



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
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December 5, 2017

Nathan Chinchurreta, Administrator
Karcher Post-Acute & Rehabilitation Center
1127 Caldwell Boulevard
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr. Chinchurreta:

On **November 15, 2017**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **October 18, 2017**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F156 -- S/S: D -- NOTICE OF RIGHTS, RULES, SERVICES, CHARGES**
- **F157 -- S/S: D -- NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC.)**
- **F166 -- S/S: D -- RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES**
- **F221 -- S/S: G -- RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS**
- **F225 -- S/S: D -- INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS**
- **F226 -- S/S: E -- DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC. POLICIES**
- **F246 -- S/S: D -- REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES**
- **F280 -- S/S: D -- RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP**
- **F281 -- S/S: D -- SERVICES PROVIDED MEET PROFESSIONAL STANDARDS**
- **F314 -- S/S: D -- TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES**
- **F323 -- S/S: G -- FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES**
- **F353 -- S/S: F -- SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS**
- **F431 -- S/S: D -- DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS**

Nathan Chinchurreta, Administrator
December 5, 2017
Page 2 of 4

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 15, 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*.

Nathan Chinchurreta, Administrator
December 5, 2017
Page 3 of 4

As noted in the Bureau of Facility Standards' letter of **October 3, 2017**, following the survey of **September 20, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions effective **December 20, 2017** and termination of the provider agreement on **March 20, 2018**, if substantial compliance is not achieved by that time.

Due to facility's continued non-compliance **and** the seriousness of the deficiency(ies) cited, we are recommending that CMS impose the following remedy(ies), in addition, to the remedy(ies) that were previously mentioned to you in the originating survey letter of:

- Civil money penalty

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

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

- BFS Letters (06/30/11)

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

Nathan Chinchurreta, Administrator
December 5, 2017
Page 4 of 4

This request must be received by **December 15, 2017**. If your request for informal dispute resolution is received after **December 15, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, RN, Supervisor
Long Term Care

DS/lj

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

PRINTED: 12/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/15/2017
NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A complaint investigation and follow-up survey was conducted at the facility from November 13, 2017 to November 15, 2017. The surveyors conducting the survey were: Linda Kelly, RN, Team Coordinator Nina Sanderson, LSW Abbreviations: AD = Activity Director ADL = Activities of Daily Living APS = Adult Protective Services cm = centimeter CNA = Certified Nursing Assistant DNS = Director of Nursing Services LN = Licensed Nurse LPN = Licensed Practical Nurse MACC = Managing Acute Change of Condition MAR = Medication Administration Record MD = Medical Doctor (physician) MDS = Minimum Data Set mg = milligrams MSW = Masters of Social Work NN = Nurses Notes NP = Nurse Practitioner POA = Power of Attorney RCM = Resident Care Manager RN = Registered Nurse RPN = Resident Progress Notes SBP = Systolic Blood Pressure w/c = wheelchair	F 000			
F 156 SS=D	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) (d)(3) The facility must ensure that each resident	F 156		12/18/17	

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

TITLE

(X6) DATE

Electronically Signed

12/13/2017

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

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F 156	<p>Continued From page 1</p> <p>remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.</p> <p>§483.10(g) Information and Communication.</p> <p>(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility.</p> <p>(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:</p> <p>(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -</p> <p>(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;</p> <p>(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.</p> <p>(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>agency for information about returning to the community and the Medicaid Fraud Control Unit; and</p> <p>(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.</p> <p>(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning</p>	F 156			

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F 156	<p>Continued From page 3 November 28, 2017 (Phase 2)]</p> <p>(v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)]</p> <p>(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.</p> <p>(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives:</p> <p>(i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and</p> <p>(ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect,</p>	F 156			

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F 156	<p>Continued From page 4</p> <p>exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.</p> <p>(g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.</p> <p>(i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.</p> <p>(ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any.</p> <p>(iii) Receipt of such information, and any amendments to it, must be acknowledged in writing;</p> <p>(g)(17) The facility must--</p> <p>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-</p>	F 156			

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F 156	Continued From page 5 (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any	F 156			

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F 156	<p>Continued From page 6</p> <p>deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a resident's Power of Attorney (POA) had the name and contact information for the resident's physician. This was true for 1 of 6 residents (#2) sampled for resident rights. The deficient practice created the potential for harm when the POA for a cognitively impaired resident did not have sufficient information to make care decisions. Findings include:</p> <p>Resident #2 was admitted to the facility on 3/1/16 with diagnoses that included Alzheimer's disease and muscle weakness. Resident #2's face sheet documented she had designated a POA to make decisions on her behalf.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 8/17/17, documented Resident #2 experienced severe cognitive impairment.</p>	F 156	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Karcher Post-Acute Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F-156</p> <p>Resident #2 POA now has the contact information for the Medical Director.</p> <p>Current residents will be given a letter</p>		

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F 156	Continued From page 7 On 11/14/17 at 8:35 am, Resident #2's POA stated she thought Resident #2's physician was the facility's medical director, and thought she knew the physician's name. Resident #2's POA stated she had never met Resident #2's physician, and was not sure how to contact him directly. Resident #2's POA stated it did not necessarily bother her that the facility's medical director was the resident's physician, but she would like to be able to meet with that person and discuss the resident's status from time to time. Resident #2's POA stated this seemed particularly important since the resident experienced a recent fall with significant injury. On 11/15/17 at 3:22 pm, the Administrator stated the facility's admission agreement included information on the facility's medical director, but did not explicitly inform residents as to whether the medical director was also their primary care physician. The Administrator stated information provided at the time of admission did not include a way for residents or their POAs to contact the physician directly, rather than going through facility nursing staff.	F 156	with the name of their primary MD on It. A letter will be added to the Admission Packet outlining the contact information for the Medical Director and any other Physician's contact information as requested by the resident. The Social Worker and/or the admissions coordinator have been educated on the use of the letter notifying a resident of their physician. New admission packets will be reviewed during morning IDT meeting. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify opportunities for performance improvement. Administrator/DNS or Designee will be responsible. Compliance date: 12/18/2017		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 157		12/18/17	

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F 157	<p>Continued From page 8</p> <p>results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p>	F 157		

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F 157	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to notify physicians and interested parties in a timely manner when residents experienced a change of condition. This was true for 2 of 5 sample residents (#1 and #2) reviewed for physician and family notification and created the potential for harm when physicians and/or residents' interested parties were not provided the opportunity to initiate and/or alter interventions to meet residents' changing needs. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 3/1/16 with diagnoses that included Alzheimer's disease and muscle weakness. Resident #2 was receiving hospice services as part of her treatment in the facility.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 8/17/17, documented Resident #2 experienced severe cognitive impairment.</p> <p>On 11/3/17 at 8:37 am, Resident #2's Nurse's Notes (NN) documented the resident was found on the floor beside her bed at 6:40 that morning, experienced lacerations and blood loss, and required transportation to a hospital by ambulance. The NN documented, "... Hospice ... immediately contacted ... stated they will notify family immediately also (they were instructed that if family had any questions to contact facility - confirmed that family updated) ..."</p> <p>On 11/14/17 at 8:35 am, Resident #2's Power of Attorney (POA) stated being notified by an</p>	F 157	<p>F157</p> <p>The family/resident representative for Resident #1 was notified of the fall on 11/3/2017 and the family/resident representative of Resident#2 was notified of the bruise found 10/25/2017 on 11/14/2017.</p> <p>Current Residents progress notes and incident reports have been reviewed for the past 30 days for medication/treatment orders, changes in condition and behaviors, for responsible party notification of changes. Corrections made when needed.</p> <p>Licensed Nurses (LN's), Resident Care Managers (RCM's), MDS nurse have been re-educated on proper Physician and Family/Resident notification process.</p> <p>During the morning Managing Acute Condition Change (MACC) meeting, the DNS, RCM's and MDS nurse will review resident interdisciplinary progress notes to ensure any change in condition or changes in the plan of care have been assessed and responsible parties notified.</p> <p>The RCM's Or designee will complete a weekly audit x 8 weeks of residents reviewed during MACC meeting to ensure any change in condition or changes in the plan of care have been assessed and responsible parties notified. Audits will be</p>		

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F 157	<p>Continued From page 10</p> <p>on-call hospice nurse of such a serious event with the resident was "very unsatisfactory." The POA stated, "The hospice nurse was very nice, but she wasn't there. She couldn't answer my questions about how much [Resident #2] was bleeding, how big her cuts were, or if she was otherwise okay." Resident #2's POA stated she would expect the facility to call her directly, and that she wouldn't need to seek facility staff to provide "answers to such very basic questions."</p> <p>On 11/14/17 at 10:55 am, the hospice Director of Nursing Services (DNS) confirmed the on-call hospice nurse was contacted by the facility on 11/3/17 and asked to notify Resident #2's POA of the fall. The hospice DNS stated this was "not normal protocol" and "had never happened before." The hospice DNS stated the request put the on-call hospice nurse in an awkward situation, as the POA had many questions the hospice nurse could not answer.</p> <p>On 11/14/17 at 1:30 pm, the facility DNS stated she was at the facility administering first aid to Resident #2 on the morning of 11/3/17. The DNS stated she directed "someone" (the DNS could not recall which specific staff member) to call hospice and ask them to call Resident #2's POA. The DNS stated she did not recall her reasons for not directing a facility staff member to contact the POA directly because her attention was focused on the resident. The DNS stated that at the time she did not think about how family was notified until the POA brought it up at an 11/8/17 care conference. The DNS stated the POA's level of upset with the lack of direct communication made her realize the facility should have made the notification directly.</p>	F 157	<p>forwarded to the DNS and Administrator for review and follow up, if needed.</p> <p>Audit findings and reports results will be reviewed by the QAPI committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>Administrator/DNS or Designee will be responsible.</p> <p>Compliance date: 12/18/2017</p>		

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F 157	Continued From page 11 2. Resident #1 was admitted to the facility on 9/13/17 with diagnoses that included progressive supranuclear ophthalmoplegia (condition that affects eye movement). A 10/25/17 Incident Investigation documented an 8.5 centimeter (cm) by 4 cm bruise was observed on Resident #1's upper left breast at 3:00 am. The report documented the physician was notified "via his box" at 3:30 am that day and the date and time of family/responsible party notification was blank. A 10/30/17 Resident Progress Note (RPN) documented Resident #1 was increasingly leaning to the left and experiencing difficulty with positioning in her wheelchair (w/c) "which potentially could have been the cause" of the bruise to the left breast. The note documented the leaning concern was discussed with the resident's family member and that Physical Therapy was ordered to help with transfers and ambulation while staff continued to monitor the resident's positioning in the w/c. An 11/7/17 RPN documented Resident #1's family member was informed of the bruise to the resident's left breast. There was no documented evidence in Resident #1's clinical record, including RPNs, dated 10/25/17 through 11/14/17, that the family member was notified of the left breast bruise until 11/7/17, 2 weeks after the incident, the physician responded to the notification, or that staff followed up with the physician regarding the	F 157			

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F 157	Continued From page 12 bruise. On 11/15/17 at 10:50 am, the Director of Nursing Services (DNS) reviewed the 10/25/17 Incident Investigation regarding the bruise on Resident #1's left bruise and said the physician was notified of the incident "via his box" on 10/25/17. The DNS said the physician would have been in the facility that morning, but there was no evidence the physician saw or responded to the notice in his box. The DNS said Resident Care Manager (RCM) #1 told her the family had been notified, but the RCM forgot to document that notification until 11/7/17 when he also "reminded" the family member about the incident. On 11/15/17 at 11:12 am, RCM #1 said he spoke with the resident and the resident's family member about the left breast bruise on 10/25/17, but "failed" to document it.	F 157			
F 166 SS=D	RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES CFR(s): 483.10(j)(2)-(4) (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 166		12/18/17	

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F 166	<p>Continued From page 13 to the resident. The grievance policy must include:</p> <p>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;</p> <p>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;</p> <p>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;</p>	F 166			

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F 166	Continued From page 14 (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and review of clinical records, grievance file, and facility policy, it was determined the facility failed to recognize and act	F 166	F166 Resident <input type="checkbox"/> s #2 and #7 grievance		

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F 166	<p>Continued From page 15</p> <p>on resident family grievances and to follow-up regarding the resolution of grievances. This was true for 2 of 6 residents (#2 and #7) reviewed for resident rights and created the potential for harm when a resident's Power of Attorney (POA) voiced concerns that were not recognized, acted upon, and/or resolved. Findings include:</p> <p>The facility's Grievance policy and procedure, revised March 2017, documented concerns/grievances could be presented either verbally or in writing and the facility should actively seek resolution to concerns and attempt to keep the resident or "griever" updated on the progress toward resolution. The policy documented a designated Grievance Officer was responsible for overseeing the grievance process by receiving, investigating and tracking grievances to their conclusion/resolution.</p> <p>1. Resident #2 was admitted to the facility on 3/1/16 with diagnoses that included Alzheimer's disease and muscle weakness. Resident #2 was receiving hospice services as part of her treatment in the facility. Resident #2's face sheet documented she had designated a POA, along with the POA's name and contact information.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 8/17/17, documented Resident #2 experienced severe cognitive impairment.</p> <p>Nurse's Notes (NN) documented Resident #2 was found on the floor next to her bed on 11/3/17 at 6:40 am with lacerations to her left cheek and neck. The resident was transported to a hospital by ambulance and required a total of 11 sutures.</p>	F 166	<p>outcomes have been communicated to the residents and/or appropriate parties.</p> <p>Administrator will audit Grievance log for past 30 days of grievances to ensure completion and communication with appropriate parties.</p> <p>Social Services Director has been educated to the proper policy and procedure for the Grievance process to ensure future residents are not impacted.</p> <p>Grievances will be reviewed work day morning by the Administrator and Interdisciplinary Team for resolution and completion for our residents. An Grievance audit will be done by the Administrator to verify resolution has been reviewed with the resident or resident representative.</p> <p>The Grievance audit will be review by the Administrator and any grievance trend or pattern will be reported to the QAPI committee to further identify areas of opportunity for improvement.</p> <p>Administrator/DNS or Designee will be responsible.</p> <p>Compliance date: 12/18/2017</p>		

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F 166	<p>Continued From page 16</p> <p>On 11/8/17 at 1:35 pm, Resident #2's NN documented a care conference was held with the resident's POA, hospice staff, the facility Administrator, Director of Nursing Services (DNS), Resident Care Manager (RCM) and social worker (MSW). The NN documented, "Administrator and DNS talked to resident's [family member] to help address some of the ... concerns ..." regarding a fall Resident #2 experienced on 11/3/17. The note also documented, "All other concerns of resident's [family member] will be addressed and a plan of correction to address [those] concerns will be initiated." The note did not document specific information about the remainder of the concerns.</p> <p>On 11/8/17, Resident #2's MSW progress notes documented the resident's POA requested a summary of the events surrounding Resident #2's fall on 11/3/17, and had questions about the facility's investigation and conclusions. The note documented the POA had additional concerns with lack of notification from the facility and delays from the facility in returning telephone calls.</p> <p>There was no documentation in the facility's grievance file regarding these concerns.</p> <p>On 11/14/17 at 8:35 am, Resident #2's POA stated she did not believe the facility recognized her concerns as grievances and she was not aware of a plan to resolve the concerns. The POA stated the facility's recognition of her grievances at the 11/8/17 care conference was "very unsatisfactory" and the overall facility response was "aloof." The POA stated in addition</p>	F 166			

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F 166	<p>Continued From page 17 to the concerns documented in the MSW note, she also had the following concerns:</p> <p>*The facility continued to clip the call light next to the resident's face while she was in bed, although it had concluded Resident #2's lacerations were caused by that clip;</p> <p>*The POA observed one staff member changing the resident's adult brief and using a mechanical lift to transfer the resident alone, rather than with an additional staff member, the evening before the care conference;</p> <p>*The facility misrepresented some of the information gathered during its investigation to support its conclusions;</p> <p>*The POA did not understand how a thin mat the facility placed at bedside would serve to protect the resident if she fell again; and</p> <p>*Since the fall, the POA had seen the sit-to-stand used to transfer Resident #2's roommate stored against Resident #2's bed when not in use.</p> <p>On 11/14/17 at 12:45 pm, the MSW stated she was the facility's Grievance Officer, but had been working at the facility only a short time and was still learning many aspects of the job. The MSW stated the 11/8/17 care conference was arranged by Resident #2's POA and the POA opened the care conference with a number of concerns. The MSW stated the Administrator asked the POA what the facility could do to "make it right," but the POA did not have a response. The MSW stated she had not documented the POA's concerns as a grievance, and assumed the</p>	F 166			

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F 166	<p>Continued From page 18</p> <p>nursing staff had a plan to address the concerns. The MSW stated she received some training about grievance intake and how grievances were assigned for investigation, but she was not sure how the facility tracked grievance resolution or how the resolution was communicated to the complainant. The MSW stated she would work with facility Administration to clarify the grievance process.</p> <p>On 11/15/17 at 11:10 am, the Director of Nursing Services (DNS) stated the facility should have recognized Resident #2's POA's concerns as grievances and initiated the formal grievance process.</p> <p>2. A 10/26/17 Grievance/Concern form for Resident #7 included an undated and unsigned attached page that documented the resident's family member had requested a care conference that day and that the resident, three family members, a nurse and Social Worker (MSW) participated in the conference. During the conference, the resident reported her call light had been on for "one hour" on 10/23/17 when a Certified Nursing Assistant (CNA) answered, turned off the call light, and said he would get help. The resident reported that "nobody" returned for an "additional hour and a half" and by that time it was too late to eat her meal in the dining room. The resident reported a meal tray was delivered to her room, but she had to wait to be transferred off the toilet "for so long that her [food] was no longer hot." Resident #7 also reported the same CNA answered her call light on 10/22/17 and said he would get a nurse, but he had not returned and after 30 minutes she walked to the nurses station to get assistance</p>	F 166			

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

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F 166	Continued From page 19 herself. The Grievance/Concern form documented the DNS followed up with the CNA; there was no evidence the facility followed up with the resident and/or family member. On 11/15/17 at 2:06 pm, the MSW said she reviewed concerns/grievances and passed them to the appropriate department. The MSW said she communicated Resident #7's concerns on 10/26/17 to nursing and the DNS "took it from there." The MSW said she did not contact the resident or family after that. The MSW said the facility's grievance process was "ambiguous" for communicating the resolution or outcome to the complainant.	F 166			
F 221 SS=G	RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 221		12/18/17	

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F 221	<p>Continued From page 20</p> <p>any physical or chemical restraint not required to treat the resident's symptoms.</p> <p>(a) The facility must-</p> <p>(1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure residents were free from physical restraints. This was true for 1 of 5 residents (#2) reviewed for restraints and resulted in psychosocial harm when Resident #2 experienced increased agitation and distress from being physically restrained. Findings include:</p> <p>Resident #2 was admitted to the facility on 3/1/16 with diagnoses that included Alzheimer's disease and muscle weakness. Resident #2 was receiving hospice services as part of her treatment in the facility.</p> <p>Quarterly Minimum Data Set (MDS) assessments, dated 5/19/17 and 8/17/17, documented Resident #2 was severely cognitively impaired, dependent on 2 staff for all Activities of Daily Living (ADLs) and mobility, and required no physical restraints.</p>	F 221	<p>F221</p> <p>The care intervention that inadvertently restrained Resident #2 is no longer being used. Staff involved were re-educated.</p> <p>Current residents have been audited by the DNS for any inappropriate usage of restraints.</p> <p>Nursing staff have been re-educated on the facility restraint free policy and on appropriate usage of restraints if it was authorized and deemed necessary to use.</p> <p>A sample of nursing staff will be randomly quizzed once per x 4 weeks on knowledge of restraints. Outcomes of the Restraint quiz will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify</p>	

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F 221	<p>Continued From page 21</p> <p>The most recent Nurse Practitioner (NP) Progress Note, dated 7/13/17, and Physician's (MD) Progress Note, dated 7/26/17, did not document the use of a physical restraint, or any concerns with rashes or itching. Resident #2's clinical record did not contain any documentation related to the use of physical restraints.</p> <p>Resident #2's care plan, reviewed and revised 8/22/17, did not document the use of physical restraints or that the resident experienced rashes or itching. Resident #2's MACC (temporary Managing Acute Change of Condition) care plan, located in a binder at the nurse's station and dated 10/23/17, documented the resident was scratching at her peri area, which had caused an open area to her skin. A third care plan, referred to by facility staff as a "Bedside Care Plan" and located on the inside of Resident #2's bathroom door, contained an undated, unsigned note at the top of the document notifying staff that Resident #2 was to have "cotton gloves on when in bed."</p> <p>On 11/3/17 at 6:40 am, a facility incident report documented Resident #2 was found on the floor in her room next to her bed with lacerations to her left cheek and neck which required the resident to be taken by ambulance to a hospital for sutures.</p> <p>On 11/13/17 from 9:52 am to 10:10 am, and from 10:45 am until 11:08 am, Resident #2 was observed laying in bed with white cotton wrist-length gloves on both hands. During these observations, Resident #2 was laying still on her bed, eyes closed, snoring. The resident had minimal movement and a relaxed facial</p>	F 221	<p>opportunities for performance improvement.</p> <p>Administrator/DNS or Designee will be responsible.</p> <p>Compliance date: 12/18/2017</p>		

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F 221	<p>Continued From page 22 expression.</p> <p>On 11/13/17 at 4:30 pm, CNA #3 said she had been caring for Resident #2 the night before she fell, and the resident had been agitated and restless. CNA #3 stated it was not unusual for Resident #2 to be "mildly agitated" during the night. CNA #3 stated, "I think she is trying to get out of the wraps. One of the things we do with [Resident #2] to stop her from digging [at her peri area] is tuck sheets around her tight. You know, 'wrap.' She tries to get out, that's one of the reasons she moves so much at night and day shift doesn't think she moves at all." CNA #3 stated the "wrap" consisted of a sheet folded in half and tucked tightly around the resident's body "sometimes from just above her belly button to just past her peri area, but sometimes from her armpits to her mid-thigh. Everyone does it differently." CNA #3 stated she did not know if there was written direction for the use of the sheet but that she "was told to do it from the time I started here about four months ago."</p> <p>On 11/14/17 at 5:04 am, Resident #3 was observed laying in bed. The resident was wearing a hospital gown, repeatedly moving her arms (right more than left) in a rubbing motion. A folded sheet was observed securely wrapped across her torso from mid-chest to her waist, where it was then covered by a blanket. Every few seconds, the resident's right hand would grasp and tug at the sheet, as if trying to remove it. The sheet was secured tightly enough that it did not move. At 5:08 am, Resident #2 reached behind her head with her right hand and lifted her head trying to look at her torso. The resident's eyes were fluttering open and closed. She was</p>	F 221			

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F 221	<p>Continued From page 23</p> <p>scowling and grimacing. Resident #2 dropped her head and began to tug at the sheet again.</p> <p>On 11/14/17 at 5:10 am, CNA #3 and CNA #4 stated they were about to perform peri care on Resident #2. CNA #4 stated after they changed the resident's brief, "we 'burrito' her because she digs at her peri area." CNA #4 glanced at Resident #2 and stated, "We did it earlier, but she has gotten it undone just a little bit. We need to tuck the sheet around her torso, roll her, then tuck it in around the other side so it's nice and tight."</p> <p>On 11/14/17 at 5:12 am, CNA #3 and CNA #4 were observed removing Resident #2's incontinence brief, providing peri care, applying cream to the peri area, and applying a new incontinence brief. The CNAs rolled the resident to her right side, placed a sheet that was folded in half under her right side, turned the resident onto her back, pulled the sheet across her body, from chest to knees, and tucked the sheet under the resident's left side. As the CNAs covered the resident with a top sheet and blanket, CNA #4 said, "That's how we do it."</p> <p>On 11/14/17 at 5:30 am, CNA #5 stated Resident #2 was "covered tight" on night shift because of her itching.</p> <p>On 11/14/17 at 5:35 am, RN #1 stated she had been working in the facility about six weeks and had not worked since 11/3/17. RN #1 stated she was not aware Resident #2 had difficulty with itching, but was told "we were supposed to give her very good peri care at night." RN #1 was not aware Resident #2 was being "wrapped" tightly in</p>	F 221			

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F 221	<p>Continued From page 24</p> <p>a sheet to prevent her from scratching herself. RN #1 stated, "That would be a restraint, wouldn't it?"</p> <p>On 11/14/17 at 5:45 am, Resident #2 was observed laying in her bed, covered with a blanket and top sheet. RN #1 removed the blanket and top sheet from Resident #2. Resident #2 was wearing a hospital gown, with a folded sheet wrapped securely from the mid-chest to her mid-thigh area. RN #1 gasped audibly and took a quick step back from the resident's bedside while covering her mouth with her hand. RN #1 stated, "That shouldn't be like that. She couldn't move." RN #1 attempted to roll Resident #2 to remove the sheet from her torso, then stopped and stated, "That's tight. That's really tight. I have to get a second person to help me." RN #1 stepped into the hallway and asked CNA #3 to help her remove the sheet.</p> <p>On 11/14/17 at 8:35 am, Resident #2's Power of Attorney (POA) stated she was aware Resident #2 had a history of itching, but had never been told what caused it. The POA noted she was not aware itching was a current problem for the resident, and stated she had been told by a CNA the previous week that the facility was "wrapping" the resident's peri area at night rather than using a brief to prevent skin breakdown. The POA said she believed this was a new treatment for the resident and stated, "That room is always so hot because her roommate keeps it hot. They told me [Resident #2] pushes and tugs at night, but I had never seen that [tightly wrapped sheet]. That must be why she does it."</p> <p>On 11/14/17 at 10:55 am, the Director of Nursing</p>	F 221			

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F 221	<p>Continued From page 25</p> <p>(DNS) for Resident #2's hospice agency stated wrapping the resident in a sheet at night was not part of the hospice plan of care, and they did not have rashes or itching in the peri area listed as a current concern for Resident #2.</p> <p>On 11/14/17 at 12:40 pm, Resident Care Manager (RCM) #1 stated he added the intervention of white cotton gloves to Resident #2's care plan to prevent her from scratching herself while she was in bed. RCM #1 stated nursing staff could provide Benadryl if the resident was scratching herself, and "we do tuck the sheet in." RCM #1 stated the facility initiated the use of gloves and the sheet "because she was itching and scratching to the point of being excoriated or opening her skin." RCM #1 could not recall when or if Resident #2's physician had been notified of the itching or scratching, or what caused the rash and itching. RCM #1 stated the facility used anti-fungal cream in August of 2017 to treat a "yeast issue" that had resolved within a few days of treatment and the cream was discontinued. RCM #1 stated the facility did not have a physician's order for the use of a sheet as a restraint, had not assessed the resident for lesser restrictive measures, did not monitor the effectiveness of the restraint at treating the resident's itching, did not have consent from the Resident's POA to use the restraint, had not updated the resident's care plan to include the use of a restraint, and was not ensuring the resident was released from the restraint to allow freedom of movement at regular intervals.</p> <p>On 11/14/17 at 12:45 pm, the MSW stated she was unaware staff were physically restraining Resident #2.</p>	F 221			

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F 221	Continued From page 26 On 11/14/17 at 1:45 pm, the DNS stated she had only become aware that morning that staff were applying a physical restraint to Resident #2. The DNS stated the facility did not have a physician's order, consent, or documentation of monitoring or releasing the restraint. The DNS stated the facility removed the restraint as soon as it was discovered by the survey team, and she would educate staff to ensure another physical restraint did not take its place. Resident #2 was harmed when the facility failed to address her physiological symptom of itching and instead physically restrained the resident to prevent her from scratching herself. Resident #2 experienced increased agitation and restlessness when the restraint was in place and her itching was unrelieved.	F 221			
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his	F 225		12/18/17	

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F 225	<p>Continued From page 27</p> <p>or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.</p> <p>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.</p> <p>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p>	F 225			

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F 225	<p>Continued From page 28</p> <p>(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and facility policy review, it was determined the facility failed to thoroughly investigate injuries of unknown origin. This was true for 1 of 3 residents (#2) sampled for accidents and incidents and created the potential for harm if the cause for injuries of unknown origin remain undetected and lead to repeat injuries, or were the result of potential abuse. Findings include:</p> <p>Resident #2 was admitted to the facility on 3/1/16 with diagnoses that included Alzheimer's disease and muscle weakness. Resident #2 was receiving hospice services as part of her treatment in the facility.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 8/17/17, documented Resident #2 experienced severe cognitive impairment and was dependent on 2 staff for all Activities of Daily Living (ADLs), transfers, and bed mobility.</p> <p>On 11/3/17 at 8:37 am, Nurse's Notes (NN) documented Resident #2 was found on the floor of her room next to her bed at 6:40 am. The NN documented Resident #2 was "on the floor on her left side next to the bed with her head noted under the bed and lower body out from the bed.</p>	F 225	<p>F225</p> <p>Resident #2 had an investigation completed at time of injury with suspected cause of injury. Staff have been interviewed who had knowledge of the incident and their statements incorporated into the summary of the investigation.</p> <p>The Director of Nursing has reviewed the Incident Reports for the last 30 days for injury of unknown origin. No other resident was affected during review of incident reports.</p> <p>Nursing staff have been re-educated on investigating any unknown injury and obtaining all statements from involved staff; abuse and neglect regulations and reporting process; proper positioning of bed height.</p> <p>During morning meeting, incident reports will be reviewed to ensure that an investigation has been initiated and statements from all staff involved have been collected and reviewed. Any injury of unknown cause will be reported to appropriate authorities within</p>		

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F 225	<p>Continued From page 29</p> <p>Resident had the chux incontinent pad underneath her and her sheet and blanket slightly under her but majority along the side ... fresh pool of blood under her, her left hand and and hair were also bloody ... source of bleeding noted to [be] a half circular laceration with what appeared to be a puncture to her left cheekbone and an 8 [centimeter long] deep laceration to [her] left jawline/upper neck area ..."</p> <p>An Incident Investigation form for the 11/3/17 fall included staff statements from CNA #3, who had worked the night shift prior to the fall, and CNA #2, who had discovered Resident #2 after the fall. The investigation did not document the position of Resident #2's bed, who was in the room, who had access to the resident in the hours leading up to the fall, or who was on duty leading up to or at the time of the fall.</p> <p>On 11/10/17, the facility's investigation summary included typed summaries of interviews with CNA #3, CNA #2, and CNA #10, who also worked the night shift prior to the fall. No other interviews or statements were documented.</p> <p>On 11/13/17 at 3:30 pm, CNA # 2 stated when she first arrived in Resident #2's room, and when she returned to assist the resident after she summoned the nurse, Resident #2's call light was clipped to the left air mattress bolster at the head of Resident #2's bed, approximately 18 inches from the top of the mattress. CNA #2 stated she was not asked for this information as part of the facility's investigation.</p> <p>On 11/13/17 at 4:20 pm, CNA #3 stated:</p>	F 225	<p>appropriate time frame in accordance with policy/regulations.</p> <p>An audit will be completed weekly x4 weeks of incident reports for thoroughness of investigation and appropriate staff interview statements are received for the next month and then monthly for 3 months.</p> <p>The Administrator will review incident reports to assure they are following Idaho Abuse and Neglect guidelines. Instances of lack of a thorough follow-up will be reviewed with the DNS immediately and corrections made as needed. Findings from the Administrator's review of incidents will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>Administrator/DNS or Designee will be responsible.</p> <p>Compliance date: 12/18/2017</p>		

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F 225	<p>Continued From page 30</p> <p>* She provided care to Resident #2 approximately an hour before the resident was found on the floor, and the call light was clipped to the left side air bed bolster when she last positioned the resident.</p> <p>* "We were exhausted that night. We had only 3 aides, and there was too much going on."</p> <p>* "I think one of the things that happened is [Resident #2] was trying to get out of the 'wraps.'" CNA #3 stated night shift staff customarily "wrapped" Resident #2 tightly in a sheet to prevent her from scratching her peri area, which caused the resident to become restless and agitated.</p> <p>* CNA #3 stated she told the Director of Nursing Services (DNS) about the wraps staff used on Resident #2 during the investigation into the incident, "but she brushed it off."</p> <p>On 11/14/17 at 5:30 am, CNA # 5 stated she was working the night shift on 11/2/17 to 11/3/17 and was among the staff who responded when Resident #2 was discovered on the floor. CNA #5 stated the bed in Resident #2's room was "high, very high," and gestured to show the bed was approximately 4 feet from the floor. CNA #5 stated the height of the bed struck her as inappropriate and may have contributed to the severity of Resident #2's injuries. CNA #5 stated she was sufficiently concerned about the bed's height to speak with other staff to determine who had last cared for Resident #2. CNA #5 stated she was not asked at any time for a statement regarding the incident during the investigation.</p>	F 225			

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

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F 225	<p>Continued From page 31</p> <p>On 11/14/17 at 5:35 am, RN #1 stated she worked the night shift and was assigned to Resident #2 the night of 11/2/17 to 11/3/17. RN #1 stated she had last seen Resident #2 between 4:00 am and 4:30 am, when she went into the room to administer medication. RN #1 stated when she entered the room, Resident #2's bed was in a high position, which concerned her, so after she gave the resident her medication she lowered the bed. RN #1 stated she was off shift but still in the facility when Resident #2 was found on the floor, so she responded to the resident's room to assist. RN #1 stated when she entered Resident #2's room, the resident's bed was again in the high position. RN #1 gestured to show the bed was approximately 4 feet from the floor and stated she was not asked to provide a statement as part of the facility's investigation, "which I thought was very strange. I thought they had to do that."</p> <p>On 11/14/17 at 8:35 am, Resident #2's POA said she was concerned the facility had missed important information as part of its investigation and may not have identified the true cause of the resident's fall and injuries.</p> <p>On 11/14/17 at 1:30 pm, the Director of Nursing Services (DNS) stated she was one of the first nurses to respond to Resident #2's room after she was found on the floor. The DNS stated after Resident #2 was taken to a hospital, she began the investigation into the event. The DNS stated she spoke with CNA #3 and RN #1. The DNS stated she did not have RN #1 provide a statement into the investigation because she was not the person who had last seen Resident #2 prior to the fall. The DNS stated CNA #3 had</p>	F 225			

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F 225	Continued From page 32 spoken about the "wraps" they used at night, and that Resident #2 was more active when the wraps were in place. The DNS stated she did not consider that information as pertinent to the investigation because she did not see a sheet wrapped around Resident #2 when she responded to the fall. The DNS stated she also had not seen Resident #2 move that much during the day and, therefore, concluded the resident was not moving more at night. The DNS stated she had not asked any staff about the bed height because, "I know what I saw. I saw the bed in the low position." The DNS stated there were a number of staff in and out of the room after Resident #2 was found and while first aid was provided and paramedics were summoned, however she did not interview all of them as part of her investigation.	F 225			
F 226 SS=E	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to	F 226		12/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/15/2017
NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
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F 226	<p>Continued From page 33</p> <p>the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-</p> <p>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and review of clinical records, policies, and accident/incident reports, it was determined the facility failed to develop and operationalize policies and procedures for investigating instances of potential abuse or neglect. This was true for 1 of 6 residents (#2) reviewed for abuse/neglect and had the potential to adversely affect any resident experiencing a potential incident of abuse or neglect. The deficient practice created the potential for harm if adverse events were not correctly reported or investigated. Findings include:</p> <p>Facility policies:</p> <p>a. The facility's "Abuse policy for the State of Idaho," dated June 2017, documented:</p> <p>* Staff would be trained how to recognize signs of burnout, frustration, and stress that may lead to abuse.</p>	F 226	<p>F226</p> <p>A new policy has been written that aligns with the Idaho state regulations for abuse and Neglect</p> <p>All incidents for the last 30 days that involved a significant injury have been reviewed to rule out abuse. None met the regulation for reporting to the Department.</p> <p>Staff have been in-serviced on the new abuse and neglect policy and procedure. All new hires will be in-serviced on the policy and all staff will be in-serviced at least yearly on the abuse and neglect policy.</p> <p>The Administrator or designee will randomly review 3 new hire packets monthly to assure they have received</p>		

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F 226	Continued From page 34 * The facility would utilize the Incident/Accident Investigation policy to investigate incidents. * The facility would utilize the Grievance policy to investigate grievances. * The facility would utilize the assessment and care planning process to identify residents with behaviors that might lead to conflict or neglect. * Mandatory reporters in the facility would report to the Idaho State Abuse Hotline; a telephone number for the Abuse Hotline was not provided in the policy. * Any suspicion of a crime, including assault, required law enforcement notification within two hours of injuries requiring treatment in a hospital. * "DSHS" (There is not an agency in the State of Idaho) would be notified of allegations of sexual abuse. * A "mandatory reporter" was defined as a "Registered social worker." There was no reference to a Licensed Social Worker. * The facility would report suspected instances of abuse or neglect by telephone, although it was not clear to whom the telephone report would be made. b. The Accident and Incident policy, revised June 2017, documented: * The charge nurse on duty at the time of the incident would initiate an incident report and	F 226	abuse and neglect training that meets the Idaho regulations. The findings of the new hire audit will be reviewed with the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify opportunities for performance improvement. Administrator/DNS or Designee will be responsible. Compliance date: 12/18/2017		

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F 226	<p>Continued From page 35</p> <p>obtain witness statements from all persons surrounding the incident.</p> <p>* The resident's family and physician would be notified within 8 hours of the incident. The policy did not require more rapid notification depending on the severity of the event.</p> <p>* No information was documented about how to report allegations of abuse or neglect to the State Agency.</p> <p>On 11/14/17 at 12:40 pm, Resident Care Manager (RCM) #1 stated the facility's policy for family and physician notification of an event depended on the time of day the event occurred and the severity of the event. RCM #1 stated notification for an event occurring on night shift would typically occur "sometime the next day." RCM #1 stated while family and physician notification would "be high on the priority list," there was no specific timeframe in which the notification must occur.</p> <p>On 11/15/17 at 3:22 pm, the Administrator stated the facility had corporate policies and procedures which were all available online, and were kept up-to-date with current regulatory requirements from a corporate level. The Administrator stated when it came to abuse, neglect, and investigations, the facility trained to Idaho specific reporting requirements, though those training activities were largely oral. The Administrator stated the policies provided to the survey team were those on the corporate website as Idaho specific.</p> <p>The facilities policy and procedures failed to</p>	F 226			

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NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
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F 226	<p>Continued From page 36</p> <p>recognize Idaho Statute, rules and reporting requirements as it relates to mandatory reporters and reporting of allegations of resident abuse, neglect and misappropriation of resident funds.</p> <p>1. Resident #2 was admitted to the facility on 3/1/16 with diagnoses that included Alzheimer's disease and muscle weakness. Resident #2 was receiving hospice services as part of her treatment in the facility.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 8/17/17, documented Resident #2 experienced severe cognitive impairment and was dependent on 2 staff for all Activities of Daily Living (ADLs), transfers, and bed mobility. The MDS documented Resident #2 did not experience restlessness or was resistive to cares.</p> <p>On 11/3/17 at 8:37 am, Resident #2's Nurses Notes (NN) documented the resident was found on the floor next to her bed with wounds to her cheek and neck. The puncture wound on her cheek measured 3 cm (centimeters) in length, and the wound to her neck was documented as an 8 cm long "deep laceration."</p> <p>The facility's Incident Investigation for the 11/3/17 event did not document who was involved with Resident #2 at the time of the incident, or statements from all individuals involved. The investigation documented that Resident #2 had been restless that night, but there was no evaluation determining the cause for the restlessness. The investigation documented the the call light clip caused Resident #2's laceration and puncture wounds and that law enforcement</p>	F 226			

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F 226	<p>Continued From page 37 officials were not contacted.</p> <p>On 11/7/17, Adult Protective Services (APS) notified the State Agency of an elder abuse allegation involving Resident #2. The report documented Resident #2's injuries were "suspicious."</p> <p>On 11/10/17, the facility's Investigation Summary documented Resident #2 required one staff to assist with bed mobility.</p> <p>On 11/13/17 at 3:40 pm, CNA #2, who noted she had worked in the facility for more than 9 years, stated, "I've never seen a call light cause those types of injuries before" in reference to both the laceration and puncture wounds. Other staff members made similar statements, including CNA #3 on 11/13/17 at 4:20 pm, CNA # 5 on 11/14/17 at 5:30 am, RN #1 on 11/17/17 at 5:45 am, and the hospice agency Director of Nursing Services (DNS) on 10/14/17 at 10:55 am.</p> <p>On 11/14/17 at 1:30 pm, the facility's DNS stated she was one of the first nurses on the scene after Resident #2 was found on the floor. The DNS stated she spoke with many of the other staff on site, but did not obtain witness statements from each staff member as she was also a witness. The DNS stated she had almost 30 years of experience working in nursing homes, and had not seen a call light clip cause Resident #2's type of injuries. The DNS stated, "I ruled out everything else in the environment, and there was a small amount of blood and tissue on the call light clip so that was my conclusion." The DNS used a gesture to show the amount of blood and tissue to be the corner of her thumb nail. The</p>	F 226			

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F 226	<p>Continued From page 38</p> <p>DNS stated it did not occur to her to notify law enforcement, as she had no definitive evidence a crime had been committed. The DNS stated she remembered being told Resident #2 had been restless the night of her fall due to "wraps," but she had not ever seen Resident #2 "move that much." The DNS stated the resident was not wrapped in blankets when she was found on the floor, so she did not pursue that reference to "wraps" as part of her investigation.</p> <p>On 11/13/17 at 3:40 pm, CNA #2 stated she worked day shift in the facility, which she said "seemed" adequately staffed, but she noted it was not unusual for night shift to be short of staff. CNA #2 stated it was not uncommon for night shift CNAs to be asked to work additional hours after "working short all night" to help day shift get residents up from bed for the day.</p> <p>On 11/13/17 at 4:20 pm, CNA #3, who worked the night shift, stated the facility should have at least 4 CNAs on night shift because of the number of residents requiring 2 staff assistance, but often the facility scheduled 3 CNAs. CNA #3 stated it was not uncommon for 3 CNAs to work night shift when 4 CNAs were scheduled due to illness and staff was left short-handed. CNA #3 stated there were currently "only" 5 CNAs who rotated to cover night shift, as many had quit. CNA #3 repeatedly described night shift CNAs as "exhausted," "burned out," and "frustrated" with their work situation.</p> <p>On 11/14/17 at 12:40 pm, RCM #1 stated he monitored staff for signs of burn-out, which he acknowledged could lead to abuse and/or neglect of residents, but stated he did not think</p>	F 226			

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F 226	Continued From page 39 there were any current concerns with staff. RCM #1 stated, "It's really up to [the scheduler and DNS] to take care of that kind of thing when they see it." On 11/14/17 at 1:45 pm, the DNS stated, "There are some people here who are frustrated due to [staff calling in sick]." The DNS did not say how the facility was addressing the issue. On 11/15/17 at 3:22 pm, the Administrator stated the facility was aware staffing issues were affecting direct care staff and that the facility had implemented several measures, such as using agency staff and offering hire-on bonuses, in an effort to increase available staff.	F 226			
F 246 SS=D	REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES CFR(s): 483.10(e)(3) 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure a call light was available to a resident in bed. This was true for 1 of 6 residents (#2) sampled for accommodation of needs and created the potential for harm if residents required assistance without the means to	F 246	F246 Resident #2 call light was replaced at her bedside. Current residents audited to ensure call lights present and within reach.	12/18/17	

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F 246	<p>Continued From page 40 summon help. Findings include:</p> <p>Resident #2 was admitted to the facility on 3/1/16 with diagnoses that included Alzheimer's disease and muscle weakness. Resident #2 was receiving hospice services as part of her treatment in the facility.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 8/17/17, documented Resident #2 experienced severe cognitive impairment and was dependent on 2 staff for all Activities of Daily Living (ADLs), transfers, and bed mobility.</p> <p>On 11/3/17 at 8:37 am, Resident #2's Nurse's Notes (NN) documented the resident was found on the floor next to her bed with lacerations to her left cheek and the left side of her neck.</p> <p>On 11/4/17, a new intervention directing staff to clip Resident #2's call light to a blanket on the resident's right side while she was in bed was added to the care plan.</p> <p>On 11/10/17, an Investigation Summary of the 11/3/17 fall documented the facility identified a call light clip caused Resident #2's injuries, and advised staff that "no call light [was] to be placed as [the] resident cannot understand/use and will reduce any further injury ..." A new intervention added to the resident's care plan on that date directed staff to remove the call light and begin "enhanced rounds."</p> <p>On 11/13/17, CNA #8 , CNA #6, CNA #1, CNA #7, CNA #2, CNA #3, CNA #4, CNA #5, and RN #1 each said they had not heard of, nor knew the</p>	F 246	<p>Nursing staff have been re-educated on call light placement to be within resident reach and away from the face.</p> <p>The RCM will complete a weekly audit for 4 weeks and then monthly x3 months to ensure that residents have call lights placed appropriately and within the resident's reach.</p> <p>The RCM or DNS will report findings of the call light audit to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>Administrator/DNS or Designee will be responsible.</p> <p>Compliance date: 12/18/2017</p>		

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

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F 246	<p>Continued From page 41 meaning of, "enchanced rounds."</p> <p>On 11/13/17 from 9:52 am to 11:10 am, Resident #2 was observed laying in her bed without a call light in place. The call light control box on the wall near her bed had been capped and the call light mechanism removed. No staff checked on the resident during that 78-minute period of time.</p> <p>On 11/13/17 at 11:10 am, CNA # 8 stated Resident #2's care plan documented she was not to have a call light.</p> <p>On 11/14/17 at 5:04 am, Resident #2 was observed laying in bed without a call light. The call light control box was capped and the call light had been removed from the room. Resident #2, who was wrapped snugly in a sheet around her torso, was restless and repeatedly tugging at the snugly wrapped sheet. CNA #4 stated the sheet was to prevent Resident #2 from scratching her peri area.</p> <p>On 11/14/17 at 8:35 am, Resident #2's Power of Attorney (POA) stated she had noticed the previous Friday (11/10/17) that the resident's call light had been removed, but had not been informed in advance by the facility. The POA stated, "It might be my fault. They kept saying the call light clip had caused her lacerations, but the call light was still there. I never believed the call light did that, but if it did, why was it still there? None of it made sense. I kept pointing that out to them, and then the call light was gone." Resident #2's POA stated the only plan the facility offered was to replace the resident's call light with a different type of mechanism and that since the 11/3/17 fall she had witnessed at least one CNA</p>	F 246			

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F 246	Continued From page 42 transferring the resident with a mechanical lift without assistance from a second staff member. Resident #2's POA stated, "If she had started to fall and that CNA had to catch her there would be no way for the CNA to let anyone know she needed help. [Resident #2] would have fallen again." On 11/14/17 at 1:30 pm, the Director of Nursing Services (DNS) stated that because Resident #2 was severely cognitively impaired, known not to use her call light, and the facility had determined the call light caused her injuries, the facility removed the call light and initiated "enhanced rounds" to compensate for the lack of a call light. The DNS stated the facility did not have a policy pertaining to "enhanced rounds," and was unable to provide a definition of "enhanced rounds" or evidence the term was understood by staff. The DNS stated she had not considered how staff would summon additional assistance to the resident's room if needed during cares.	F 246			
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the	F 280		12/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/15/2017
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F 280	<p>Continued From page 43</p> <p>expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.</p> <p>(iv) The right to receive the services and/or items included in the plan of care.</p> <p>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.</p> <p>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p>	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/15/2017
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F 280	Continued From page 44 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents' care plans were regularly reviewed and revised as warranted. This was true for 1 of 6 residents (#2) reviewed for care plan revisions and created the potential for harm if care was not provided or decisions were made based on inaccurate or outdated information. Findings include: Resident #2 was admitted to the facility on 3/1/16	F 280	Resident #2 care plan was reviewed and updated to reflect the resident's current needs. Comprehensive Care Plans and care plans have been reviewed and updated to reflect current care needs. The RCM's have been educated on the importance of updating care plans. Care plans will be reviewed and updated during		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/15/2017
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F 280	<p>Continued From page 45 with diagnoses that included Alzheimer's disease and muscle weakness. Resident #2 was receiving hospice services as part of her treatment in the facility.</p> <p>The resident's most recent quarterly Minimum Data Set (MDS) assessment was completed 8/22/17. Discrepancies between the resident's MDS, care plan, and provision of care included:</p> <p>* The 8/22/17 MDS documented the resident was dependent on 2 staff for assistance with bed mobility and incontinence care. The resident's care plan, revised 8/22/17, did not document the level of assistance required by the resident. On 11/3/17 at 8:37 am, Resident #2's Nurse's Notes (NN) documented the resident was found on the floor next to her bed at 6:40 am that day. On 11/10/17, the facility's Investigative Summary of the 11/3/17 fall documented 1 staff had been providing bed mobility assistance and incontinence care on the shift prior to her fall, and other staff had historically provided 1-person assistance as well.</p> <p>* Neither the 8/22/17 MDS nor Resident #2's care plan documented the use of a physical restraint. The care plan did not document the resident had a rash, that she habitually scratched that rash, or that she was to wear white cotton gloves while in bed. On 11/13/17 at 4:30 pm, CNA #3 stated Resident #2 was "wrapped tightly" in a sheet when in bed at night to prevent her from scratching herself. On 11/14/17 at 5:04 am, Resident #2 was observed in bed with a sheet wrapped around her torso extending from the armpits to mid-thigh and tight enough to prevent the resident from accessing that part of her body.</p>	F 280	<p>AM MACC meeting as needed.</p> <p>The DNS or designee will review 3 charts / week x 4 weeks, then 1 chart per week x 4 weeks for completeness and review and revision of care plans. The DNS will report findings to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>Administrator/DNS or Designee will be responsible.</p> <p>Compliance date: 12/18/2017</p>		

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F 280	<p>Continued From page 46</p> <p>* Resident #2's care plan, dated 8/22/17, documented the resident had a fall mat on the floor next to her bed beginning 2/28/17. On 11/4/17, after the resident was found on the floor beside her bed, the care plan was updated to include the same approach. The fall mat was observed beside Resident #2's bed on 11/13/17 at 9:52 am. On 11/13/17 at 4:30 pm, CNA #3, who identified herself as one of Resident #2's regular caregivers, stated prior to the 11/3/17 fall the resident did not have a fall mat. On 11/14/17 at 1:45 pm, the DNS stated Resident #2 did not have a fall mat in place prior to the 11/3/17 fall.</p> <p>* On 11/4/17, Resident #2's care plan documented staff were to clip a call light to the pillow on the right hand side of her head. The approach was not discontinued. On 11/10/17, staff were directed on the care plan to remove the resident's call light. On 11/13/17 at 9:53 am, Resident #2 was observed in bed without a call light, and the call light control box on the wall had been capped to prevent installation of another call light.</p> <p>* An undated, unsigned Bedside Care Plan documented staff were to encourage the use of white cotton gloves when Resident #2 was in bed. This item was not included in the care plan in the clinical record or a third care plan located in a binder at a nurse's station. On 11/13/17 at 9:52 am, Resident #2 was observed in bed wearing white cotton wrist length gloves.</p> <p>* On 11/10/17, Resident #2's care plan documented "enhanced rounds" would be initiated due to the removal of the call light. The</p>	F 280			

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

PRINTED: 12/22/2017
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F 280	<p>Continued From page 47</p> <p>facility had no documentation of what "enhanced rounds" entailed or the frequency with which they occurred, and staff interviewed about "enhanced rounds," including CNA #8, CNA # 6, CNA #1, CNA #7, CNA #2, CNA #3, CNA #4, CNA #5, and RN #1, had neither heard of the term nor understood its meaning.</p> <p>On 11/14/17 at 12:40 pm, Resident Care Manager (RCM) #1 stated he had worked as the unit's RCM where Resident #2 resided since her admission to the facility. RCM #1 stated the facility kept three separate and differing documents, which were all considered care plans - a care plan in the resident's clinical record, a temporary MACC (Managing Acute Change of Condition) form in a binder at the nurse's station, and a Bedside Care Plan stored on the inside of Resident #2's bathroom door. RCM #1 stated Resident #2 had a history of scratching herself, so the facility applied cotton gloves and wrapped a sheet around her to keep her from scratching her peri area. RCM #1 stated if the gloves and wrapped sheet were not on the resident's care plan in the clinical record, then they may be included on one of the other care plan documents.</p> <p>On 11/14/17 at 1:30 pm, the Director of Nursing Services (DNS) stated Resident #2's care plan did not include the use of the folded sheet or cotton gloves as interventions to prevent the resident from scratching. The DNS stated there were no additional care plans beyond the care plan in the clinical record, bedside care plan, and MACC care plan that had already been provided.</p> <p>On 11/15/17 at 3:22 pm, the DNS stated it was</p>	F 280			

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F 280	Continued From page 48 the facility's expectation that if there was any change in a resident's care, the RCM would update both the comprehensive care plan in the resident's clinical record, and the bedside care plan. The DNS stated the MDS nurse should review and update the entire care plan with each assessment.	F 280			
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and review of clinical records and Incident Investigations, it was determined the facility failed to ensure nurses adhered to professional standards of practice. This was true for 3 of 7 residents (#2, #4 and #6) reviewed for receiving treatment and services per professional standards of practice. These deficient practices created the potential for harm if Resident #4 were to experience complications when an antihypertensive medication was not held as ordered and for Resident #6 to experience subtherapeutic effects when the wrong dose of an antibiotic was administered. Resident #2 also had the potential for harm when she was moved following a fall with facial and neck injuries without staff first stabilizing her neck. Findings include:	F 281	F281 Residents #4, and #6 did not experience any adverse effects from medication errors and resident #2 did not experience any signs of neck/spine injury. Current residents had an audit completed of Medication Administration Record to determine if there was any further medication errors that caused any adverse effects. If medication errors were identified, they were reviewed with the physician and resident assessed for adverse side effects. Licensed nurses were re-educated regarding avoiding medication errors, the	12/18/17	

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F 281	<p>Continued From page 49</p> <p>According to nursingcenter.com., the 8 rights of medication administration included, "2. Right medication; Check the medication label; Check the order. 3. Right dose; Check the order ..."</p> <p>1. Resident #4 was admitted to the facility on 10/31/17 with diagnoses that included hypertension.</p> <p>Resident #4's Physician Orders and Medication Administration Record (MAR), both dated 11/1/17 - 11/15/17, documented the resident was to receive Metoprolol twice daily for hypertension and the medication was to be held for systolic blood pressures (SBP) less than 105 mmHg (millimeters of mercury).</p> <p>The 11/1/17 - 11/15/17 MAR documented Metoprolol was administered on 3 occasions when Resident #4's SBP was less than 105 mmHg as follows:</p> <ul style="list-style-type: none"> * 11/8/17 morning administration - SBP = 102 mmHg * 11/8/17 evening administration - SBP = 100 mmHg * 11/14/17 evening administration - SBP = 104 mmHg <p>There was no documentation in the November 2017 MAR or Resident Progress Notes (RPN) from 10/31/17 to 11/15/17 explaining why Metoprolol was not held as ordered by the physician.</p> <p>On 11/15/17 at 9:30 am, the Director of Nursing</p>	F 281	<p>8 rights of medication pass, and avoiding interruptions. Pharmacy nurse consultant completed an audit of all units. Medication pass audits have been completed on licensed nurses by the DNS or designee.</p> <p>Residents with falls have been reviewed for any potential injury. Staff have been educated on how to identify potential neck injuries and the precautions to be used thereafter.</p> <p>The RCM/DNS will complete a weekly audit of the MAR for any medication errors x4 weeks then once monthly x3 months.</p> <p>The DNS or designee will review med errors to assure parameters are being followed and the physician's orders regarding IV administration are carried out. The result of the number and type of medication errors as well as any lack of following orders or parameters will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>Administrator/DNS or Designee will be responsible.</p> <p>Compliance date: 12/18/2017</p>		

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F 281	<p>Continued From page 50</p> <p>Services (DNS) said she was not aware of Resident #4's Metoprolol medication errors. The DNS said the nurses who committed the errors "probably" did not read the physician's order to hold the medication for SBP less than 105 mmHg.</p> <p>On 11/15/17 at 1:35 pm, Licensed Practical Nurse (LPN) #1 said she "usually" looked at orders with parameters to hold medications, "but I must not have that time."</p> <p>2. Resident #6 was admitted to the facility on 11/3/17 with multiple diagnoses, including decubitus ulcer, edema, peripheral arterial disease and history of leg amputation.</p> <p>An 11/4/17 physician's order directed staff to administer 2 Meropenem (intravenous antibiotic) 1-gram vials every 8 hours to Resident #6.</p> <p>An Incident Investigation documented an 11/6/17 medication error in which staff administered 1 vial of Meropenem to Resident #6 rather than 2 vials as ordered by the physician. The report documented a day shift nurse "admitted to failure to follow the directions that were on the bag. She stated she was trying to go too fast, and made the error."</p> <p>On 11/15/17 at 10:50 am, the DNS said the nurse who erred in the administration of Resident #6's Meropenem "didn't read the [physician's] instructions."</p> <p>3. Resident #2 was admitted to the facility on 3/1/16 with diagnoses that included Alzheimer's disease and muscle weakness.</p>	F 281			

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F 281	<p>Continued From page 51</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 8/17/17, documented Resident #2 experienced severe cognitive impairment and was dependent on 2 staff for all Activities of Daily Living (ADLs), transfers, and bed mobility.</p> <p>Mayoclinic.org on 3/2/16 documented those responding to a potential spinal injury should not move the injured person as "permanent paralysis and other serious complications" could occur. Rather, "if an injury has exerted substantial force on the back or head ... [or] if you suspect someone has a spinal injury ... keep the person still. Place heavy towels on both sides of the neck or hold the head and neck to prevent movement ..."</p> <p>On 11/3/17 at 8:37 am, Nurse's Notes (NN) documented Resident #2 was found on the floor at bedside with a laceration to her neck and a puncture wound to her left cheek. The resident's head and neck were under the bed frame at the time she was discovered on the floor of her bedroom.</p> <p>On 11/14/17 at 6:45 am, RN #1 stated she had been one of the first staff in the room when Resident #2 was found. RN #1 stated there was "blood all over the floor," which was "coming from her jaw and neck." RN #1 stated prior to the arrival of emergency medical personnel, facility staff "log rolled" Resident #2 onto a blanket, which was then used by staff to lift the resident onto her bed. RN#1 stated there was one staff at each corner of the blanket when the lift occurred, and that none of those present stabilized</p>	F 281			

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F 281	Continued From page 52 Resident #2's neck during the entire transfer procedure. On 11/14/17 at 1:30 pm, the DNS stated she was on the scene with RN #1 after Resident #2 was discovered on the floor. The DNS stated Resident #2's head and neck were slightly under the bed and there was fresh blood on her left hand, hair, and shoulder at the time the resident was discovered on the floor. The DNS stated the resident's neck was "checked" the best she could in that position and then staff moved her out from under the bed with one person holding the resident's neck for support. The DNS stated in that position, she was able to assess the resident's neck and address the bleeding. The DNS stated the resident "seemed restless and like she didn't want to be on the floor," so the DNS directed staff to "log roll" the resident onto a blanket, then transfer the resident back to bed with a staff member stationed at each corner of the blanket. The DNS stated when the resident's neck was not stabilized when she was lifted from the floor and to the bed. The DNS stated responding paramedics placed a towel on the resident's neck to control the bleeding and a hard collar on her neck to stabilize her spine before proceeding with any other treatments.	F 281			
F 314 SS=D	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-	F 314		12/18/17	

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F 314	<p>Continued From page 53</p> <p>(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</p> <p>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to implement interventions to prevent the development of pressure ulcers. This was true for 1 of 1 resident (#2) sampled for pressure ulcer prevention and created the potential for harm if Resident #2 developed pressure ulcers. Findings include:</p> <p>Resident #2 was admitted to the facility on 3/1/16 with diagnoses that included Alzheimer's disease and muscle weakness. Resident #2 was receiving hospice services as part of her treatment in the facility.</p> <p>The quarterly Minimum Data Set (MDS), dated 8/17/17, documented Resident #2 had severe cognitive impairment and was dependent on 2 staff for all Activities of Daily Living (ADLs), transfers, and bed mobility. The MDS documented the resident was at risk of developing pressure ulcers.</p> <p>An 8/22/17 care plan documented Resident #2 was to wear heel protectors or have her heels</p>	F 314	<p>F314</p> <p>Resident #2 without any signs of pressure injury. Heels were floated and protective material placed in between any area of skin to skin contact.</p> <p>Current residents had full skin assessment to determine any areas of skin breakdown with no other resident affected. Care plans updated as needed to address skin breakdown. Residents reviewed for appropriate cushions and bed surfaces for their risk factor. Nursing staff have been re-educated on pressure injury breakdown prevention.</p> <p>Preventative devices (keen heel lifts and bed positioners) have been ordered. RCM will complete a weekly audit on any resident that requires staff assistance for mobility for appropriate devices in place to prevent skin breakdown and for any redness present x4 weeks then once monthly x3.</p>		

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F 314	Continued From page 54 floated in bed, initiated 2/28/17, and an air mattress provided by a hospice agency. On 11/13/17 from 9:52 am to 11:10 am, Resident #2 was observed laying in bed on her back with white cotton socks on her feet. The resident's heels were resting directly on the surface of the bed. On 11/14/17 at 5:12 am, Resident #2 was observed wearing socks on both feet. The resident's right lower leg/ankle was crossed over the top of the left lower leg/ankle and the resident's left heel was in contact with the mattress. As CNA #3 and CNA #4 began incontinence care, CNA #3 uncrossed the resident's legs and the resident's heels remained in contact with the mattress during and after the incontinence care was provided. On 11/5/17 at 10:10 am, Resident #2 was observed laying in bed with her legs separated by a pillow and cotton socks on her feet. The resident was laying on her right side with the outer aspect of her right heel in direct contact with the mattress. The heel was slightly red where it was touching the mattress. The Director of Nursing (DNS), who was present, stated the resident's heels should have been floated or heel protectors in place. During the above observations, no heel protectors were observed in the room. There were no pillows present to float Resident #2's heels during the first two observations.	F 314	The outcome of the RCM weekly skin audits will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify opportunities for performance improvement. Administrator/DNS or Designee will be responsible. Compliance date: 12/18/2017		
F 323 SS=G	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3)	F 323		12/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/15/2017
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F 323	<p>Continued From page 55</p> <p>(d) Accidents. The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(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.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with 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: Based on observation, interview, and record review, it was determined the facility failed to provide adequate supervision and assistance to prevent falls. This was true for 1 of 3 residents (#2) reviewed for falls and resulted in harm to Resident #2 when she fell from bed and sustained lacerations to her left cheek and neck which required 11 sutures. Findings include:</p> <p>Resident #2 was admitted to the facility on 3/1/16</p>	F 323	<p>F323 Resident #2 sustained an injury relating to her fall. Resident #2 received treatment for the injuries related to the fall. The care plan was reviewed and updated to reduce the risk of future falls and to clarify the amount of assistance needed with transfers.</p> <p>Review of all residents that require</p>		

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NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
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F 323	<p>Continued From page 56 with diagnoses that included Alzheimer's disease and muscle weakness. Resident #2 was receiving hospice services as part of her treatment in the facility.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 8/17/17, documented Resident #2 experienced severe cognitive impairment and was dependent on 2 staff for all Activities of Daily Living (ADLs), transfers, and bed mobility.</p> <p>Resident #2's care plan, revised 8/22/17, did not document the level of assistance Resident #2 required for ADLs, transfers or bed mobility. The care plan directed staff to check for airbed placement and inflation as needed.</p> <p>A hospice Clinical Summary, dated 9/3/17, documented Resident #2 had an air mattress.</p> <p>A Bedside Care Plan, provided to surveyors on 11/13/17, contained an undated intervention documenting Resident #2 required the assistance of 2 staff for positioning.</p> <p>On 11/3/17 at 8:37 am, Resident #2's Nurse's Notes (NN) documented, "... CNA came into nursing station [and] stated that she found resident on the floor ... on her left side next to the bed with her head noted under the bed and her lower body out from the bed ... had a fresh pool of blood present under her, her left hand and hair were also bloody ... source of bleeding noted to [be] a half circular laceration with what appeared to be a puncture to her left cheekbone and an 8 [centimeter long] deep laceration to left jawline/upper neck area ... Paramedics arrived</p>	F 323	<p>extensive to total assistance with bed mobility were reviewed to determine the need for 2 assistance and care plans updated to reflect the need and proper bed positioning. Nursing staff have been re-educated on proper bed positioning, use of 2 assist with residents that require assistance, and prevention of falls/injury</p> <p>RCM will complete weekly audits of residents at high fall risk to ensure proper positioning in bed, call light within reach, bed in the lowest position, and nursing staff providing 2 assist for residents that require the need, and no restraints being used x8 weeks and then monthly for 3 months.</p> <p>All residents at risk of falls will have a care plan with interventions to prevent falls or minimize significant injury from falls. The care plans will be reviewed and updated quarterly and with any change in condition. CNA's and Licensed Nurses will receive ongoing education on fall prevention.</p> <p>The RCM fall risk audit will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>Administrator/DNS or Designee will be responsible.</p> <p>Compliance date: 12/18/2017</p>		

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F 323	<p>Continued From page 57 and resident transported via 911 ambulance with 2 attendants ..."</p> <p>On 11/3/17 at 3:06 pm, a NN documented Resident #2 returned to the facility with 3 sutures to her left cheek and 8 to the left side of her neck.</p> <p>On 11/3/17 at an undocumented time, CNA #3's staff statement regarding the incident documented, "I have seen her move by pushing with hands. Her right hand was out and so was her left hand. She was on her right side facing the wall, her hips were out a little more towards the side of the bed."</p> <p>On 11/3/17, Resident #2's care plan was updated to inform staff she could neither understand the call light's purpose nor how to use it. Staff were directed to conduct "enhanced rounds" and to remove the call light from Resident #2's room "to avoid any injury." The call plan also documented 2 staff were to provide assistance with bed mobility/repositioning and incontinence care.</p> <p>On 11/10/17, a facility Investigations Summary documented:</p> <p>* "...[CNA #3] reported she turned [Resident #2] four times total while providing peri care, twice to remove the old attend and [absorbent pad] then two more times to put the new items underneath her. She reports that [Resident #2] is generally easy to roll with one person assist and during cares she rolled well without difficulty..."</p> <p>* "...Through demonstration...[CNA #3] said/showed she [Resident #2] had her upper body directly in the center of the bed with her</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/15/2017
NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
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F 323	<p>Continued From page 58</p> <p>head on the pillow but her buttocks area was at an angle (buttocks angled outward towards the side of the mattress..."</p> <p>* "...[due to] the air mattress surface being more slippery potentially could have caused her to slide off the bed. The resident is unable to stop any momentum of her body falling which probably caused her to fall off the bed."</p> <p>* "Conclusion...no call light to be placed as resident cannot understand/use and will reduce any future injury; Enhanced rounding which staff will check on her more frequently due to no call light; will always use 2 staff assist with bed mobility and incontinent care..."</p> <p>On 11/13/17 at 3:40 pm, CNA #2 stated she was the staff member who discovered Resident #2 on the floor the morning of 11/3/17. CNA #2 stated she entered Resident #2's room at approximately 6:40 am to get the resident up from bed and ready for breakfast, but did not see the resident in her bed. CNA #2 stated she initially presumed the night shift aides had already awoken Resident #2 and taken her to the dining room for breakfast when she heard Resident #2 "jabbering." CNA #2 noticed Resident #2 laying on the floor "on her left side with her head and neck under the bed." CNA #2 stated there was blood coming from Resident #2's neck and shoulder, and she quickly left the room to get a nurse.</p> <p>On 11/13/17 at 4:20 pm, CNA #3 stated she had been assigned to care for Resident #2 the night before her fall. CNA #3 stated Resident #2 required assistance to change her brief twice that</p>	F 323			

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F 323	<p>Continued From page 59</p> <p>night. CNA #3 stated 2 CNAs changed the resident's brief on the first occasion, and that she (CNA #3) changed Resident #2's brief the second time without assistance. CNA #3 stated she rolled Resident #2 back and forth in the bed several times to change the brief, then positioned the resident on her right side in the bed. CNA #3 stated she was told Resident #2's position on the bed caused her to fall to the floor when the air mattress fluctuated. CNA #3, however, stated, "But I don't think that's what happened." CNA #3 stated Resident #2 was wrapped tightly in a blanket at night to prevent her from scratching her peri area, which caused the resident to become restless and agitated. CNA #3 stated, "I think she was trying to get out of the wrap and pushed herself out of the bed."</p> <p>On 11/14/17 at 10:55 am, a hospice nurse familiar with Resident #2 stated, "[Resident #2] did not fall out of bed by rolling herself. She couldn't have done that in July, and hospice patients don't get better and more independent. There is no way she had that ability in November."</p> <p>On 11/14/17 at 1:45 pm, the Director of Nursing Services (DNS) stated she was the first licensed nurse (LN) on the scene when Resident #2 was discovered on the floor. The DNS stated she did her best to recreate the scene before the fall, and determined Resident #2 most likely fell due to her positioning on the bed. The DNS stated when Resident #2 was positioned on her right side in the air bed, her hips and buttocks would have been angled towards the edge of the bed. The DNS stated Resident #2's functional status would not have enabled her to stop her momentum</p>	F 323			

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F 323	<p>Continued From page 60</p> <p>when the alternating pressure of the air bed likely led to the resident's hips and buttocks sliding off the edge of the bed. The DNS stated the facility had recently changed MDS nurses, and she was unaware Resident #2's MDS assessment documented 2 staff were required to assist the resident with bed mobility, positioning, and incontinence care. The DNS stated the facility updated Resident #2's care plan after the fall to require the assistance of 2 staff for all cares.</p> <p>On 11/13/17 at 9:52 am, Resident #2 was observed laying on her back in bed on an Air Dyne Pro air mattress. The resident's body alignment was straight and she was in the center of the bed, which was in the corner of the room with the headboard and right side each against a wall. The bed was not visible from the hallway and required an observer to take several steps into the room before it could be seen. From 9:52 am to 10:10 am, the resident did not move or open her eyes. The bed had bolsters at the head and foot of the mattress on both sides, with an approximate one-foot gap in the bolsters that aligned with Resident #2's hips and buttocks. There was no odor in the room, and no staff or visitors entered the room during the 18 minute observation.</p> <p>On 11/13/17, from 10:12 am to 11:05 am, the following was observed:</p> <p>* Between 10:12 am and 10:30 am, CNA #8, who was charting while standing at a kiosk in the hallway several doors down from Resident #2's room, stated he was assigned to care for residents on the hall, including Resident #2. When asked about "enhanced rounding," CNA #8</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/15/2017
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F 323	<p>Continued From page 61</p> <p>looked puzzled and stated, "That doesn't mean anything to me. I've never heard of it."</p> <p>* At 10:12 am, a nurse aide student entered Resident #2's room, retrieved a used water mug, brought it into the hallway, filled it with fresh water, and returned it to the resident's room. The student was in the room for 15 seconds.</p> <p>*No staff or visitors entered or approached the resident's room from 10:12 am to 10:49 am.</p> <p>*At 10:43 am, CNA #6, who was at the end of the hallway where Resident #2's room was located, stated she "guessed" enhanced rounds meant "you double check" the resident.</p> <p>*At 10:45 am, Resident #2 remained in bed, in the same position she had been since 9:52 am and the room now had a strong odor of urine and feces.</p> <p>*At 10:49 am, Resident #2's roommate entered the room in her wheelchair, went to her own side of the room, and activated her call light.</p> <p>* At 10:50 am, CNA #1 and CNA #7 entered Resident #2's room in response to the roommate's call light. For the next 10 minutes, the 2 CNAs assisted Resident #2's roommate to transfer onto the toilet with a sit-to-stand mechanical lift before leaving the room without approaching or speaking to Resident #2. The odor of urine and feces remained.</p> <p>* At 11:05 am, an unknown staff member entered the room to speak to Resident #2's roommate in the bathroom, but did not come far enough into</p>	F 323			

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F 323	<p>Continued From page 62</p> <p>the room to see Resident #2. CNA #s 1 and 7 entered the room as the unidentified staff person was leaving, went into the bathroom and assisted Resident #2's roommate off the toilet. At 11:08 am, both CNAs left the room, along with Resident #2's roommate; neither CNA #1 nor CNA #7 approached or spoke to Resident #2.</p> <p>On 11/13/17 at 11:10 am, CNA #1 said she was "just now told" Resident #2 required "enhanced rounds." CNA #1 stated she was told "enhanced rounds" included ensuring Resident #2 was in the center of the bed and "not on the floor." CNA #7 said, "And her call light is in reach." CNA #8, who was standing nearby at the charting kiosk, said, "No call light. She's care planned for no call light." CNA #8 stated, "I check on [Resident #2] every time I go in to take care of her roommate." All three CNAs present stated they checked on Resident #2 every 20 minutes and had done so that morning.</p> <p>On 11/13/17 at 12:25 pm, the DNS stated she had initiated "enhanced rounds" after Resident #2's fall on 11/3/17 and directed staff to remove the resident's call light. The DNS stated there was no documented policy or protocol for "enhanced rounds." The DNS stated she expected staff to observe Resident #2 hourly. When informed of the 10:12 am to 11:10 am observation, the DNS stated, "The problem is, if they don't know what [enhanced rounding] means, it's hard to do." The DNS said the amount of time that staff did not check on Resident #2 was "too long."</p> <p>On 11/13/17 at 4:30 PM, CNA #3, who was assigned to care for Resident #2 the night of the</p>	F 323			

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F 323	Continued From page 63 fall, stated she had worked many times with the resident since the fall. When asked about "enhanced rounds" as directed in Resident #2's care plan, CNA #3 stated, "I have no idea. I've never heard that term before." On 11/14/17 at 12:40 pm, Resident Care Manager (RCM) #1 stated he had all staff sign an educational inservice directing staff to provide "enhanced monitoring" after Resident #2 fell. RCM #1 stated though there was no policy, procedure, or written direction as to what "enhanced monitoring" entailed, he "presumed" all staff understood they should check on Resident #2 at least hourly.	F 323			
F 353 SS=F	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	F 353		12/18/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/15/2017
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F 353	<p>Continued From page 64</p> <p>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 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, interview, and record review, it was determined the facility failed to ensure adequate staffing and effective communication between staff was provided to meet residents' needs. This was true for 1 of 6 sampled residents (#2) and 3 random sample residents (#8, #9, and #10) reviewed for adequate staffing and created the potential for harm should residents not receive the care and services necessary to attain or maintain their</p>	F 353	<p>F353</p> <p>Resident council minutes were reviewed for the last 90 days and staffing concerns were addressed.</p> <p>Residents will be interviewed to determine harm or dissatisfaction from lack of staffing.</p>		

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F 353	<p>Continued From page 65</p> <p>highest practicable level of well being. Findings include:</p> <p>1. Resident Council</p> <p>Resident Council meeting minutes documented 9 residents attending an 8/28/17 meeting voiced concerns about the nurses "attitude in the morning," call lights not being answered in a timely manner, and an inadequate number of Certified Nursing Assistants (CNAs).</p> <p>The minutes from a 9/25/17 Resident Council meeting attended by 9 residents documented concerns with sufficient numbers of staff to meet residents' needs, call lights not being answered in a timely manner, and the need for "more consistent" showering.</p> <p>Resident Council meeting minutes documented 10 residents attending a 10/30/17 meeting voiced no concerns with call light response times, showering, or inadequate staffing.</p> <p>On 11/15/17 at 2:30 pm, the Activities Director (AD) said she attended the Resident Council meetings in August, September and October 2017, and communicated the Resident Council's concerns in August and September to the Director of Nursing Services (DNS). The AD said nursing staff were in-serviced and there were no Resident Council concerns regarding call light response times voiced at the October 2017 meeting.</p> <p>On 11/15/17 at 2:35 pm, Resident #8, who was the Resident Council President, stated staffing had been an ongoing issue of concern in the</p>	F 353	<p>Staffing schedules are reviewed on an ongoing basis for adequate staff. Contract staff is used to ensure adequate staffing as needed. Progressive Hire on bonuses are being advertised to attract all levels of Nursing staff (C.N.A, LPN, RN). Shift bonuses are offered, to current staff to fill-in for any call-ins, as determined by DNS and Administrator. Staffing Plan Duty protocols are in place to accommodate any failed attempts to fill staff call-in's to ensure patient care needs are met.</p> <p>Residents with concerns will be interviewed once a week for 8 weeks then once a month for 3 months to resolve any further dissatisfaction from lack of staffing.</p> <p>Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>Administrator/DNS or Designee will be responsible.</p> <p>Compliance date: 12/18/2017</p>		

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F 353	<p>Continued From page 66</p> <p>facility for several months. The Resident Council President stated Council members agreed an "ideal" staffing level would consist of 2 CNAs for each of the facility's 2 units with an additional CNA "float" between the two for additional support. Resident #8 stated the facility typically staffed 2 CNAs per unit without an additional CNA providing supplemental support. Resident #8 stated, "They have a shower aide instead. But the problem with that is, if someone calls in, they take the shower aide for the day. And if there is no shower aide when someone calls in, they just work short-staffed. We've talked about it for months in Council." Resident #8 stated staffing assignment changes had recently been enacted, however "it's only been in the last week or so, not long enough yet to make sure it's working."</p> <p>2. Resident Interviews</p> <p>a) On 11/13/17 at 7:55 am, Resident #9 said it "sometimes" took half an hour for night shift staff to answer her call light.</p> <p>b) On 11/13/17 at 8:30 am, Resident #10 stated there were not enough staff and that it was common for staff to take 20 - 25 minutes for staff to answer her call light. Resident #10 stated she often used a motorized wheelchair to search for staff rather than wait for their response to her call light. Resident #10 stated, "I don't think it's any faster [now]; there are never enough of them, but at least I feel like I'm doing something."</p> <p>3. Staff Interviews</p> <p>a) On 11/13/17 at 3:40 pm, CNA #2 stated the facility was short-staffed on night shift, often with</p>	F 353			

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F 353	<p>Continued From page 67</p> <p>"only" 3 CNAs working due to a lack of available staff and call-ins, which was not enough to take care of several residents who required assistance from 2 staff. CNA #2 stated it was not uncommon for the facility to ask CNAs who were "exhausted" after finishing a difficult night shift to stay extra hours so all of the residents were assisted from bed on time.</p> <p>b) On 11/13/17 at 4:20 pm, CNA #3 stated there were not enough staff working in the facility, and critical information was not communicated to direct care staff. Specifically, CNA #3 cited:</p> <p>* Residents who were supposed to have 2-staff assistance at night often only had the assistance of 1 staff, especially when there were call-ins or an inadequate number of staff scheduled to work.</p> <p>* Night shift CNAs were not consistently updated with information on those residents in their care. CNA #3 stated, "We get shift report when we first come on, but that information is not always good. We can ask the nurse, and sometimes the nurse knows, but not always. If the nurse doesn't know, we check to see if the [bedside care plan] is in the room, but it's not always there, and often it's not updated, so then we just guess how much help they need."</p> <p>* CNA #3 stated staff were not provided with adequate information even for those residents whose care needs had not changed. CNA #3 stated, "We don't know who is diabetic. If someone asks for juice, we have been told to give them juice. We don't know who is on thickened liquids. If they ask for a drink, we are told to give it to them. "</p>	F 353			

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F 353	<p>Continued From page 68</p> <p>* CNA #3 stated, "When there are less than [sic] 4 CNAs on night shift, we just get exhausted. It's frustrating. There's no way we can keep an eye on everyone." CNA #3 stated since she had started working at the facility several months prior, many new staff had been hired "then just walked out when they saw how short [staffed] we have to work." CNA #3 stated the facility now had "about 5 CNAs" rotating through the 4-position schedule 7 nights per week. CNA #3 stated when more than one staff was scheduled to have a night off, 3 CNAs were left to cover the 4 positions. CNA #3 stated, "We just run and run all night. We don't take breaks. We are frustrated, exhausted, and burned out. I've seen aides just start crying because someone falls, and they know it's because the person needed help and we couldn't get there. That's what happened the night [Resident #2] fell. We only had 3 aides that night. We had been running for 8 hours nonstop. That's when mistakes happen. "</p> <p>c) On 11/14/17 at 1:45 pm, RN #2 stated the facility needed more staff, especially for residents who required 2-staff assistance. RN #2 stated the facility had hired a number of new staff recently, but it was difficult to ensure senior staff members worked with new staff while they became familiar with the residents. RN #2 stated many staff expressed frustration when there were call-ins or not enough staff scheduled for a shift.</p> <p>d) On 11/14/17 at 2:30 pm, the DNS stated the facility had been working to address staffing issues. The DNS stated she was working on more consistent assignments and ensuring newer staff were paired with more senior</p>	F 353			

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F 353	<p>Continued From page 69 personnel for training and orientation.</p> <p>e) On 11/15/17 at 2:20 pm, CNA #9 stated her primary duty was to provide Restorative Nursing services to residents in the facility. CNA #9 stated it was common for her to be pulled away from Restorative duties on Sundays due to staff shortages providing direct care to residents outside of restorative services. CNA #9 stated, "On Sundays, I'm supposed to [weigh residents], but when I get pulled to the floor the weights don't get done. Then on Tuesday, when the dietician comes in, she doesn't have the information to get her job done. At one time, I was supposed to weigh over 30 residents on my shift."</p> <p>f) On 11/15/17 at 2:20 pm, LPN # 2 stated, "I'm usually the one who [reassigns CNA #9] and I don't like to. Residents get upset when they don't get their Restorative. One resident not too long ago was crying when she didn't get it, because she had worked so hard on her fine motor abilities in her hand. She was terrified she was going to lose it, but basic care has to come first."</p> <p>4. Record Review</p> <p>Resident #2 was admitted to the facility on 3/1/16 with diagnoses that included Alzheimer's disease and muscle weakness. Resident #2 was receiving hospice services as part of her treatment in the facility.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 8/17/17, documented Resident #2 had severe cognitive impairment and was dependent on 2 people for all</p>	F 353			

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F 353	<p>Continued From page 70 incontinence care, transfers, and bed mobility.</p> <p>On 11/3/17 at 8:37 am, Resident #2's Nurses Notes (NN) documented she was found on the floor next to her bed with lacerations to her left cheek and neck.</p> <p>On 11/13/17 at 4:20 pm, CNA #3 stated she had been assigned to care for Resident #2 on the night shift leading up to the fall. CNA #3 stated the last time she had cared for Resident #2 on 11/3/17 between 5:00 am and 5:30 am, she had provided care alone, as there were only 3 CNAs assigned to that shift and no other staff was available to assist her.</p> <p>On 11/14/17 at 8:35 am, Resident #2's Power of Attorney (POA) stated the facility did not have enough staff. On 11/7/17, Resident #2's POA stated she had been present when 1 CNA entered Resident #2's room, provided incontinent care, and transferred the resident from bed to a wheelchair with a mechanical lift. Resident #2's POA stated the CNA told her it was acceptable for her to provide the care alone because she was a more experienced CNA, which is why the facility had scheduled her to work alone. Resident #2's POA stated, "Watching her do this by herself, you could see how an accident could happen."</p> <p>On 11/14/17 at 10:55 am, the DNS for Resident #2's hospice agency stated hospice had "long ago" determined the resident required 2 staff assistance for "almost everything." The hospice DNS stated when hospice staff came in to provide services to the resident, the availability of facility staff to provide 2-staff assistance for cares</p>	F 353			

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F 353	Continued From page 71 was "inconsistent," so the agency had started sending two caregivers at a time to ensure safety. 5. Leadership Interviews On 11/15/17 at 3:22 pm, in a joint interview with the DNS and Administrator, the DNS stated the Resident Council had made the facility aware that residents were concerned with call light response times. The DNS stated the facility educated all staff to respond to call lights. The DNS stated if a resident had a simple need, such as refreshing their water or adjusting the heat in the room, anyone who answered the call light was expected to address that need. The Administrator stated the facility identified staffing to be an area of concern, had been using "agency galore" in an effort to ensure adequate numbers of staff, and had begun offering sign-on bonuses and bonuses to staff who referred a successful candidate.	F 353			
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving,	F 431		12/18/17	

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F 431	<p>Continued From page 72</p> <p>dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>(h) Storage of Drugs and Biologicals.</p> <p>(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose</p>	F 431			

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F 431	<p>Continued From page 73 can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure a discontinued medication was secured from unintended unauthorized access. This was true for 1 of 5 residents (#2) reviewed for medication administration and created the potential for harm if an independently mobile resident, or unauthorized staff, accessed the medication or used it incorrectly. Findings include:</p> <p>On 11/14/17 at 5:12 am, Certified Nursing Assistant (CNA) #3 and CNA #4 were observed providing incontinence care for Resident #2. Upon completion of cares, CNA #4 removed a tube from the resident's bedside table drawer, squeezed out some cream, and applied it to the resident's peri area. CNA #4 then returned the tube to the resident's bedside drawer.</p> <p>On 11/14/17 at 5:40 am, Registered Nurse (RN) #1 was observed finding a tube of barrier cream and ointment, and a partially used 3.75 ounce tube of 2% Miconazole nitrate antifungal cream in Resident #2's bedside table drawer. The RN said the antifungal cream should not be in the drawer, it was not labeled with Resident #2's name, and only a nurse was authorized to administer the medication. RN #1 removed medication from the resident's room and said she would appropriately dispose of it.</p> <p>On 11/14/17 at 6:05 am, CNA #4 said she applied the "barrier cream" to Resident #2's peri area after incontinence care at 5:12 am that day.</p>	F 431	<p>F431</p> <p>Resident #2 had all treatment creams removed from resident's bedside table.</p> <p>Current residents' rooms checked for any treatment supplies present. Contacted Hospice services were to avoid placing any treatment supplies at resident's bedside and to be given to licensed nursing staff for proper storage in the treatment cart. Nursing staff re-educated on scope of practice and appropriate orders for treatments. Pharmacy nurse consultant completed full house assessment of proper medication storage.</p> <p>The RCM will conduct weekly audits of resident rooms and all medication storage areas to ensure no medications or treatments are at bedside and stored properly once a week x4 weeks then monthly x3 months.</p> <p>Audit findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to identify opportunities for performance improvement.</p> <p>Administrator/DNS or Designee will be responsible.</p> <p>Compliance date: 12/18/2017</p>		

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

PRINTED: 12/22/2017
FORM APPROVED
OMB NO. 0938-0391

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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December 22, 2017

Nathan Chinchurreta, Administrator
Karcher Post-Acute & Rehabilitation Center
1127 Caldwell Boulevard
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr. Chinchurreta:

On **November 15, 2017**, an unannounced on-site complaint survey was conducted at Karcher Post-Acute & Rehabilitation Center.

The complaint was investigated during a Complaint Survey conducted at the facility from November 13, 2017 to November 15, 2017.

Immediately after entering the facility, the survey team conducted a general tour of residents' rooms and common areas. Throughout the survey, five individual residents and all residents in general were observed for quality of care, signs of distress, and quality of life issues. In addition, facility staff was observed providing care, interacting with residents and responding to residents' needs and requests.

The clinical records of the identified resident and four other residents were reviewed for quality of life and quality of care concerns, including falls, accommodation of need, abuse and neglect concerns, pressure ulcers, medication management, grievances, and care planning. The facility's grievance files, Incident and Accident reports, staffing records, and self-reported-incidents were reviewed. A full medication pass review was completed and an abridged abuse task investigation was completed. The identified resident's records documented she sustained a fall with injury.

Interviews were conducted with multiple individual residents. Several direct care staff, including nurses and nursing aides, were also interviewed, as well as the Director of Nursing Services, Social Worker, Resident Care Manager, Activities Director, and Hospice personnel. Interviews

included questions about staffing, abuse and neglect, restraints, care plans, falls, grievances and investigations, pressures ulcers, and other quality of life and quality of care issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007668

ALLEGATIONS #1:

The facility failed to provide sufficient monitoring to ensure an identified resident did not fall and sustain injuries. The facility failed to ensure the identified resident was positioned properly in bed.

FINDINGS #1:

Based on interviews with residents and facility staff, there were concerns with residents sustaining injuries after falls and grievances not investigated or resolved.

Based on observation, interview, and record review, the allegation was substantiated and the facility was cited at F221, F246 and F323. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility failed to ensure it completed a thorough investigation after an identified resident sustained injuries of unknown origin.

FINDINGS #2:

An abridged abuse and neglect task was completed in which five sampled residents, five random residents, and all other residents were observed while staff provided care throughout the survey.

The identified resident was observed tightly wrapped in blankets while in bed.

The identified resident's record and injury of unknown origin investigation were reviewed. The injury of unknown origin did not include interviews from all staff present and/or those who responded to the event. The investigation did not include pertinent information provided by staff who cared for the identified resident the night of the injury.

Based on observation, record review, and investigation review, the allegation was substantiated and the facility was cited at F225 and F226. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility did not respond to complaints or follow-up on grievances.

FINDINGS #3:

Three individual residents and one family member were interviewed regarding grievances, complaints, and voiced concerns regarding the facility's failure to follow-up on complaints and grievances.

The facility grievance file and Incident and Accident reports were reviewed and noted to have concerns with inconsistent follow-up.

Multiple residents' records were reviewed and determined not to have included documentation regarding complaints and/or grievances that were filed, but not investigated or resolved.

Interviews were conducted with various staff members, including the Social Worker, Director of Nursing Services, and Certified Nursing Assistants who stated the facility's grievance system needed to be reevaluated to correct issues of concern.

Based on observation, interview, record review, and review of the facility's grievances and Incident and Accident reports, the allegation was substantiated and the facility was cited at F166. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The facility did not have an adequate number of staff.

Nathan Chinchurreta, Administrator
December 22, 2017
Page 4

FINDINGS #4:

Interviews were conducted with four individual residents and an interested party who had concerns the facility was inadequately staffed.

Several direct care staff, including nurses and nursing aides, were also interviewed and stated they thought the facility should have more staff to care for residents.

The facility's Resident Council Meeting minutes documented nine residents attended the meeting on August 28, 2017 and reported staff took an excessive amount of time to answer call lights. The residents stated the facility was inadequately staffed.

Based on interviews with residents and facility staff, there were concerns with inadequate staffing levels, and the allegation was substantiated and cited at F280, F281, F314, F353, and F431. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

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

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

NS/lj