



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS 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
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January 22, 2018

Landon Taylor, Administrator
Life Care Center Of Idaho Falls
2725 East 17th Street
Idaho Falls, ID 83406-6601

Provider #: 135091

Dear Mr. Taylor:

On **January 12, 2018**, a survey was conducted at Life Care Center Of Idaho Falls by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 1, 2018**. Failure to submit an acceptable PoC by **February 1, 2018**, may result in the imposition of penalties by **February 16, 2018**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **February 16, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on

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April 12, 2018. A change in the seriousness of the deficiencies on **February 26, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 12, 2018** includes the following:

Denial of payment for new admissions effective **April 12, 2018**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 12, 2018**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 12, 2018** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **February 1, 2018**. If your request for informal dispute resolution is received after **February 1, 2018**, 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, appearing to read "David Scott", written in a cursive style.

David Scott, RN, Supervisor
Long Term Care

ds/dr
Enclosures

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

PRINTED: 06/05/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2018
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from January 9, 2018 through January 12, 2018.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Edith Cecil, RN Cecilia Stockdill, RN</p> <p>Survey Abbreviations: CNA = Certified Nurse Assistant D/C = Discontinue DM = Director of Maintenance DON = Director of Nursing F = Fahrenheit LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = milligrams RN = Registered Nurse W/C = Wheelchair</p>	F 000		
F 584 SS=E	<p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p>	F 584		2/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/01/2018
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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 584	<p>Continued From page 1</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and resident and staff interview, it was determined the facility failed to ensure shower water temperatures were comfortable for residents. This was true for 2 random residents (#s 42 and 48), 2 of 7 residents in a group interview (#30 and #42), and 3 of 5 shower/tub rooms and had the potential to adversely affect all residents bathed in the 100,</p>	F 584	<p>F584 Safe/Clean/Comfortable/Homelike Environment</p> <p>Specific Resident: Resident #30, #42, and #48 have been interviewed for shower water temperature satisfaction and educated on comment and concern program.</p>		

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F 584	<p>Continued From page 2</p> <p>200, and 400 hallway shower rooms. Findings include:</p> <p>The facility's December 2017 Water Temperature Log documented that on 12/27/17 water temperatures throughout the facility ranged from 94.8 F (Fahrenheit) to 108.3 F, and on 1/5/18 water temperatures ranged from 99.1 F to 118 F.</p> <p>On 1/9/18 at 1:00 PM, Resident #42 said the water temperature in the 200-hallway shower room would initially feel adequate, but would often turn "cold" during her shower.</p> <p>On 1/9/18 at 4:20 PM, Resident #48 said the water temperature in the 400-hallway shower room fluctuated from being "too cold" or "too hot."</p> <p>On 1/10/18 at 2:00 PM, during a resident group interview, Resident #30 said the water temperature in the 200-hallway shower room was "cold" and Resident #42 said she agreed.</p> <p>On 1/11/18 at 8:35 AM, CNA #1 said shower temperatures in the 200-hallway had been low a few months prior, had improved, but had turned cold again a few weeks later. CNA #1 said it took several minutes for the water to heat up in the shower.</p> <p>On 1/11/18 at 8:39 AM, CNA #2 said some residents told her the showers were not always hot enough.</p> <p>On 1/11/18 at 10:19 AM, CNA #3 said shower water in the 400-hallway took a few minutes to heat up to a comfortable temperature.</p>	F 584	<p>Other Residents: Residents residing in the facility requiring use of shower/tub rooms will receive bathing at temperatures within the regulated guideline.</p> <p>Systemic Changes: 1) Facility maintenance staff received education on regulatory guidelines for acceptable water temperature ranges. 2) Facility maintenance personnel adjusted water temperature gauge to meet regulatory guidelines. 3) Facility wide audit completed on utilized shower/tub room water temperatures to ensure temperature within regulatory guidelines. 4) Direct care educated on comment and concern program for resident voiced concerns.</p> <p>Monitoring: Maintenance Director or designee to audit utilized shower/tub room water temperatures to ensure they fall within regulatory parameters. 3x weekly x4 weeks continuing 2x weekly x 4weeks continuing 1x weekly x 4 weeks. Audit results will be reviewed by ED weekly X12 weeks. Audit results to be presented at Resident Council and concerns related to water tempiture to be addressed if any x3 months. Results of audit will be reviewed at QAPI for trending and ongoing education and compliance.</p>		

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F 584	Continued From page 3 On 1/11/18 at 11:02 AM, CNA #4 said shower temperatures had warmed and cooled recently, been corrected, but "iffy" water temperatures had returned and the maintenance department had been informed. On 1/11/18 from 1:20 PM to 1:40 PM, water temperatures tested by the DM in the 200-hallway shower room reached a high of 102 F; water temperatures in the 400-hallway shower room reached a high of 96 F; and water temperatures in the 100-hallway shower room reached a high of 103.6 F. The DM said the shower room water temperatures were low.	F 584			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		2/15/18	

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F 623	<p>Continued From page 4</p> <p>made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related</p>	F 623			

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F 623	<p>Continued From page 5</p> <p>disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to ensure transfer notices were provided to a resident and the local ombudsman. This was true</p>	F 623	<p>F623 Notice Requirements Before Transfer/Discharge</p> <p>Specific Resident: Resident #52 was</p>		

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F 623	<p>Continued From page 6</p> <p>for 1 of 2 residents (#52) sampled for transfers and had the potential for harm if residents were not aware of- or able to exercise their rights as members of a long-term care facility. Findings include:</p> <p>Resident #52 was admitted to the facility on 6/17/16, and readmitted on 12/21/17, with diagnoses that included multiple sclerosis.</p> <p>Nursing progress notes and a 12/18/17 Physician's Order documented Resident #52 was sent to a local emergency room by non-emergent ambulance for evaluation. The clinical record did not document Resident #52 or the local ombudsman were notified of the transfer.</p> <p>On 1/9/18 at 9:40 AM, Resident #52 said she was recently transferred and admitted to a local hospital.</p> <p>On 1/11/18 at 9:18 AM, the DON said the resident had not been given a notice of transfer and that the facility had not informed the ombudsman of the transfer to a local hospital emergency room.</p>	F 623	<p>transferred on 12/14/17 and readmitted to facility on 12/21/17; resident no longer requires written notification of discharge and transfer notification. If resident requires discharge/transfer will be provided written notification of discharge at time of discharge or when practicable. Ombudsman will be notified with monthly report.</p> <p>Other Residents: Residents and/or resident representative residing in the facility and are transfer to a acute care setting for evaluation /treatment which leads to temporary admission to acute care setting will be provided written notification of discharge at time of discharge or when practicable. Ombudsman will be notified of this type of discharge in addition monthly.</p> <p>Systemic Changes: 1) Social Services to add facility initiated discharges and/or transfers to acute care settings to monthly Ombudsman notification. Social Services educated on this. 2) LN education provided related to resident/representative written notification including discharge/transfer to acute care setting at time of discharge/transfer or when practicable.</p> <p>Monitoring: 1) ED or designee will audit monthly Ombudsman's list of applicable discharge/transfer notification completeness. Weekly x 12 weeks, and monthly review for submission x3 months. 2) Social services or designee will audit</p>		

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F 623	Continued From page 7	F 623			
F 625 SS=D	<p>Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced</p>	F 625	<p>for discharge/transfer notification provided to resident or representative. 2x weekly for 4 weeks, continuing, weekly for 8weeks. Results of audit will be reviewed at QAPI for trending and ongoing education and compliance.</p>	2/15/18	

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F 625	<p>Continued From page 8</p> <p>by: Based on record review and resident and staff interview, it was determined the facility failed to ensure bed-hold agreements were provided to a resident. This was true for 1 of 4 residents (#52) sampled for discharges. The deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include:</p> <p>Resident #52 was admitted to the facility on 6/17/16, and readmitted on 12/21/17, with diagnoses that included multiple sclerosis.</p> <p>The facility's Bed Hold policy, dated 11/28/16, documented residents would be provided bed-hold information by written notification, either upon transfer or within 24 hours of an emergent transfer.</p> <p>Nursing progress notes and a physician's order, dated 12/18/17, documented Resident #52 was sent to a local emergency room by non-emergent ambulance for evaluation.</p> <p>The clinical record did not document Resident #52 received a bed-hold notification.</p> <p>On 1/9/18 at 9:40 AM, Resident #52 said she was recently sent and admitted to a hospital.</p> <p>On 1/11/18 at 9:18 AM, the DON said the resident was not given a bed-hold notice.</p>	F 625	<p>F625: Notice of Bed Hold Policy Before/Upon Transfer</p> <p>Specific Resident: Resident #52 was transferred on 12/14/17 and readmitted to facility on 12/21/17; resident no longer requires written notification of Bed Hold Policy. If resident requires transfer will revive notification of bed hold policy. Resident will also receive policy with facility population.</p> <p>Other Residents: Residents residing in the facility and/or their representative who are transferred to a acute care setting for evaluation /treatment which leads to temporary admission to acute care setting will be provided written notification of Bed Hold Policy at time of discharge or transfer or when practicable.</p> <p>Systemic Changes: 1) Resident and/or resident representative to be provide state/facility Bed Hold Policy at time of discharges and/or transfers to acute care settings or within 24 hours of discharge and/or transfer. 2) Bed Hold Policy will be entered into facility admission packet and all active residents and/or resident representative will be provided a copy of Bed Hold Policy. 3) LN and social services education related to resident/representative written notification of Bed Hold Policy prior to discharge/transfer or within 24 hours to acute care setting prior to discharge/transfer or within 24 hours. 4)</p>		

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F 625	Continued From page 9	F 625	Admission packet developer will have education to include bed hold policy in admission packet. Monitoring: Medical Records or designee will audit for Bed Hold Policy provided to resident and/or representative at time of discharge/transfer to acute care setting and/or therapeutic leave within 24 hours and present in medical record. 3x weekly for 12 weeks. Admission packets will be reviewed monthly by ED to ensure Bed Hold Policy present X3 months. Results of audit will be reviewed at QAPI for trending and ongoing education and compliance.		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		2/15/18	

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F 656	<p>Continued From page 10 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to develop a resident-specific care plan for medications used to treat anxiety. This was true for 1 of 19 residents (#35) sampled for care plan development and had the potential for harm if residents experienced continued anxiety or a deterioration in mental health status when medication prescribed for anxiety was not monitored in a timely manner and resident-specific behaviors were not identified. Findings include: Resident #35 was admitted to the facility on</p>	F 656	<p>F656 Develop/Implement Comprehensive Care Plan</p> <p>Specific Resident: Resident #35 had anxiety behavior monitoring initiated 1/11/2018. Comprehensive care plan updated to direct staff to record anxiety episodes in behavior monitoring in MAR.</p> <p>Other Residents: Residents residing in the facility with a diagnosis of anxiety with medications for treatment will have a comprehensive care plan developed to address mental illness diagnosis and</p>		

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F 656	<p>Continued From page 11 8/29/17 with diagnoses that included depression, insomnia, and anxiety.</p> <p>Resident #35's admission physician orders included Fluoxetine 80mg daily for depression, Ambien 10mg at bedtime for insomnia, and Hydroxyzine 50mg 4 times daily for anxiety.</p> <p>A Social Service assessment, dated 8/30/17, questioned if the resident displayed signs of depression, anxiety, or was exhibiting behavioral symptoms, to which LSW #1 documented Resident #35 exhibited signs of depression and insomnia. The assessment did not address Resident #35's anxiety diagnosis nor the resident's anti-anxiety medication.</p> <p>Resident #35's care plan for alteration in mood and social behavior due to depression, dated 8/29/17, included a hand-written entry for the diagnosis of anxiety, dated 9/14/17. Interventions directed staff to record depression episodes on the behavior chart in the MAR. There was no direction for staff to record behaviors related to anxiety, which specific behaviors related to anxiety should be monitored, or what interventions should be implemented when the resident exhibited signs/symptoms of anxiety.</p> <p>Behavior/Intervention Monthly Flow Records for tracking Resident #35's anxiety-related behaviors were located in the clinical record for November 2017, December 2017, and January 2018. The clinical record did not contain anxiety-related behavior monitoring for September and October 2017.</p> <p>On 1/11/18 at 10:13 AM, the DON stated specific</p>	F 656	<p>behavior monitoring will also be initiated.</p> <p>Systemic Changes: 1) Social Services educated on non-psychotropic medication off label use of treatment of mental illness. 2) Social Services to review diagnosis of facility residents when developing comprehensive care plan and need for any behavior monitoring. 3) House wide audit completed for diagnosis of anxiety for adequate monitoring and plan of care.</p> <p>Monitoring: DON or designee will audit comprehensive care plans specific to behavior monitoring in relation to anxiety to ensure that behavior monitoring current on residents with medications in relation to anxiety. 2x week for 4 weeks continuing, 1x week for 8 weeks. Results of audit will be reviewed at QAPI for trending and ongoing education and compliance.</p>		

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F 656	Continued From page 12 anxiety-related behaviors had not been identified for Resident #35 that staff were to monitor, and LSW #1 stated she did not know Hydroxyzine, an antihistamine, required a behavior monitor when used to treat anxiety as it was not a psychotropic medication.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) 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:	F 657		2/15/18	

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F 657	<p>Continued From page 13</p> <p>Based on observation, record review, and interview, it was determined the facility failed to ensure residents' care plans were revised as care needs changed. This was true for 2 of 14 sampled residents (#18 and #24) reviewed for care plan revision and had the potential for harm if cares and/or services were not provided due to inaccurate information. Findings include:</p> <p>1. Resident #18 was readmitted to the facility on 9/8/17 with multiple diagnoses, including Down Syndrome.</p> <p>The 11/3/17 quarterly MDS assessment documented Resident #18 was severely cognitively impaired and required extensive assistance from staff for all activities of daily living.</p> <p>From 1/9/18 at 2:09 PM through 1/11/18 at 9:50 AM, Resident #18 was observed in his room watching various movies on a DVD player on nine separate occasions.</p> <p>On 1/10/18 at 3:47 PM, Resident #18's Interested Party said the resident enjoyed watching movies and that family had recently brought in several new DVD movies for the resident to watch. The Interested Party said the resident had been going out of the facility several times a month with a family member for music programs and other activities designed for adults with special needs. The Interested Party said the resident had not been going to the programs during the previous month due to concerns with the influenza season.</p> <p>On 1/10/18 at 4:05 PM, CNA #5 said Resident</p>	F 657	<p>F657 Care Plan Timing and Revision</p> <p>Specific Resident: Resident #18 care plan was revised to include DVD, musical movies, for enjoyment and out of facility specialized programs with family including transportation. Resident #24 has returned to community with spouse.</p> <p>Other Residents: Residents who enjoy viewing movies in their room for personal activity will have comprehensive care plan to reflect resident preference. Residents whom attend out of facility specialized programs will have comprehensive care plans to reflect resident preference and transportation. Residents who have wedge cushions in wheelchair discontinued will be reflected in comprehensive care plan.</p> <p>Systemic Changes: 1) Facility and facility Activity Director at time of survey have had a separation of employment. 2) MDS coordinator, Social Services, upon hire Activity Director will have education on comprehensive care plan development and revision to include DVD enjoyment and out of facility specialized programs including transportation. 3) ADON educated on discontinuation of wedge cushion and care plan revisions. 4) House wide audit completed for resident with care planned intervention for wedge cushion is still active. 5) House wide audit completed for residents who enjoy in room movie activities and attend off of facility specialized programs to also</p>		

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F 657	<p>Continued From page 14</p> <p>#18 liked to watch DVDs and leave the facility with family for a special program for disabled adults.</p> <p>On 1/10/18 at 4:21 PM and 1/11/18 at 1:01 PM, the Activity Director (AD) said Resident #18 enjoyed watching movies and that family had brought in several new movies for Christmas. She said after admission to the facility, the resident began off-campus excursions with family twice a month to attend a special community sponsored activity. The AD said Resident #18 also began leaving the facility with family twice a month to attend a church-sponsored religious musical activity designed for disabled adults with special needs. She said the facility transported the resident when he went to the church sponsored activity, but the community-sponsored program drove the resident when the facility van was unavailable to take him. The AD said Resident #18 had not been going out recently due to the family's concern with flu, but would resume when the family was ready. She said neither programs nor transportation arrangements had been added to the resident's care plan, and noted the resident's fondness for movies, new DVD movies, and off-campus activities were not on the care plan.</p> <p>2. Resident #24 was admitted to the facility on 11/16/17 with diagnoses that included traumatic subdural hemorrhage, ataxia (difficulty with muscle coordination) following a stroke, and cognitive communication deficit.</p> <p>The Admission MDS, dated 11/23/17, documented Resident #24 was unable to communicate verbally, cognitively impaired, and rarely made decisions. Resident #24 was able to</p>	F 657	<p>include transportation.</p> <p>Monitoring: ED or designee will audit 10% of resident population care plans specific to activities. Weekly x12 weeks. Nurse Manager or designee to audit residents with wedge cushions care planned weekly for 12 weekly. Results of audit will be reviewed at QAPI for trending and ongoing education and compliance.</p>		

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F 657	Continued From page 15 find her room and recognize family and staff; required extensive staff assistance for bed mobility, transfers, dressing, eating, toileting, and personal hygiene; and was totally dependent on staff for locomotion. An 11/16/17 Fall Risk Evaluation documented Resident #24 was at high risk for falls with a score of 24. The Fall Risk Evaluation documented any resident with a score of 10 or greater was at risk for falls. Resident #24's Fall Care Plan, dated 11/27/17, directed staff to keep the call light within the resident's reach, and to report any fall to the physician and interested party. A 12/12/17 revision directed staff to place a wedge cushion in Resident #24's wheelchair. On 1/11/18 at 8:45 AM, Resident #24 was observed in the therapy room. The Occupational Therapist (OT), when asked to describe the cushion in the resident's wheelchair, stated it was not a wedge cushion. On 1/11/18 at 9:10 AM, the Assistant Director of Nursing (ADON), assisted by another staff member, confirmed the cushion in Resident #24's wheelchair was not a wedge cushion. The ADON reviewed the care plan and stated, "That is my fault. Therapy asked me to d/c that (wedge cushion) and I didn't get it done."	F 657			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		2/15/18	

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F 689	<p>Continued From page 16 as free of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure fall prevention interventions were implemented following a fall. This was true for 1 of 2 residents sampled for falls (#24) and had the potential for harm if the resident sustained an injury from a fall. Findings included:</p> <p>Resident #24 was admitted to the facility on 11/16/17 with diagnoses that included traumatic subdural hemorrhage, ataxia (difficulty with muscle coordination) following a stroke, and cognitive communication deficit.</p> <p>The Admission MDS, dated 11/23/17, documented Resident #24 could not communicate verbally, was cognitively impaired, and rarely made decisions. Resident #24 could find her room and recognize family and staff; required extensive staff assistance for bedmobility, transfers, dressing, eating, toileting, and personal hygiene; and was totally dependent on staff for locomotion.</p> <p>A Fall Risk Evaluation, dated 1/9/18, documented Resident #24 was at high risk for falls with a score of 24. The Fall Risk Evaluation documented any score of 10 or greater represented a risk for falls.</p> <p>An Incident/Accident report, dated 1/9/18,</p>	F 689	<p>F689 Free of Accident Hazards/Supervision/Devices</p> <p>Specific Resident: Facility investigation completed after Resident #24 discovered in her room alone in WC after completing a therapy session. Resident #24 had care plan reviewed and continuation of interventions. Resident #24 has returned to community with spouse.</p> <p>Other Residents: Rehabilitative residents residing in facility with a fall intervention directing staff to not leave resident unsupervised in room in wheelchair will be communicated to therapy staff when intervention initiated.</p> <p>Systemic Changes: 1) Rehab/direct care staff educated on communicating with LN prior to leaving resident independently in wheelchair in resident room. 2) Rehab/direct care staff educated on communicating with Rehab department per changes in plan of care related to supervision in room.</p> <p>Monitoring: DON or designee to audit residents participating in rehabilitation that are not to be left independently in room for intervention compliance.</p>		

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F 689	Continued From page 17 documented Resident #24 was found sitting on the floor in her room within 4 steps of her w/c and with an abrasion to the left side of her forehead. The resident was transferred to an emergency room for treatment. The Fall Care Plan, revised on 1/9/18, directed staff not to leave Resident #24 in her wheelchair alone in her room. On 1/11/18 at 9:10 AM, the ADON and surveyor observed Resident #24 alone in her wheelchair in her room. At 9:27 AM, a nurse entered Resident #24's room and offered to place her in a recliner or bed, or take her to activities.	F 689	3x a week for 4 weeks, continuing, 2x weeks for 4 weeks, continuing, 1x a week for 4 weeks. Results of audit will be reviewed at QAPI for trending and ongoing education and compliance.		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		2/15/18	

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F 755	<p>Continued From page 18</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(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>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure narcotic counts were consistently verified by an oncoming or off-going nurse. This was true for 1 of 2 medication carts as well as Narcotic Cards Count for 4 of 42 opportunities. This failure created the potential for undetected misuse and/or diversion of controlled medications and the potential for harm if a controlled medication was not available when needed. Findings include:</p> <p>The facility's undated Policy and Procedure regarding Controlled Drugs documented, "Narcotics are counted at the change of each shift by the off-going and the on-coming nurse and both sign the Change of Shift Count Record."</p> <p>The Hallway 2 medication cart narcotic count sheet documented the following:</p> <p>* 1/1/18: 6:00 AM - 6:00 PM - the on-duty nurse signature space was blank.</p>	F 755	<p>F755 Pharmacy Services/Procedure/Records</p> <p>Specific Resident: No specific resident noted.</p> <p>Other Residents: Residents who receive narcotic medication will have their verification of on-going and off-going LNs sheet completed.</p> <p>Systemic Changes: 1) Direct care LN staff educated on completion of shift change narcotic log. 2) Nurse Management educated on monitoring completion of shift change narcotic log.</p> <p>Monitoring: Nurse Manager and or designee to audit completion of shift change narcotic log. 3x week for 4 weeks, continuing, 2x week for 4 weeks, continuing, 1x week for 4 weeks.</p>		

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F 755	Continued From page 19 * 1/6/18: 6:00 AM - 6:00 PM - the off-duty nurse signature space was blank. * 1/7/18: 6:00 AM - 6:00 PM - the off-duty nurse signature space was blank. The off-duty nurse signature space was blank on the Narcotic Cards Count for 1/7/18, 6:00 AM - 6:00 PM. On 1/11/18 at 3:28 PM, LPN #1 said he did not know the reason there were not two signatures in the indicated areas where there should have been two signatures from each shift change nurse.	F 755	Results of audit will be reviewed at QAPI for trending and ongoing education and compliance.		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the	F 880		2/15/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/12/2018
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F 880	<p>Continued From page 20</p> <p>facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.</p>	F 880			

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F 880	<p>Continued From page 21</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff consistently performed standard hand hygiene to reduce the risk of infection. This was true for one RN (DON) and one CNA (#4) during observation of a meal and had the potential to affect two residents (#13 and #3) who were assisted with eating in Hallway #3 dining room. This failed practice created the potential for harm if residents developed infection from cross-contamination. Findings include:</p> <p>The Centers for Disease Control and Prevention web page Hand Hygiene in Healthcare Settings, updated 3/24/17, documented hand hygiene should be performed "before and after having direct contact with a patient's intact skin" and "after contact with inanimate objects ... in the immediate vicinity of the patient."</p> <p>The facility's Hand Hygiene Policy, revised 4/1/15, did not address hand hygiene between resident contacts.</p> <p>On 1/9/18 at 12:34 PM, the DON was observed feeding Resident #13 and Resident #3 in Hallway #3 dining room. At multiple times, the DON made direct contact with Resident #13 and Resident #3's intact skin by touching the residents' arms</p>	F 880	<p>F880 Infection Prevention & Control</p> <p>Specific Resident: Resident #13 has deceased since time of annual survey. Resident #23 not able to receive direction or education due to cognitive limitations.</p> <p>Other Residents: Residents requiring direct assistance for eating will receive assistance from qualified facility staff using proper hand hygiene.</p> <p>Systemic Changes: 1) Education provided to qualified facility staff able to assist with feeding on proper hand hygiene.</p> <p>Monitoring: SDC or designee to audit proper hand hygiene while assisting residents to eat during meal time. 3x week for 4 weeks, continuing, 2x week for 4 weeks, continuing, 1x week for 4 weeks. Results of audit will be reviewed at QAPI for trending and ongoing education and compliance.</p>		

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F 880	<p>Continued From page 22 and hands. The DON did not perform hand hygiene after touching one resident and prior to feeding the other resident.</p> <p>On 1/9/18 at 12:41 PM, CNA #4 was observed feeding Residents #13 and Resident #3 in Hallway #3 dining room. At multiple times, CNA #4 made direct contact with Resident #13 and Resident #3's intact skin by touching the residents' arms, hands, and faces. CNA #4 did not perform hand hygiene after touching one resident and prior to feeding the other resident.</p> <p>On 1/9/18 at 12:52 PM, the DON said if staff touched only the residents' utensils, performing hand hygiene was not necessary. However, the DON stated, if anything else was touched then staff must sanitize their hands between residents.</p> <p>On 1/9/18 at 12:55 PM, CNA #4 said she tried not to use both hands for one resident, but instead attempted to use one hand for each resident. CNA #4 said if she used both hands for feeding a resident then she sanitized her hands between residents.</p> <p>On 1/12/18 at 9:35 AM, the Staff Development Coordinator said a staff member feeding two residents should keep one hand dedicated to each resident and perform hand hygiene if there was any contact with either resident.</p>	F 880			

Bureau of Facility Standards

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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey conducted at the facility from January 9, 2018 through January 12, 2018.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Edith Cecil, RN Cecilia Stockdill, RN</p>	C 000		
C 445	<p>02.120,13,c Hot Water Temps 105-120 Degrees F</p> <p>c. The temperature of hot water at plumbing fixtures used by patients/residents shall be between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit.</p> <p>This Rule is not met as evidenced by: Based on observation, and resident and staff interview, it was determined the facility failed to ensure shower water temperatures were comfortable for residents. This was true for 2 random residents (#s 42 and 48), 2 of 7 residents in a group interview (#30 and #42), and 3 of 5 shower/tub rooms and had the potential to adversely affect all residents bathed in the 100-, 200-, and 400 hallway shower rooms. Findings include:</p> <p>The facility's December 2017 Water Temperature Log documented that on 12/27/17 water temperatures throughout the facility ranged from 94.8 F (Fahrenheit) to 108.3 F, and on 1/5/18 water temperatures ranged from 99.1 F to 118 F.</p> <p>On 1/9/18 at 1:00 PM, Resident #42 said the water temperature in the 200-hallway shower</p>	C 445	C445 Hot Water Temps 105-120 degrees F. Refer to F584.	2/15/18

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
02/01/18

Bureau of Facility Standards

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C 445	<p>Continued From page 1</p> <p>room would initially feel adequate, but would often turn "cold" during her shower.</p> <p>On 1/9/18 at 4:20 PM, Resident #48 said the water temperature in the 400-hallway shower room fluctuated from being "too cold" or "too hot."</p> <p>On 1/10/18 at 2:00 PM, during a resident group interview, Resident #30 said the water temperature in the 200-hallway shower room was "cold" and Resident #42 said she agreed.</p> <p>On 1/11/18 at 8:35 AM, CNA #1 said shower temperatures in the 200-hallway had been low a few months prior, had improved, but had turned cold again a few weeks later. CNA #1 said it took several minutes for the water to heat up in the shower.</p> <p>On 1/11/18 at 8:39 AM, CNA #2 said some residents told her the showers were not always hot enough.</p> <p>On 1/11/18 at 10:19 AM, CNA #3 said shower water in the 400-hallway took a few minutes to heat up to a comfortable temperature.</p> <p>On 1/11/18 at 11:02 AM, CNA #4 said shower temperatures had warmed and cooled recently, been corrected, but "iffy" water temperatures had returned and the maintenance department had been informed.</p> <p>On 1/11/18 from 1:20 PM to 1:40 PM, water temperatures tested by the DM in the 200-hallway shower room reached a high of 102 F; water temperatures in the 400-hallway shower room reached a high of 96 F; and water temperatures in the 100-hallway shower room</p>	C 445		

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C 445	Continued From page 2 reached a high of 103.6 F. The DM said the shower room water temperatures were low.	C 445		