1:1 supervision after the second elopement, but that intervention was not consistently implemented.</p> <p>Please refer to F 323 for details.</p> <p>2. Sufficient Nursing Staff</p> <p>The facility failed to ensure sufficient numbers of nursing staff to provide adequate supervision for resident acuity. Resident #7 was harmed when the facility had four vacancies on the evening shift of 9/26/17, and the resident used his hand to break the window in his room and elope. Resident # 7 sustained a laceration which required 43 sutures to repair. Through observation and interview, it was determined that</p>	F 490	<p>Supervision audits are in place. Please see F323.</p> <p>2. Sufficient Nursing Staff Resident #7 has a 1:1 staff member 24 hour/ 7 days a week Staff has been educated on the need to provide adequate supervision of residents and prioritizing their time to ensure important supervision is paramount. Multiple interventions from aggressive recruitment to training, to a halt on admissions have been implemented. Multiple audits are in place. Please see F353</p> <p>3. Vaccinations Residents #s1, 2,3,4,5,6,and 7. Have been or their responsible parties have been provided with the needed pneumonia vaccinations education in line with CDC guidelines. All vaccinations and refusal of vaccinations have been documented. Infection control nurse will quarterly consult the CDC for new guidelines. Vaccination Audit is in place. Please see 334.</p> <p>4. Pressure Ulcer Prevention and Treatment Resident #4 was evaluated by the physician who indicated that the area in question was not a deep tissue injury. All nursing staff has been trained that only licensed nurses must perform weekly resident skin checks. Please refer to F314</p> <p>5. Quality Assurance Program Resident #7 has current 24/7 1:1 staff member. Resident #4 was evaluated by the</p>		

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F 490	<p>Continued From page 39</p> <p>vacancies were a frequent occurrence on the facility's assignment roster, which placed the remaining residents in the facility at risk of injury.</p> <p>Please refer to F 353 for details.</p> <p>3. Vaccinations</p> <p>The facility failed to update their policies and implement procedures to maintain standards of practice with current Centers for Disease Control and Prevention guidelines regarding pneumococcal vaccinations. This failed practice placed all residents in the facility at risk for contracting pneumonia, and resulted in a substandard quality of care determination.</p> <p>Please refer to F 334 for details.</p> <p>4. Pressure Ulcer Prevention and Treatment</p> <p>Resident # 4 developed an unstageable pressure ulcer to her left ankle, which was documented as discovered on 10/26/17. The resident's clinical record documented skin checks were completed by Certified Nurse Aides but not consistently by Licensed Nurses; the facility was not following physician orders and care planned interventions for pressure ulcer prevention; and had incomplete documentation regarding the characteristics and appearance of the resident's skin issues.</p> <p>Please refer to F 314 for details.</p> <p>5. Quality Assurance Program</p> <p>On 10/27/17 at 11:30 am, the Administrator</p>	F 490	<p>physician who indicated that the area in question was not a deep tissue injury</p> <p>The Quality Assurance Committee has been trained to make special note of emergency QAPI meeting issues on the minutes. Please refer to F520.</p> <p>The Corporate Representative will attend and oversee all audits and assist the Administrator in assuring compliance with the whole Plan of Correction.</p>		

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F 490	Continued From page 40 stated he was the chairman of the QAPI committee. The Administrator stated that the facility had not identified the above issues as quality assurance concerns, and had not developed, implemented, or monitored performance improvement plans in these areas.	F 490			
F 520 SS=D	<p>Please refer to F 520 for further details.</p> <p><b>QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</b></p> <p>CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i)</p> <p>(g) Quality assessment and assurance.</p> <p>(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:</p> <p>(i) The director of nursing services;</p> <p>(ii) The Medical Director or his/her designee;</p> <p>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and</p> <p>(g)(2) The quality assessment and assurance committee must :</p> <p>(i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and</p> <p>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;</p>	F 520		11/28/17	

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NAME OF PROVIDER OR SUPPLIER  <b>MINI-CASSIA CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1729 MILLER AVENUE BURLEY, ID 83318</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	Continued From page 41  (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.  (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and evidence of non-compliance in quality of care and nursing services, it was determined the facility failed to maintain a quality assessment and assurance committee (QAA) that identified concerns or developed and implemented action plans in the areas of supervision, sufficient numbers of nursing staff, current Centers for Disease Control and Prevention (CDC) guidelines for pneumococcal vaccinations, or the prevention of pressure ulcers. Resident #s 4 and 7 were harmed, and all other residents in the facility placed at risk of harm, due to the facility's failure. Findings include:  During the recertification and complaint survey ending on 10/27/17, the facility was cited at:  *F 323. Resident #7 was placed in immediate jeopardy of serious harm, impairment, or death when he eloped on 9/9/17 through the window in his room. The facility's QAA committee did not identify resident elopements as an area of concern or implement an action plan to prevent	F 520	The facility has maintained a quality assurance program that has identified and deficient practices in the facility and continues to work to correct them with good faith attempts and has made significant improvements as it has done so. 1. The citation will be corrected for individuals per tag: Residents found to have been affected: F323- The citation was corrected on 9/9/2017 when the IDT which are members of the QA Committee reviewed the situation on 9/9/17 and again on 9/26/17, resident #7 was provided a 1:1 staff member on 9/26/17: F353- The citation was corrected on 9/9/2017 when the IDT which are members of the QA Committee reviewed the situation on 9/9/17 and again on 9/26/17. resident #7 was provided a 1:1 staff member on 9/26/17: F334- No injuries were incurred as a result of the deficient practice.		

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F 520	<p>Continued From page 42</p> <p>further occurrences. Resident #7 again eloped on 9/26/17, when he used his hand to break the window in his room and crawled through the broken glass. Resident #7 sustained a laceration to his hand which required 43 sutures to repair.</p> <p>*F 353. The facility had frequent vacancies in the nursing staff assignment roster, which resulted in insufficient numbers of nursing staff to meet resident needs. Resident #7 eloped on the evening shift on 9/26/17, when the facility had four nursing personnel assignments vacant.</p> <p>*F 334. The facility failed to maintain an immunization program consistent with CDC guidelines for the pneumococcal vaccine. The deficient practice created the potential for all residents in the facility to sustain harm, resulting in the identification of substandard quality of care.</p> <p>*F 314. Resident #4 was harmed when the facility failed to accurately assess the resident for current or developing skin impairment, and failed to implement care plan interventions to prevent pressure ulcers. Resident #4 developed an unstageable pressure ulcer to her left ankle.</p> <p>On 10/27/17 at 11:30 am, the Administrator stated he was the chairman of the QAA committee. The Administrator stated the facility had not identified these care areas for review in the QAA committee, or developed or implemented action plans or monitoring for these issues.</p>	F 520	<p>F314- Resident was assessed by the physician who was aware of her condition and determined this was not a deep tissue injury.</p> <p>2. The citations will identify residents who have the potential to be affected by the cited issues as follows per tag number: F323- A new elopement tool was implemented and those residents with high elopement potential are receiving 15 minute checks. Securing residents with high and medium potential for elopement on a secured unit and giving residents with high elopement potential Plexiglas windows will significantly decrease the likelihood of elopement. F353- Training staff to be aware of resident needs Please see F353. F334- A review of all residents showed no injuries were incurred as a result of the deficient practice. F314- All nursing staff has been trained that only licensed nurses must perform weekly resident skin checks. Please refer to F314</p> <p>3. Measures and systematic changes to ensure that deficient practice does not recur: F323- All high elopement risk residents have 15 minute checks. Separating high and medium elopement risk residents from low elopement risk residents and securing the area will help to increase security for the residents. F353- The citation will be corrected by staff being educated on the need to provide adequate supervision of residents and prioritizing their time to ensure</p>		

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F 520	Continued From page 43	F 520	<p>important supervision is paramount. Multiple interventions from aggressive recruitment to training, to a halt on admissions have been implemented. On 10/25/17 the staff assignment form that showed vacancies (at a census of 49, which was created when our census was 59), was redone to show appropriate staffing are maintained. Staffing is reviewed in Standup each week day to ensure coverage. Shifts have often been covered by administrative staff. There has been no attempt to prevent those who want overtime to come and work. Multiple approaches have been implemented to reduce resident load and increase staff numbers.</p> <p>F334- The infection control nurse will, as part of her reporting to the Quality Assurance Committee, show she has consulted to CDC quarterly in order to be up to date on changes. The Policy and Procedure has been updated to include newer regulations on Pneumonia Vaccinations.</p> <p>F314- All nursing staff has been trained that only licensed nurses must perform weekly resident skin checks. Please refer to F314</p> <p>4. The corrective action monitoring to ensure cited issues do not recur for each respective areas are as follows: F323- Audits will be completed as per F323 for all high elopement risk residents have 15 minute checks. Separating high and medium elopement risk residents from low elopement risk residents and securing the area will help to increase</p>		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 520	Continued From page 44	F 520	<p>security for the residents.</p> <p>F353- Staffing will continue to be reviewed in standup meeting each week-work day and positions filled. Competencies for nursing staff will continue and audits for assignment sheets and competencies will be completed. Please refer to F353.</p> <p>F334- Pneumonia vaccination Audit tool will be completed and brought to quality assurance and used as part of the infection control meeting. Please refer to F334</p> <p>F314- Skin audit audits will be conducted weekly by the DNS or designee to ensure skilled assessment of resident skin issues. Please refer to F314</p> <p>5. The Administrator with corporate review will be responsible to ensure that the plan of correction is followed properly. Education to the Quality Assurance Committee members to make note of issues addressed on the meeting minutes was made on 11/22/17.</p>		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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RUSSELL S. BARRON – Director

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January 16, 2018

Darrin Radeke, Administrator  
Mini-Cassia Care Center  
1729 Miller Avenue, Po Box 1224  
Burley, ID 83318

Provider #: 135081

Dear Mr. Radeke:

On **October 27, 2017**, an unannounced on-site complaint survey was conducted at Mini-Cassia Care Center.

An on-site complaint investigation was conducted at the facility from October 23, 2017 through October 27, 2017. Observations were conducted throughout the facility in resident rooms, hallways, and common areas. Multiple interviews were conducted with residents and staff on all shifts. No observations of the identified resident took place as the resident no longer lived at the facility.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007559**

**ALLEGATION #1:**

The facility failed to ensure residents were treated with dignity and respect.

**FINDINGS:**

Residents were observed sitting in chairs throughout the facility at different times. No concerns were identified during these observations. Staff were observed to be attentive to all residents throughout the observations, which were conducted across all shifts. At no time during the

survey did the team observe a resident to be isolated and/or ignored. At no time were staff observed to treat residents disrespectfully.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The facility failed to ensure residents received appropriate oral care.

#### FINDINGS:

The identified resident's clinical record, which included a review of personal hygiene tracking logs, documented the resident received extensive staff assistance with personal hygiene cares.

The investigation uncovered no concerns with residents not receiving adequate oral care and this allegation was not substantiated for lack of evidence.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #3:

The facility failed to ensure residents' personal clothing was appropriately cared for and protected from theft or damage. The facility's administration was not available to address an identified resident's and/or the representative's concerns.

#### FINDINGS:

This allegation involved an event that occurred in 2013 and an identified resident who no longer lived at the facility.

There were no current grievances on file regarding staff treatment of residents' personal property, and residents interviewed throughout the investigation survey did not express concerns regarding the manner in which staff treated their personal belongings.

This allegation was not substantiated for lack of evidence.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #4:

The facility failed to appropriately administer residents' financial accounts.

#### FINDINGS:

The identified resident no longer resided at the facility, however the resident's trust funds included a number of clothing purchases posted to the account.

Residents were observed to be dressed appropriately in varying areas of the facility at different times across all shifts. Interviews with individual residents and during a group interview did not elicit any complaints regarding clothing or expenditures from resident's personal funds. The investigation did not reveal any mismanagement of resident funds by the facility.

This allegation was not substantiated for lack of evidence.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #5:

The facility failed to ensure residents received an accurate accounting of personal funds from the facility's bookkeeper.

#### FINDINGS:

The investigation determined the facility's business office staff were available and provided residents with quarterly financial account statements. A review of the identified resident's account determined quarterly statements were sent to the Reporting Party. The statements were itemized and documented receipt of Social Security payments, interest on the account, "spousal income" paid to the spouse, clothing purchases, burial fund payments, and hairdresser expenses.

This allegation was not substantiated for lack of evidence.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #6:

The facility failed to appropriately expend residents' funds for clothing items, which resulted in residents receiving clothing of poor that was purchased at an excessive price.

#### FINDINGS:

The identified resident's account documented a check for more than \$1,800 was sent with the resident to the new facility. Transactions posted to the resident's account prior to his/her transfer to another facility included receipt of Social Security payments, interest on the account, "spousal income" paid to the spouse, clothing purchases, burial fund payments, and hairdresser expenses. All itemized entries appeared reasonable with included appropriate documentation. The investigation revealed the facility managed and forwarded the resident's funds appropriately. The facility's documentation also included evidence that a check for the correct amount of account funds sent with the resident to the new facility had been processed.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #7:

The facility failed to ensure residents could transfer to other facilities.

#### FINDINGS:

A review of referrals determined one of the identified resident's requested transfers to an assisted living facility could not be processed as the requested facility was unable to meet the resident's needs. The investigation determined the facility forwarded medical records and other information requested by potential facilities upon Reporting Party referral.

This allegation was not substantiated for lack of evidence.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #8:**

The facility failed to provide statements and accounting of resident funds when requested.

**FINDINGS:**

A review of the resident's trust account from March 2017 through June 2017 determined checks for approximately \$700 were appropriately sent each calendar month to the resident's spouse.

This allegation was not substantiated for lack of evidence.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #9:**

The facility failed to ensure a social worker was available to provide social services.

**FINDINGS:**

The facility employed a non-licensed Residential Service Director (RSD) who was responsible for providing medically related social services. The identified resident's clinical record included a note by the RSD regarding a visit by the Responsible Party concerning the resident's transfer to a location 10 hours from the resident's home. The identified resident's clinical record included documentation of a phone call and e-mail correspondence consenting to the transfer of the identified resident's clinical record to an Assisted Living facility closer to the resident's home. The RSD also presented handwritten notes regarding potential transfer facilities she had been working on for the Reporting Party.

The investigation determined the facility had staff who provided medically-related social services and that while that person was not a licensed social worker, the RSD maintained contact with the

Darrin Radeke, Administrator  
January 16, 2018  
Page 6 of 7

Reporting Party and the resident was transferred to another facility as requested by the Reporting Party.

This allegation was not substantiated for lack of evidence.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

A handwritten signature in black ink that reads "David Scott". The signature is written in a cursive style with a large initial "D" and "S".

David Scott, R.N., Supervisor  
Long Term Care

DS/lj