



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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February 12, 2018

Mark High, Administrator
Idaho State Veterans Home - Lewiston
821 21st Avenue
Lewiston, ID 83501-6389

Provider #: 135133

Dear Mr. High:

On **January 26, 2018**, a survey was conducted at Idaho State Veterans Home - Lewiston by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 22, 2018**. Failure to

submit an acceptable PoC by **February 22, 2018**, may result in the imposition of penalties by **March 19, 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*.

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The remedies, being recommended includes the following:

- Civil Monetary Penalty
- Denial of payment for new admissions effective **April 26, 2018**. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 25, 2018**, if substantial compliance is not achieved by that time.

Mark High, Administrator
February 12, 2018
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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 Debby Ransom, RN, RHIT Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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.

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

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/ta/bid/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 22, 2018**. If your request for informal dispute resolution is received after **February 22, 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 me at (208) 334-6626, option 5.

Sincerely,



Debra Ransom, RN, RHIT,
Chief, Bureau of Facility Standards

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

PRINTED: 02/26/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/26/2018
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501		
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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from January 22, 2018 through January 26, 2018. The surveyors conducting the survey were: Edith Cecil, RN Team Coordinator Brad Perry, LSW Cecilia Stockdill, RN Survey Abbreviations: ADLs = Activities of Daily Living CM = centimeters CNA = Certified Nursing Assistant C/O = complains of COPD = Chronic Obstructive Pulmonary Disease DON = Director Of Nursing HTN = Hypertension LN = Licensed Nurse LPN = Licensed Practical Nurse MAR = Medication Administration Record mcg = micrograms MD = Medical Director/Doctor mg = milligrams MDS = Minimum Data Set R/T = Related to RN = Registered Nurse SDTI = suspected deep tissue injury SNF = Skilled Nursing Facility WA = Wound Assessment WCN = Wound Care Note WS = Weekly Skin/Wound Progress Note	F 000			
F 637 SS=D	Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility	F 637		2/23/18	

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

TITLE

(X6) DATE

Electronically Signed

02/21/2018

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 637	<p>Continued From page 1</p> <p>determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, it was determined the facility failed to complete a comprehensive assessment when a resident experienced a significant change in their health and functional status. This was true for 1 of 14 sample residents (#26) and had the potential for harm if facility staff did not recognize changes in the resident's health status and needs. Findings include:</p> <p>Resident #26 was admitted on 11/16/17 with multiple diagnoses including malignant neoplasm (cancer) of the pancreas, prostate, and colon.</p> <p>Resident #26's 11/22/17 Admission MDS Assessment documented the following:</p> <ul style="list-style-type: none"> * Cognitively intact. * No behaviors indicating an acute change in mental status. * There were no verbal behavioral symptoms towards others. * Did not reject care. * Did not exhibit wandering. 	F 637	<p>F <input type="checkbox"/> 637 D <input type="checkbox"/> the facility failed to complete a comprehensive assessment when a resident experienced a significant change in their health and functional status.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. The resident affected by the deficient practice was being assessed as a change of condition when identified by the survey team. The resident passed away from a terminal illness prior to the completion of the assessment therefore no further action was required.</p> <p>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>a. All current and future residents have the potential to be affected by the deficient practice. A review of each current residents' status was conducted</p>		

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F 637	<p>Continued From page 2</p> <p>* The resident required supervision-oversight, encouragement or cueing when walking in his room, extensive assistance with bed mobility, one person physical assistance with transfers, supervision when walking in his room, and one person physical assistance with locomotion.</p> <p>* Always continent of bowel.</p> <p>* There were no falls in the last 1-6 months prior to admission or since admission.</p> <p>Resident #26's Nursing Note, dated 11/16/17 at 1:52 PM, documented he appeared alert and oriented times 4.</p> <p>A Physician Note, dated 11/22/17, documented "no anxiety, no depression, no memory loss."</p> <p>Resident #26's Nursing Notes documented the following:</p> <p>* On 12/6/17 at 3:21 PM, Resident #26 fell in his room and sustained two skin tears on his left arm.</p> <p>* On 12/27/17 at 10:50 AM, new orders were received to increase the Fentanyl patch to 25 mcg and morphine sulfate 5 mg every 4 hours as needed for breakthrough pain.</p> <p>* On 1/6/18 at 1:57 PM, Resident #26 was "in a very grumpy mood" and "refused to let me help him at all...refused to let me change his dressing on his forehead too."</p> <p>*On 1/8/18 at 3:16 AM, Resident #26's "day and night seems up side down." The resident used his call light to ask for the time and where his medications were, then came out of his room to</p>	F 637	<p>by the facility's ITD team and those experiencing a change of condition was evaluated against RAI Change of Condition guidelines. Three additional residents were identified as meeting the RAI/MDS criteria for a change of condition and the required assessment period was initiated, according to RAI guidelines/regulations.</p> <p>3. What measure will be put into place or why systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>a. The MDS Coordinator will review MDS assessment information and participate as a member of the Clinical team to determine if a resident's situation/change of condition constitutes a "change of condition" by RAI definition and initiate a change of condition assessment.</p> <p>b. The facility's ITD and licensed nursing staff were educated related to the RAI criteria that constitutes a "change of condition". Staff encouraged to notify the nursing management team if they believe/identify a resident who is experiencing a change of condition.</p> <p>c. The Clinical Meeting, conducted each business day, will review of the 24-hour report, PPC documentation for Behaviors, Skin/Wound, Nurse progress notes, and resident weights, to identify residents who may be experiencing a change of condition and ensure a "Change of Condition" MDS assessment was initiated.</p> <p>4. How the corrective action(s) will be</p>		

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F 637	<p>Continued From page 3 ask for the time.</p> <p>Resident #26's Incident Note, dated 1/9/18 at 9:39 PM, documented he was found on the floor in his room.</p> <p>A Restorative Progress Note, dated 1/10/18 at 12:17 PM, documented a transfer bar was placed on the right side of his bed to assist with turning, repositioning, and "safe transfer."</p> <p>A Behavior Progress Note, dated 1/15/18 at 5:38 AM, documented Resident #26 seemed restless for the past three nights, coming to the nurse's station to ask the time then traveling back and forth between the nurse's station and his room. "Once [in] a while he would talked to staffs [sic] in a[n] angry tone and loud voice."</p> <p>A Nursing Note, dated 1/22/18 at 5:48 PM, documented a Wanderguard (alarm) was placed due to the Resident #26 propelling himself outside the building.</p> <p>Resident #26's clinical record documented he had additional falls on 1/23 and 1/25/18.</p> <p>*Nursing Note, dated 1/24/18 at 10:58 PM, documented Lorazepam (an anti-anxiety medication) 0.5 mg one-half tablet every 4 hours as needed for anxiety related to end of life, anxiety, air hunger, or restlessness.</p> <p>On 1/25/18 at 10:08 AM, the DON said it was noticed the resident exhibited changes starting on 1/5/18, such as his behavior and wandering, anxiety and restlessness. The DON said they had been "looking at" doing a change in condition</p>	F 637	<p>monitored to ensure the deficient practice will not recur.</p> <p>An audit will be conducted by the DNS/designee on random resident medical records to ensure resident's experiencing a change of condition (consistent with RAI criteria) were assessed for a significant change of condition. This audit will be done weekly x 4, then monthly x 3. The results of this audit will be discussed/acted upon on the monthly QA/PI Committee meeting.</p> <p>5. When corrective action will be completed: 02/23/18</p>		

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F 637	Continued From page 4 assessment all week and discussed doing the assessment on that day. On 1/25/18 at 12:59 PM, the MDS nurse said the care plan was updated on that day due to the resident's fall earlier in the day. The MDS nurse said the change in condition assessment was mentioned in the morning on that day, they were going to do the assessment the next day anyway, and the resident had a few changes but "not as extensive as I would expect." Resident #26's admission MDS documented he did not have cognitive deficits, did not have behaviors or wandering, did not have bowel incontinence, and had no falls in the previous 1-6 months prior to admission. Beginning on 12/27/17, Resident #26 began to demonstrate significant changes in mood, sleep patterns, behavioral symptoms, bowel continence and experiencing falls. The facility failed to recognize a major decline in Resident #26's physical and mental condition.	F 637			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		2/23/18	

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F 655	<p>Continued From page 5</p> <p>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-</p> <p>(A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to develop and implement a baseline care plan within 48 hours of admission for 1 of 3 residents (#43) sampled for accurate and person-centered care plans.</p>	F 655	<p>F <input type="checkbox"/> 655 <input type="checkbox"/> D <input type="checkbox"/> the facility failed to develop and implement a baseline care plan within 48-hours of admission</p> <p>1. What corrective action(s) will be accomplished for those residents found to</p>		

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F 655	<p>Continued From page 6</p> <p>This created the potential for harm when the care plan failed to provide direction for care. Findings include:</p> <p>Resident #43 was admitted to the facility on 12/13/17 with diagnoses that included Adult Failure to thrive, Diabetes Mellitus Type 2, and dementia.</p> <p>A hospital Patient Discharge Report, dated 12/13/17, documented open skin measuring 1.0 cm by 1.0 cm to the left posterior hip with Mepilex placed and red/excoriated skin to the buttocks and scattered bruising and abrasions on the arms, legs, hands, and feet.</p> <p>The Admission Nursing Assessment, dated 12/13/17, documented a scar to the right lower leg and to the side of right foot as the only skin impairments.</p> <p>A Progress note, dated 12/13/17, documented Resident #43's feet were very dry with layers of skin present between toes and very long, thick toe nails.</p> <p>The baseline care plan, dated 12/13/17, documented preventative care for skin integrity. The assessment area for staff to document pressure ulcer, stages, and locations was blank.</p> <p>On 1/25/18 at 9:00 AM, the Director of Nursing stated she saw the skin impairment was not documented on the nursing assessment the day after admission.</p>	F 655	<p>have been affected by the deficient practice.</p> <p>The affected resident's baseline care plan was updated to reflect the skin integrity issue/interventions.</p> <p>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All newly admitted residents have the potential to be affected by the deficient practice. The ITD team reviewed all current 48-hour care plans to ensure they accurately reflected the resident's condition including but not limited to a) initial goals based on admission orders, b) physician orders, c) dietary orders, d) therapy services e) social services and f) PASARR recommendation(s) and updated as necessary.</p> <p>3. What measure will be put into place or why systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>a. An MDS Coordinator will be in the facility 7 days/week to ensure baseline care plans are completed timely and accurately reflect the condition of the newly admitted resident.</p> <p>b. The Baseline Care Plan was revised to ensure inclusion of all necessary items required to properly care for the resident (see above). The Baseline Care Plan was also revised to include a resident/family member signature line.</p> <p>c. Licensed nursing staff were trained to ensure Baseline Care Plans are timely updated based on assessments, resident</p>		

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F 655	Continued From page 7	F 655	condition, etc. d. New Admits will be reviewed/audited in the Clinical Meeting (conducted each business day) x 7 days to ensure assessment documentation is complete, baseline care plan is in place/accurate, etc. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur. a. The DNS/designee will conduct audits to ensure baseline care plans reflect interventions necessary to care for the residents and are developed within 48 hours following admit. The audits will be conducted weekly x 4, then monthly x 3 and the results of these audits will be reported at the monthly QA/PI meeting. 5. When corrective action will be completed: 02/23/18		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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 observation, record review, and staff interviews, the facility failed to ensure: * Neurological assessments were completed appropriately after resident falls. * Narcotic Card Count sheets were consistently signed by both the offgoing and oncoming nurse.	F 658	F <input type="checkbox"/> 658 E <input type="checkbox"/> the facility failed to ensure 1) neurological assessments were completed appropriately after resident falls 2) narcotic card count sheets were consistently signed by both the off-going and ongoing nurse 3) the quantify of remaining narcotic medication cards was consistently documented.	2/23/18	

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F 658	<p>Continued From page 8</p> <p>* The quantity of remaining narcotic medication cards was consistently documented.</p> <p>This was true for 3 of 3 sampled residents (#26, #50, and #205) reviewed for accidents and 2 of 2 medication carts reviewed for narcotic count sheets. This failure had the potential for harm should residents have undetected changes in neurological status after a fall and had the potential for undetected misuse and/or diversion of controlled medications, and had the potential for harm if a controlled medication was not available when needed. Findings include:</p> <p>The facility's Policy and Procedure for Neurological Assessments, dated 1/2015, documented the following: "Residents that have a fall with a suspected head injury such as: bruise, scrap[e], lying in suspected position suggestive of hitting head, or any other condition which warrants neurological checks will have a Neurological Assessment completed."</p> <p>The procedure for neurological assessment was documented as follows:</p> <ul style="list-style-type: none"> * every 15 minutes times 4 * every 30 minutes times 4 * every 1 hour times 4 * every 4 hours times 4 * every 24 hours times 2 <p>The facility's Policy and Procedure for Controlled Substances, dated 1/2015, documented the following:</p> <p>* Licensed nursing staff were directed to "account for all controlled substance inventory."</p>	F 658	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The three residents identified as being affected by the deficient practice (incomplete neuro-checks) did not sustain subsequent injury by the lack of complete neuro-checks. Timeframe for completing the neuro-checks had passed by the time the survey was conducted. No resident was negatively impacted by the missing signatures on the narcotic card count sheets, nor the missing quantity count.</p> <p>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>Any resident who experiences an unwitnessed fall or a fall with suspected head injury has the potential to be affected by the deficient practice. At the time of the survey no resident was being evaluated/neuro-checks in process for a possible head injury. Any resident who receives controlled narcotics has a potential to be impacted <input type="checkbox"/> no incidences of harm were identified related to the missing count/signatures. All medications were accounted for by the pharmacist.</p> <p>3. What measure will be put into place or why systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>a. Licensed nursing staff were educated related to the need to accurately and completely assess the resident per the neuro-check form guidelines. Staff were</p>		

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F 658	<p>Continued From page 9</p> <p>* The oncoming nurse and outgoing nurse were directed to physically count each controlled substance and verify the count with the inventory sheet.</p> <p>1. Resident #50 was admitted on 9/25/17 with multiple diagnoses including COPD, chronic atrial fibrillation (irregular heart rhythm), and abdominal aortic aneurysm.</p> <p>Resident #50's quarterly MDS Assessment, dated 12/26/17, documented moderate cognitive impairment, one person physical assist with transfers, and supervision-oversight when walking in his room or corridor.</p> <p>Resident #50's care plan documented he was at risk for falls and directed staff to provide interventions including the following: a rolling walker, wheelchair, gait belt, non-skid socks, auto-locking wheelchair brakes, extensive assist times 1 with bed mobility, and follow facility fall protocol if a fall should occur. The interventions were initiated on 10/5/17.</p> <p>Resident #50's Incident Report, dated 12/30/17 at 6:30 PM, documented an un-witnessed fall in his room. The "CNA reported to [the] LN that [the] resident told her he had a fall in his room and had got himself up [sic]."</p> <p>Resident #50's Incident Note, dated 12/30/17 at 10:03 PM, documented he reported to a CNA that he fell in his room when he "got weak and fell to the floor on his left side." The resident was able to get up by himself and denied hitting his head.</p>	F 658	<p>also inserviced to ensure resident was assessed even when the resident appeared to be sleeping. Nurses were also educated related to the newly revised Narcotic Card Count sheet which requires both nurses to sign/count at change of shift to ensure accurate count/presence of signatures.</p> <p>b. Neuro-check completion was included in the Licensed Nurse Competencies which are completed upon hire and annually thereafter.</p> <p>c. RN Manager has been assigned the responsibility to ensure neuro-checks are initiated and completed as directed. (On-going neuro-check forms will be located on the applicable medication cart).</p> <p>d. During the Clinical Meeting incident/accidents will be reviewed to ensure complete investigation has occurred, prevention interventions are in place, neuro-checks were initiated according to procedure, etc.</p> <p>e. The Narcotic Card Count sheet was revised to require the subtraction/addition of any narcotic cards to occur at change of shift, with ongoing/off-going nurses signing and verifying count.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur.</p> <p>a. Completed neuro-checks will be submitted to the DNS for review/further action and signature prior to scanning into the resident's medical record.</p> <p>b. Results of the review/audit of the neuro-checks will be presented to the</p>		

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F 658	Continued From page 10 Resident #50's Secure Conversation Note, dated 12/31/17 at 8:57 PM, documented he fell in his room "right after dinner" and did not tell a staff member until 8:30 PM. The resident got himself up and no injuries were found. The resident denied hitting his head, and neurological checks were initiated. Resident #50's Neurological Assessment Flowsheet documented "sleeping" on 12/31/17 at 12:15 AM, 1:15 AM, and 2:15 AM. On 1/25/18 at 4:51 PM, the DON said neuro checks probably should have been done in the areas indicated on the Neurological Assessment Flowsheet. 2. Resident #26 was admitted on 11/16/17 with multiple diagnoses including malignant neoplasm (cancer) of the pancreas, prostate, and colon. Resident #26's 11/22/17 Admission MDS Assessment documented he was cognitively intact, required extensive assistance with bed mobility, one person physical assistance with transfers, supervision when walking in his room, and one person physical assistance with locomotion. Resident #26's care plan directed staff to follow the facility fall protocol when a fall occurs. The intervention was initiated on 11/17/17. Resident #26's Incident Report, dated 1/5/18 at 6:15 AM, documented he was found on the floor in his room lying on his right side. There was blood on his fingers and the floor and a "3 X 2" (3	F 658	QA/PI monthly meeting x 3 months and quarterly thereafter. c. An audit of the Narcotic Card Count sheet will be conducted by the DNS/Designee weekly x 4, then monthly x 3. Results of the audit will be presented at the monthly QA/PI meeting. 5. When corrective action will be completed: 02/23/18		

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F 658	<p>Continued From page 11 by 2) wound on his forehead. The Resident Description documented "I was trying to get up." The Incident Report documented the "Resident self transfers without regard to safety." He transferred from bed and slipped, hitting his forehead on the bed frame.</p> <p>Resident #26's Incident Note, dated 1/5/18 at 10:11 AM, documented the unwitnessed fall as documented in the Incident Report.</p> <p>Resident #26's Neurological Assessment Flowsheet documented "BREAKFAST" on 1/5 at 7:00 and 7:15 AM and "Sleeping" on 1/5 at 9:15 PM and 1/6 at 1:15 AM.</p> <p>Resident #26's Incident Note, dated 1/23/18 at 10:08 PM, documented he was found on the floor next to his bed, sitting on buttocks, and the resident "claims he just slid out of bed." The incident note documented a pile of blankets was intertwined with his legs.</p> <p>On 1/23/18 at 10:35 AM, LPN #1 said Resident #26 was found on the floor this morning at 3:30 AM. A bruise was noted on the resident's right knee.</p> <p>On 1/25/18 at 9:46 AM, Resident #26's legs were on the floor and he was on his right side, hanging onto the side rail with his upper body partially on the bed. The resident's right knee was on the floor with the lateral (side) aspect of the knee and lower leg in full contact with the floor. Several staff members assisted the resident back into bed by lifting him off the floor and onto the bed.</p> <p>Resident #26's Nursing Note, dated 1/25/18 at</p>	F 658			

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F 658	<p>Continued From page 12</p> <p>10:39 AM, documented he was "sliding out of bed" and was "hanging onto the transfer rail..." The nursing note documented "This LN blocked [the] resident's feet so they would not continue sliding, a gait belt was placed on [the]resident...Staff assist of 4 bucket lifted resident back to a sitting position on the bed...neuro checks will continue from previous fall, 15 minute checks were implemented and staff in serviced. Will continue to monitor [the] resident."</p> <p>Resident #26's Incident Note, dated 1/25/18 at 10:00 AM, documented the fall as in the Nursing Note. A small abrasion was noted to the sacrum (tailbone area).</p> <p>Resident #26's Incident Report, dated 1/25/18 at 10:00 am, documented the un-witnessed fall as in the Nursing Note and Incident Note. The resident recently started Ativan (an anti-anxiety medication) as needed, was "trying to get out of bed without assistance, agitated and anxious."</p> <p>Resident #26's Neurological Assessment Flowsheets documented the facility failed to document neuro checks 4 times out of 38 opportunities from 1/5-1/12/18 and 25 out of 57 opportunities from 1/23-1/27/18, as directed by the facility's policy and procedure and the resident's care plan.</p> <p>On 1/25/18 at 4:51 PM, the DON said neuro checks probably should have been done in the areas indicated on the Neurological Assessment Flowsheet.</p> <p>3. Resident #205 was admitted on 1/18/18 with</p>	F 658			

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

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F 658	<p>Continued From page 13</p> <p>multiple diagnoses including cerebrovascular disease (disease of the vessels of the brain), low back pain, generalized osteoarthritis, and lack of coordination.</p> <p>Resident #205's Fall Risk Assessment, dated 1/18/18 at 4:13 PM, documented he had 1-2 falls in the past 3 months and was at moderate risk for falls.</p> <p>Resident #205's care plan, dated 1/19/18, documented he was at risk for falls and directed staff to provide cueing/limited assistance with ambulation, a walker, gait belt, shoes, non-skid socks, wheelchair with auto-locking brakes, and limited assist of 1 with bed mobility. The resident experienced a fall on 1/19/18 at 2:40 PM and fell again on 1/20/18 at 4:55 PM. Staff were directed to check on Resident #205 frequently and complete neurological checks according to facility policy,</p> <p>Resident #205's Incident Report, dated 1/19/18 at 2:40 PM, documented an un-witnessed fall in his room. The resident's roommate saw him slide to the floor when he attempted to get up and he landed "on his bottom." Resident #205 was unable to provide a description of what happened.</p> <p>Resident #205's Medicare A: Skilled Note, dated 1/19/18 at 4:10 PM, documented he required extensive assist of 2 for transfers and he "Will try to get up without help. Had a fall on day shift. Pleasantly confused."</p> <p>Resident #205's Incident Report, dated 1/20/18 at 4:20 AM, and Incident Note, dated 1/20/18 at</p>	F 658			

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F 658	<p>Continued From page 14</p> <p>4:20 AM, documented an un-witnessed fall in the dining room. Resident #205 was found by a CNA sitting on the floor and his left hand was holding onto the rail next to the dining room. The resident said he was "trying to go over there" as he pointed toward the medication cart.</p> <p>Resident #205's Neurological Assessment Flowsheet documented the following:</p> <ul style="list-style-type: none"> * "in therapy" on 1/19 at 2:45 PM and 3:15 PM * "Refused" on 1/19 at 3:45 PM and 4:15 PM * "Dinner" on 1/19 at 5:15 PM * "Refused" on 1/19 at 6:15 PM, 7:15 PM, and 8:15 PM * "Breakfast" on 1/20 at 7:15 AM, 8:15 AM, and 9:15 AM <p>On 1/25/18 at 4:51 PM, the DON said "we know he could move and there was no change because he was eating breakfast." The DON said neuro checks probably should have been done in the areas indicated on the Neurological Assessment Flowsheet.</p> <p>4. On 1/26/18 at 8:41 AM, the Narcotic Card Count sheet was reviewed for the West Hall medication cart. The "#" column (area where the quantity of remaining medication cards should be entered) was blank in 6 out of 76 opportunities. RN #1 said there was no reason why the numbers were not entered. RN #1 said the numbers should be entered in each indicated area and should match the actual count.</p>	F 658			

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F 658	Continued From page 15	F 658			
F 686 SS=G	<p>Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, resident interview, and record review, it was determined the facility failed to prevent the development and worsening of pressure ulcers, and failed to provide services to promote healing, prevent infection, and prevent new ulcers from developing for 2 of 7 residents (#43 and #107) reviewed for pressure ulcers. This failure resulted</p>	F 686	<p>F <input type="checkbox"/> 686 G <input type="checkbox"/> The facility failed to prevent the development and worsening of pressure ulcers, and failed to provide services to promote healing, prevent infection, and prevent new ulcers from developing.</p> <p>1. What corrective action(s) will be accomplished for those residents found to</p>	2/23/18	

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F 686	<p>Continued From page 16</p> <p>in harm to Resident #107 when he developed multiple pressure ulcers which became infected. Resident #43 was also harmed when he developed multiple pressure ulcers. Findings include:</p> <p>1. Resident #107 was admitted to the facility on 10/3/16 with multiple diagnoses which included diabetes mellitus, type 2, stroke, chronic kidney disease, and vascular dementia. The medical record indicated he was discharged on 1/3/17 to the hospital and readmitted to the facility on 1/6/17.</p> <p>The Admission Nursing Assessment, dated 10/3/16, documented a stage 1 pressure sore on the coccyx. The pressure ulcer was described as non-blanchable skin with redness, measuring 0.03 cm L(length) x (by) 0.03 cm W(width) x 0.00 cm D (depth).</p> <p>Resident #107's Admission MDS assessment, dated 10/10/16, documented significant cognitive impairment, a stage 1 pressure ulcer (intact skin with non-blanchable redness of a localized area usually over a bony prominence), pressure reducing devices were in place for bed and chair, required extensive assist of two or more staff for bed mobility, transfers, and toileting and did not reject care.</p> <p>The Braden Scale assessment, completed on 10/3/16 placed Resident #107 at risk for pressure ulcers.</p> <p>A Care Plan for wound to right heel, dated 10/4/16, documented the wound would resolve without complication. Interventions directed staff</p>	F 686	<p>have been affected by the deficient practice.</p> <p>a. Resident #43 was referred to the wound care specialist and new orders were received. Resident was referred to NAR (Nutrition-at-Risk) Committee. Wound is currently improving, according to the wound care physician.</p> <p>b. Resident #107 passed away prior to the survey.</p> <p>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>a. All current residents have the potential to be impacted by the deficient practice and were evaluated for skin integrity issues and results were reviewed by the Clinical Committee and interventions implemented as appropriate. No new pressure ulcers were identified. Residents with current pressure ulcers were evaluated for appropriateness of pressure relieving devices/wound care orders.</p> <p>3. What measure will be put into place or why systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>a. Admission Nursing Assessment will be completed on each new admit and re-admit, including comprehensive skin assessment.</p> <p>b. Residents will be evaluated for the potential for skin breakdown using the Braden Scale for predicting pressure wounds on admit and quarterly thereafter and interventions implemented according</p>		

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F 686	<p>Continued From page 17 to inform MD of worsening and signs and symptoms of infection.</p> <p>A care plan, dated 10/18/16, documented the Resident was not consistently able to manage pressure relief. The care plan goal, dated 10/18/16 and revised on 1/19/17, and 4/7/17, documented measures will be in place to ensure his skin remains intact and free of breakdown through the review period. Interventions included an air mattress to bed, and directed staff to check inflation every shift and as needed, observe heels daily for redness, purple discoloration, blistering, and bogginess when providing cares, changing clothes, and assisting to bed for naps or the night, complete skin assessments weekly and notify MD of any new areas of concern, observe skin for signs of infection and breakdown, report any areas of open skin, document location, size, treatment of skin injury, and report failure to heal, signs or symptoms of infection to MD, float heels while in bed wheelchair cushion to assist off-loading.</p> <p>An unscheduled MDS assessment, dated 11/21/16, documented Resident #107 had an unstageable wound with slough and/or eschar, no measurements were documented. The location was not documented.</p> <p>Nurse progress notes, dated 1/3/17, documented Resident #107 was seen at the wound clinic that day.</p> <p>A hospital History and Physical, dated 1/3/17, documented Resident #107 was transferred from the wound clinic to the emergency room for significantly worsening bilateral heel pressure</p>	F 686	<p>to identified risk.</p> <p>c. Residents with pressure injuries will be referred to NAR (Nutrition-at-Risk) Committee for further evaluation/intervention.</p> <p>d. Weekly skin assessments are conducted/documented on each resident and interventions put into place as skin integrity issues identified.</p> <p>e. Clinical Committee, each business day, reviews new admit skin assessments and nurse and skin/wound progress notes for any newly identified skin issues.</p> <p>f. A Weekly Skin and Wound Assessment (PCC) is completed on each pressure injury, surgical wounds, and other ulcers/wounds that have the potential to worsen/get infected.</p> <p>g. Weekly Skin and Wound Assessments are reviewed by the RN Sr. for completion and appropriate interventions/notifications, etc.</p> <p>h. Weekly Wound Rounds are conducted by the RN Mgr and floor nurse to evaluate wounds, ensure accurate assessment/documentation.</p> <p>i. A Weekly Skin Committee was instituted to review the weekly skin/wound documentation and related care plans to ensure proper interventions are in place for residents with impaired skin integrity and to ensure wound healing and to update care plans, as applicable and referrals made as applicable.</p> <p>j. Medical Records Director will audit weekly skin assessments to ensure they are complete and submit report to RN Mgr for review.</p>		

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F 686	<p>Continued From page 18</p> <p>ulcers, in the setting of uncontrolled diabetes. The assessment documented the right foot had a very large right heel blister which appeared ruptured. The left foot also had a very large blister which appeared intact. The redness extended across the top of the foot and up onto the middle aspect of the shin. X-ray of the right foot showed diffuse forefoot and midfoot soft swelling suggestive of edema or cellulitis. An X-ray of the left foot showed similar findings.</p> <p>A hospital Discharge Summary, dated 1/6/17, documented a debridement of the heel ulcers in the operating room was completed on 1/4/17. Resident #107 received antibiotic therapy for cellulitis.</p> <p>The facility's Admission Nursing Assessment, dated 1/6/17, documented the wound to the right heel measured 4.0 cm length x 6.2 cm width x 0.01 cm depth and the wound to the left heel measured 5.2 cm length x 3.0 cm width x 0.1 cm depth. The assessment documented the wounds as "other"-debridement. The note documented bilateral heels with superficial debridement, skin surrounding macerated soft edges, no drainage noted, applied new dressings per orders.</p> <p>A Care Plan, dated 1/9/17, documented Resident #107 had pressure ulcers to bilateral heels and shearing, pressure to coccyx, gluteal folds r/t decreased sensation, fragile skin, immobility, poor circulation, and incontinence. The goal, dated 1/9/17 and revised on 4/7/17, was for the wounds to show signs of healing over next review. Interventions included staff to assess and document location, size, depth, undermining, color, odor, and presence of necrotic tissue,</p>	F 686	<p>k. Licensed nursing staff will be inserviced related to weekly skin/wound assessments, wound rounds, notification of change of wound status. How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur.</p> <p>a. DNS/Designee will audit to ensure weekly rounds occurred, care plans are current related to skin integrity issues, weekly skin assessments are completed, weekly skin/wound assessments are completed, notification of changes in skin integrity issues were communicated to the appropriate parties. This audit will be conducted weekly x 4, the monthly x 3 and results of the audit will be presented to the facility's monthly QA/PI meeting. When corrective action will be completed: 02/23/18</p>		

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F 686	<p>Continued From page 19</p> <p>assess treatment plans for further decline, describe exudate or wound drainage, alert MD for signs of infection: redness, swelling, drainage, warmth at site, or elevated temperature, culture drainage as MD orders, notify of results, float heels while in bed wheelchair cushion to assist off-loading. Each intervention was dated 1/9/17. The care plan did not direct staff to use off-loading heel sage boots for the resident.</p> <p>The quarterly MDS assessment, dated 1/10/17, documented 2 unstageable pressure ulcers not present on prior assessment. The MDS provided measurement of the largest ulcer, which measured 7.0 cm in length, 5.0 cm wide, and 0.5 cm deep.</p> <p>Physician's order, dated 1/12/17, documented for Resident #107 to wear sage boots at all times for off-loading due to bilateral heel wounds.</p> <p>Resident #107's Weekly Skin/Wound Progress Note (WS,) Wound Care Note (WCN,) and Wound Assessment (WA,) documented pressure ulcers to the right heel, gluteal fold and left heel as follows:</p> <p>-Wound #1-Right Heel: *1/12/17-WS-not documented, *1/19/17-WS-pink with no eschar, no measurements, *1/19/17- WCN-4.0 cm x 5.9 cm x 0.05, wound bed was 76-100% eschar, unstageable, resident is inactive at the skilled nursing facility and was in a wheelchair most of the time and noticed that both of the heels were resting on foot pedals with sage boots on, *1/26/17-WS-pink, very dry and flaky, no</p>	F 686			

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F 686	Continued From page 20 measurements, *2/2/17-WS-yellow drainage with scant amount of bleeding, heel black with macerated edges, spongy, no measurements, *2/9/17-WS-draining a small amount of yellow discharge, resident complained of pain to the right heel during dressing change, no measurements, *2/10/17-WCN-3.6 cm x 5.3 x 0.4 cm, wound bed 76-100% eschar, unstageable, macerated callous and increased light green drainage, culture completed, resident's wife said the resident is not compliant with off-loading the right heel and makes successful attempts to remove the sage boots, physical therapy to evaluate wheelchair for positioning to maximize off-loading of heels. A wheelchair evaluation was completed on 3/28/17, *2/17/17-WCN-3.6 cm x 5.9 cm x 0.3 cm, culture results showed multiple bacteria, dry, black adherent eschar over the calcaneal tuberosity (bone near the heel.) *2/21/17-WS-slightly larger than a silver dollar, gray in center, pink around the center with yellow/white along the edges, a small amount of drainage noted, no odor or bleeding, *2/28/17-WS-slightly larger than a silver dollar with yellow and spongy pink tissue surrounding, old dressing shows small amount of yellow discharge, no measurements, *3/3/17-WCN-3.0 cm x 3.0 cm x 0.1 cm, a large amount of serosanguineous, (yellowish fluid with small amounts of blood,) strong odor, removed devitalized tissue, biofilm, and slough, *3/7/17-WS-wound bed yellow and spongy with pink skin surrounding, no eschar, *3/7/17-WA-3.0 cm x 2.0 cm x 0.01 cm, wound bed pink with yellow, spongy tissue, small	F 686			

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F 686	Continued From page 21 amount of drainage, no odor, no tunneling or undermining, surrounding skin normal color for resident, wound edges irregular and smooth, improved since last dressing change, *3/14/17-WS-wound bed yellow/pink, firm, *3/14/17-WA-3.0 cm x 2.5 cm x 0.0cm, wound bed yellow and firm with smooth pink tissue surrounding, no odor, no tunneling or undermining, small amount of yellow drainage, *3/17/17-WCN-2.7 cm x 2.2 cm x 0.1 cm, debrided devitalized tissue, biofilm, and slough, *3/21/17-WS-slightly yellow with pink, granulated wound bed, *3/28/17-WS-dressing clean, dry and intact, no measurements, *3/30/17-WCN-resident was in a new wheelchair with right padding along pressure points, 2.3 cm x 1.4 cm x 0.1 cm, removed devitalized tissue, biofilm, and slough, unstageable, *4/2/17-WA-2.0 cm x 1.5 cm x 0.1 cm, minimal yellow drainage with a foul smell, resident complained of some pain, surrounding skin is pink and improving, *4/4/17-WS-dressing changed and dry and intact, *4/9/17-WA-stage 2 pressure ulcer, 2.0 cm x 1.5 cm x 0.1 cm, wound appears to be healing, some yellow drainage with a foul smell, resident complained of some pain, surrounding skin is pink. *4/11/17-WS- dressing changed and dry and intact, *4/11/17-WCN-2.0 cm x 0.9 x cm x 0.1 cm, stage 3 pressure injury, *4/17/17-WA-stage 2 pressure ulcer, 4.0 cm x 1.5 cm x 0.2 cm, purulent scant drainage with moderate odor, pink/beefy surroundings, *4/18/17-WS- dressing changed and dry and intact,	F 686			

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F 686	<p>Continued From page 22</p> <p>*4/20/17-vascular stage 2 wound, 4.0 cm x 1.4 cm x 0.2 cm, small amount of yellow drainage, pink/beefy surroundings with scant bleeding.</p> <p>-Wound #2, #4, & #5-Gluteal Fold:</p> <p>*1/12/17-WS-reddish/purple to bilateral buttocks, the skin to coccyx was blanchable, raw/pink skin,</p> <p>*1/19/17-WS-blanchable to the coccyx,</p> <p>*1/26/17-WS-blanchable to the coccyx,</p> <p>*2/9/17-WS-blanchable to the coccyx, excoriation to bilateral buttocks,</p> <p>*2/21/17-WS-blanchable to the coccyx, excoriation to bilateral buttocks improving,</p> <p>*2/28/17-WS-blanchable to the coccyx,</p> <p>*3/7/17-WS-blanchable to the coccyx,</p> <p>*3/14/17-WS-blanchable to the coccyx, excoriation to bilateral buttocks continued, no open areas,</p> <p>*3/21/17-WS-blanchable to the coccyx, excoriation to buttocks almost resolved, open area to right gluteal fold, bleeding a small amount, no measurements,</p> <p>*3/27/17-WA-shearing impairment to the right gluteal fold, 3.8 cm x 4.0 cm x 0.1 cm, superficial shearing with rough edges with greenish, yellow, color, pink wound bed with surrounding wound red, very tender to the touch.</p> <p>*4/2/17-WA-right gluteal fold "shearing" wound, 4.0 cm x 3.8 cm x 0.1 cm, pink with yellow drainage, thin line of black skin.</p> <p>*4/4/17-WS-blanchable to the coccyx, excoriation to the buttocks improving, gluteal fold showed no drainage or bleeding,</p> <p>*4/9/17-WA- "shearing" wound stage 2, 4.0 cm x 6.0 cm x 0.1 cm.</p> <p>*4/11/17-WS-excoriation continues to buttocks, blanchable to the coccyx, gluteal fold grayish color, no bleeding or drainage,</p>	F 686			

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F 686	<p>Continued From page 23</p> <p>*4/11/17-WCN-wound #4-a new unstageable wound to the left ischial, 7.0 cm x 4.8 cm x 0.05 cm, obscured full-thickness, wound #5-a new stage 2 pressure sacral ulcer, 2.3 cm x 0.4 cm x 0.05 cm, with eschar, a new patch of dull gray skin (pressure necrosis) under left buttock skin fold,</p> <p>*4/17/17-WA-right gluteal fold "shearing" wound, 5.5 cm x 5.0 cm x 0.2 cm, unstageable,</p> <p>*4/18/17-WS-excoriate site to coccyx with no open area, brownish/black spongy sore to left gluteal fold with yellow/pink surrounding skin, scant amount of bleeding with a foul odor,</p> <p>*4/20/17-WA-left gluteal fold "vascular" unstageable wound, 6.0 cm x 5.2 cm x 0.7 cm, thick gray eschar, very foul odor, moderate yellow drainage with scant bleeding, wound bed tunneling 2 cm toward 1 o'clock position, surrounding skin reddened, wound condition deteriorating since last treatment.</p> <p>-Wound #3-Left Heel: *1/12/17-WS-heel raw/pink, *1/19/17-WS-pink, no eschar, *1/19/17-WCN-unstageable pressure injury with obscured full-thickness skin and tissue loss, 1 cm x 0.9 cm x 0.05 cm, wound bed is 76-100% epithelialization, *1/26/17-WS-pink, no measurements, *2/2/17-WS-pink and intact, no measurements, *2/9/17-WS-pink and intact, no measurements, *2/10/17-WCN-resolved.</p> <p>-Wound #6-Left Lateral Abdomen: *3/14/17-WS-not documented, *3/17/17-WCN-stage 2 pressure ulcer to the left lateral abdomen, 2.1 cm x 2.0 cm x 0.05 cm, small amount of sero-sanguineous drainage,</p>	F 686			

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F 686	<p>Continued From page 24</p> <p>Resident #107 was in a new larger wheelchair, order to place a pillow under arm to alleviate pressure and for physical therapy to evaluate, *3/21/17-WS-shearing site to left abdomen is improving, the wound bed is pink/yellow, *3/28/17-WS-shearing to left side continues to improve with treatment, *3/30/17-WCN-1 cm x 0.9 cm x 0.05 cm, small amount of sanguineous drainage, no odor, wound bed 76-100% slough, *4/4/17-WS-scabbed site to left side abdomen improving, *4/11/17-WS-scabbed site to left side abdomen improving, *4/18/17-WS- scabbed site to left side abdomen.</p> <p>A progress note dated 4/22/17, documented Resident #107 was transferred to the hospital via ambulance and admitted to the hospital with a diagnosis of sepsis.</p> <p>On 1/26/18 at 7:45 AM, RN #2 (Senior RN) stated she would expect family and MD to be notified immediately when changes in wounds were observed and for notification be documented in the progress notes under nursing. RN #2 said that with any change of condition, the MD would be notified and staff would follow direction from the MD.</p> <p>On 1/26/18 at 8:15 and 10:40 AM, the DON stated she or RN #2 were to be notified regarding wounds. "The wounds should show up on weekly skin checks and hopefully would show up in the clinical notes, or they would call you or show the DON."</p> <p>The DON stated the MD rounded every 60 days</p>	F 686			

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F 686	<p>Continued From page 25</p> <p>on the residents in the facility and said the MD seldom looked at the wounds. The DON stated the MD was responsible for the management of all care and the wound clinic MD would make recommendations.</p> <p>The DON stated the interventions were put in place, but could not force the resident to keep the sage boots on. The DON stated the resident was repositioned and turned, "if we could", even on an air bed. She said there were only a few notes which documented the resident refused or resisted cares.</p> <p>The DON said there was inconsistent monitoring of the wounds and there was inconsistency regarding staging, sizing and characterizing the wounds. She said she was not sure why there was a delay regarding the wheelchair evaluation. The DON said she was not aware Resident #107 had a pressure to the left heel.</p> <p>The DON stated Resident #107 did not come back to the facility. "I think he passed away. He was a very sick man."</p> <p>2. Resident # 43 was admitted to the facility on 12/13/17 with diagnoses that included adult failure to thrive and type 2 diabetes mellitus, HTN, COPD, Dementia, and depression.</p> <p>The Admission Nursing Assessment, dated 12/13/17, documented Resident #43 had scars to the right leg and foot, and extremely dry skin to feet and toes.</p> <p>The hospital Discharge Report, dated 12/13/17, documented Resident #43 had excoriation to the</p>	F 686			

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F 686	<p>Continued From page 26</p> <p>buttocks and an open area to the left posterior hip.</p> <p>The baseline care plan, dated 12/13/17, documented preventative care under the skin integrity.</p> <p>A Care Plan, dated 12/14/17 and revised on 1/11/18, documented the Resident was not consistently able to manage pressure relief. The care plan goal, dated 12/14/17 and revised 12/27/17, documented measures will be in place to ensure his skin remains intact and free of breakdown through the review period. Interventions included sage boots to bilateral feet as resident will allow, if Resident #43 refuses, encourage resident feet on heel lift, initiated on 12/22/17 and revised on 12/27/17 and an air mattress initiated on 12/14/17 and revised on 12/22/17.</p> <p>A Care Plan, dated 12/22/17 and revised on 1/11/17, documented shearing to coccyx and vascular wounds to right and left heel. The care plan goal was for Resident #43 to remain comfortable during anticipated declines. Interventions directed staff to turn and reposition every 2 hours and as needed as he will allow.</p> <p>Physician Orders, dated 12/13/17, did not include direction to staff for wound care.</p> <p>The Admission MDS, dated 12/19/17, Resident #43 had minimal impairment, required extensive assist for bedmobility, dressing, and personal hygiene. The MDS documented Resident #43 had one stage 2 pressure ulcer.</p> <p>A Treatment Administration Record, dated</p>	F 686			

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F 686	<p>Continued From page 27</p> <p>1/12/18 directed staff to check proper inflation of air mattress every shift. The task was signed each shift from 12/30/17 to 1/12/18.</p> <p>The facility's Weekly Skin and Wound Assessments documented Resident #43 developed 3 wounds.</p> <p>Wound #1 Coccyx: 12/20/17 Pressure/SDTI -a deep purple/red area to the entire coccyx area measured and measured 6.0 x 6.0 cm 1/11/18 Shearing/Stage two- 1.3 x 0.1 x 0.1 cm slight purulent slough. 1/14/18 Vascular- 2.2 x 1.0 x 0.0 cm wound bed yellow/white slough 1/16/18 Vascular- 2.0 x 1.1 x 0.01 cm white center 1/23/18 Vascular-2.0 x 1.1 x 0.01 cm</p> <p>Wound #2 Right heel 1/11/18 Vascular/unstageable 3.0 x 2.0 x .00 cm eschar area black in color. 1/14/18 Vascular/unstageable 3.5 x 2.0 x 0.0 cm Wound black 1/16/18 Vascular/unstageable 3.8 x 3.8 x 0.0 cm dark area with soft black tissue 1/23/18 Vascular/unstageable 2.8 x 2.8 x 0.0 cm dark area surrounding heel with thick hard center</p> <p>Wound #3 Left heel 1/11/18 Vascular/unstageable 3.0 x 3.0 x 0.0 cm eschar area black in color. 1/14/18 Vascular/unstageable 4.0 x 3.0 x 0.0 cm wound black 1/16/18 Vascular/unstageable 1.8 x 1.8 x 0.0 cm dark area with hard black tissue 1/23/18 Vascular/unstageable 3.8 x 3.8 x 0.0 cm</p>	F 686			

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F 686	<p>Continued From page 28</p> <p>dark area surrounding heel with thick hard center.</p> <p>A nursing note, dated 1/11/18, documented attempt to contact family regarding Resident #43's declining health.</p> <p>On 1/25/18 at 9:00 AM, the DON stated, it is hard to meet the care plan goal when the resident came in with a wound. When asked about the changes in the types of wounds, i.e. vascular, pressure, SDTI, shearing, etc., the DON stated the wrong terminology was used. The DON stated the nurses do assessments, treatment, and documentation of the wounds but they do not have certification or training in wound care.</p> <p>When asked where the direction to nursing the airbed settings are checked was, the DON stated, "We push down on it, if you feel the frame, or if they are on it, if it is too tight, they are going to roll out." LPN #3 stated to determine the proper airbed setting she put her hand between the bedframe and mattress to see if you feel the resident.</p> <p>The manufacturer's directions for use guided user: to check to see if suitable pressure is selected by sliding one hand between the air mattress and the air/foam base under the resident's buttock. User should be able to feel the space between their hand and the resident's buttocks with the acceptable range being 1-1.5 inches.</p> <p>On 1/26/18 at 8:05 AM, LN #3 stated Resident #43 had pedal pulses and his feet were warm to the touch. No documentation was found in the</p>	F 686			

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F 686	Continued From page 29 medical record to indicate Resident #43 had vascular impairment. On 1/26/18 at 10:40AM, RN #2 stated she completed wound rounds and compared weekly wound measurements provided by the nurses. RN #2 stated she did not assess the wounds, complete dressing changes or measurements. The medical record did not reflect referal to the wound clinic. The DON stated Resident #43 had bad skin, we tried turning him, he just wanted to be left alone.	F 686			
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 as free of accident hazards as is possible; and §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, staff interview and record review, the facility failed to ensure adequate supervision of residents to prevent falls. This was true for 2 of 3 sample residents (#26 and #205) reviewed for accidents and who experienced multiple falls after admission to the facility. This failure placed the residents at risk for harm and injury from falling. Findings include: The facility's undated policy and procedure for Falls and Fall Risk Managing documented the following:	F 689	F <input type="checkbox"/> 689 <input type="checkbox"/> D <input type="checkbox"/> the facility failed to ensure adequate supervision of residents to prevent falls What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #26 had passed away prior to the surveyors identifying the deficient practice. Resident #205's care plan was updated with a planned fall prevention intervention	2/23/18	

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F 689	Continued From page 30 * Staff were directed to identify appropriate fall risk interventions with input from the attending physician. * The attending physician, in corroboration with the consultant pharmacist and nursing staff, would "identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped..." * If the underlying cause of falling could not be readily identified or corrected, staff were directed to try a variety of interventions until falling decreased or stopped or until the falls were identified as unavoidable. * Staff were directed to monitor and document the resident's response to fall risk interventions. * In the case where the resident continued falling, staff were directed to re-evaluate whether the interventions were appropriate. The attending physician would assist staff as needed in identifying causes of the resident's falls. 1. Resident #26 was admitted on 11/16/17 with multiple diagnoses including malignant neoplasm (cancer) of the pancreas, prostate, and colon. Resident #26's Fall Risk Assessment, dated 11/16/17 at 2:02 PM, documented he had 1-2 falls in the past 3 months and was at moderate risk for falls. Resident #26's 11/22/17 Admission MDS assessment documented he was cognitively	F 689	prior to the survey, however it was not updated in a timely manner therefore the surveyors identified it as a deficient practice. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents who experience a fall or other incident have the potential to be affected by the deficient practice. Current resident care plans were reviewed to ensure fall prevention interventions were present and complete. What measure will be put into place or why systemic changes you will make to ensure that the deficient practice does not recur. Licensed nurses were inserviced related to the need to immediately implement fall prevention interventions and update care plan accordingly. Licensed nurses were also inserviced related to the Compliance Store's information - 100 different interventions to consider/implement in the event of a resident fall. This information will be laminated and available for the nurses at the nursing station. Licensed nurses were also instructed to contact DNS for further guidance if unable to determine immediate appropriate fall prevention intervention. Fall prevention interventions/care planning will be included in the Licensed Nurse competency list. These competencies are completed upon hired and annually thereafter. The Clinical Meeting will include the		

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F 689	<p>Continued From page 31</p> <p>intact , required extensive assistance with bed mobility, one person physical assistance with transfers, supervision when walking in his room, one person physical assistance with locomotion, extensive assistance with dressing, and extensive assistance with toileting and personal hygiene. The MDS assessment documented Resident #26 used a cane or crutch and walker, was occasionally incontinent of urine, and had no falls in the two months prior to admission.</p> <p>Resident #26's care plan documented he had impaired mobility and was at risk for falls. The following interventions were documented on Resident #26's care plan:</p> <ul style="list-style-type: none"> * Staff were directed to provide extensive assistance with ambulation, bed mobility, and transfers, and offer greater assistance as needed. The interventions were initiated on 11/17/17 and updated on 1/25/18. * Resident #26 used a walker, gait belt, shoes, non-skid socks, and wheelchair. The interventions were initiated on 11/17/17. * Staff were directed to follow the facility fall protocol when a fall occurs. The intervention was initiated on 11/17/17. * Staff were directed to encourage Resident #26 to use the call light to ask for assistance. * Staff were directed to observe and report to the charge nurse any signs or symptoms such as unsteady gait, disorientation, confusion, somnolence (appearing sleepy or lethargic), dehydration, or unstable blood pressure. The 	F 689	<p>review of recent incident/accidents. The template in PCC allows for the nurse entering the data to indicate immediate planned intervention(s), as well as indicate that the care plan has been updated. The Clinical team will verify care plan has been updated and revise per ITD discussion/effectiveness of intervention.</p> <p>Fall Risk Assessments are completed for all new admits and then quarterly thereafter. Fall prevention interventions/care plans are developed, in part, based on these assessments. When a new resident is admitted then for the first 48-hours in the facility there is an increased level of supervision by the direct care and licensed staff. In addition, there is a 48-hour care conference scheduled with the resident and/or family members to discuss specifics of care, history, habits, etc. These items are then incorporated into the plan of care. Prior to admit the resident's background, including diagnoses, are reviewed by the DNS/RN Mgr, Admissions Coordinator, and Social Services. Based on this information the baseline care plan is started and fall prevention interventions are put into place, as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>The DNS/Designee will audit incidences/accidents and the residents' fall risk assessments to ensure they are complete and accurate. The DNS/Designee will also audit resident</p>		

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F 689	<p>Continued From page 32 intervention was initiated on 11/17/17.</p> <p>* Resident #26's care plan documented he used a transfer bar on the right side of his bed to increase independence with bed mobility. The intervention was initiated on 1/10/18 and updated on 1/11/18.</p> <p>Resident #26's Order Summary Report, active as of 12/1/17, documented a Fentanyl Patch (a narcotic pain medication) 12 mcg to be applied every 3 days. The Fentanyl patch was ordered on 11/17/17.</p> <p>Resident #26's Order Summary Report, active as of 1/1/18, documented Fentanyl Patch 25 mcg to be applied every 3 days. The increased dosage of Fentanyl patch was ordered on 12/27/17.</p> <p>Resident #26's January MAR documented lorazepam (an anti-anxiety medication) 0.5 mg, one-half tablet was administered on 1/24/18 at 7:47 PM.</p> <p>Resident #26's Incident Report, dated 12/6/17 at 2:10 PM and Incident Note, dated 12/6/17 at 3:12 PM, documented a staff member witnessed the resident fall in his room as he walked to the restroom. Resident #26 was using a cane and was wearing non-skid socks as he walked in the room. He reached for the toilet handle and "his right leg wasn't working right." When the nurse arrived, the resident was sitting on his bed and two skin tears were discovered on his left arm. Resident #26 said he was trying to reach the handle so he could use the bathroom, he missed the handle and fell. The Incident Note documented current care plan interventions as</p>	F 689	<p>care plans to ensure that they accurately represent the residents' risk for falls and also that fall prevention intervention(s), as applicable, were put into place immediately following a fall.</p> <p>Audits will be conducted weekly x4, then monthly x3 with the results of the audit being presented to the facilities monthly QA/PI meeting.</p> <p>When corrective action will be completed: 02/23/18</p>		

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F 689	<p>Continued From page 33</p> <p>"Ambulate independent or standby assist." New care plan interventions were documented as "Ambulate independent or standby," which was identical to the current care plan intervention.</p> <p>Resident #26's Nursing note, dated 12/6/17 at 3:21 PM, documented he fell and sustained two skin tears on his left arm. The skin tears were cleansed with normal saline, steri-strips (adhesive skin closure strips) and a dressing were applied.</p> <p>Resident #26's Incident Report, dated 1/5/18 at 6:15 AM, and Incident Note, dated 1/5/18 at 10:11 AM, documented he was found on the floor in his room lying on his right side. There was blood on his fingers and the floor and a "3 X 2" (3 by 2) wound on his forehead. The Resident Description documented, "I was trying to get up." Range of motion was normal, the resident was transferred to a wheelchair, vital signs were taken and the wound was cleaned and dressed. The Incident Report documented the "Resident self transfers without regard to safety." He transferred from bed and slipped, hitting his forehead on the bed frame. The Incident Note documented current care plan interventions as "he is able to transfer without without assistance, wear non skid socks." New care plan interventions were documented as "to continue with care plan."</p> <p>Resident #26's Incident Report, dated 1/9/18 at 9:00 PM, and Incident Note, dated 1/9/18 at 9:39 PM documented he was found on the floor between the bed and caught under the bedside table. A small skin tear was noted on his left hand and redness was noted on the left side of his head. The Resident Description documented the</p>	F 689			

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F 689	<p>Continued From page 34</p> <p>resident was attempting to transfer from his wheelchair to the "couch" ("known as the bed") and he fell. Resident #26 did not cooperate well with questions or commands and was assisted off the floor into bed. the Incident Report documented a transfer bar would be added to Resident #26's bed, he would be encouraged to use the call light more often, and staff would be educated to assist him to bed before 9:00 PM. The Incident Note documented current care plan interventions included non-skid socks, use wheelchair to transfer, and encourage the resident to call for assistance with transfers. New care plan interventions were to encourage the resident to use his call light. The intervention that directed staff to encourage the resident to use the call light was initiated on 11/17/17, which was prior to the fall.</p> <p>Resident #26's Incident Note, dated 1/23/18 at 10:08 PM documented he was found on the floor next to his bed, sitting on buttocks, and the resident "claims he just slid out of bed." The incident note documented a pile of blankets was intertwined with his legs. Current care plan interventions were frequent checks, encouraging use of the call light, offer toileting, and reposition every 2-4 hours. New care plan interventions included continuing the care plan, attempting to toilet the resident more, offering soft music, and having personnel sit with the resident "as advised."</p> <p>On 1/23/18 at 10:35 AM, LPN #1 said Resident #26 was found on the floor that morning at 3:30 AM. A bruise was noted on the resident's right knee.</p>	F 689			

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F 689	<p>Continued From page 35</p> <p>On 1/23/18 at 12:15 PM, Resident #26's family member said the resident refused to go to the hospital after a fall earlier this month when he got out of bed without asking for help.</p> <p>On 1/25/18 at 9:46 AM, Resident #26 was partially on the floor in his room, lying on his right side with his legs on the floor and his upper body partially on the bed. Resident #26 was hanging onto the side rail, his right knee was on the floor with the lateral (side) aspect of the knee and lower leg in full contact with the floor. Several staff members assisted the resident back into bed by lifting him off the floor and onto the bed. Resident #26 smelled of fecal material and was found to be incontinent of stool as staff checked and changed his incontinence brief.</p> <p>On 1/25/18 at 9:46 AM, CNA #1 said she walked by and saw Resident #26 sliding out of bed, he smelled of fecal material and was probably trying to get to the bathroom. Per CNA #1, Resident #26 was last taken to toilet at 6:00 AM and toileting was offered every 2 hours.</p> <p>Resident #26's Nursing Note, dated 1/25/18 at 10:39 AM, documented he was "sliding out of bed" and was "hanging onto the transfer rail..." The nursing note documented the LN blocked the resident's feet so they would not continue sliding, a gait belt was placed on the resident, and "Staff assist of 4 bucket lifted resident back to a sitting position on the bed...neuro checks will continue from [the] previous fall, 15 minute checks were implemented and staff in serviced. Will continue to monitor [the] resident."</p> <p>Resident #26's Incident Note, dated 1/25/18 at</p>	F 689			

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F 689	<p>Continued From page 36</p> <p>10:00 AM, documented the fall as in the Nursing Note. A small abrasion was noted to the sacrum (tailbone area). New care plan interventions documented every 15 minute checks.</p> <p>Resident #26's Incident Report, dated 1/25/18 at 10:00 AM, documented the un-witnessed fall as in the Nursing Note and Incident Note. The resident recently started taking Ativan (an anti-anxiety medication) as needed, he was "trying to get out of bed without assistance, agitated and anxious. Noted to be incontinent of bowel at [the] time of [the] fall."</p> <p>On 1/25/18 at 10:08 AM, the DON said Resident #26 exhibited changes in status on 1/5/18, such as his anxious/restless behavior and wandering. A Wanderguard was initiated, (a device attached to the resident's wheelchair that triggers an audible alarm if the resident passes a certain point when traveling throughout the building) and the frequency of checking on the resident was increased to every hour. The frequency of checking on the resident was increased to every 15 minutes. The physician was notified of Resident #26's restlessness and an order for Ativan (an anti-anxiety medication) was obtained. The DON said she would expect staff to toilet Resident #26 before meals and at bedtime and offer when he is restless. The DON said that an increase in dosage of Fentanyl patch (a narcotic pain medication) and adding Ativan might make Resident #26 more confused, but maybe he would rest better. The DON said she did not think the increased dose of Fentanyl patch was related to Resident #26 having more falls.</p> <p>Resident #26's Resident Safety Checks</p>	F 689			

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F 689	<p>Continued From page 37</p> <p>documented every 15 minute safety checks were initiated on 1/25/18 at 10:15 AM.</p> <p>Resident #26 was assessed to be at moderate risk for falls on admission and subsequently experienced 5 falls while in the facility. The facility failed to implement changes to the resident's care in a timely manner to prevent additional falls.</p> <p>2. Resident #205 was admitted on 1/18/18 with multiple diagnoses including cerebrovascular disease (disease of the vessels of the brain), low back pain, generalized osteoarthritis, and lack of coordination.</p> <p>Resident #205's Fall Risk Assessment, dated 1/18/18 at 4:13 PM, documented he had 1-2 falls in the past 3 months and was at moderate risk for falls.</p> <p>Resident #205's care plan, dated 1/19/18, documented he was at risk for falls and directed staff to provide cueing/limited assistance with ambulation, a walker, gait belt, shoes, non-skid socks, wheelchair with auto-locking brakes, and limited assist of 1 with bed mobility. The care plan documented Resident #205 fell on 1/19/18 at 2:40 PM and fell again on 1/20/18 at 4:55 PM. Staff were directed to check on Resident #205 frequently, complete neurological checks according to facility policy, ensure the resident was wearing "proper fitting footwear," ensure that his environment was free from clutter and obstacles, increase the level of supervision when in his room and/or in common areas, and observe for signs and symptoms of "acute illness."</p>	F 689			

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F 689	Continued From page 38 Resident #205's Incident Report, dated 1/19/18 at 2:40 PM, documented an un-witnessed fall in his room. The resident's roommate saw him slide to the floor when he attempted to get up and he landed "on his bottom." Resident #205 was unable to provide a description of what happened. After the fall, Resident #205 was taken to the lobby and was sitting in a recliner. Resident #205's Medicare A: Skilled Note, dated 1/19/18 at 4:10 PM, documented he required extensive assist of 2 for transfers, and he "Will try to get up without help. Had a fall on day shift. Pleasantly confused." Resident #205's Nursing Note, dated 1/19/18 at 9:21 PM, documented he was very "antsy" on evening shift. The resident was trying to get up and walk without assistance, and a few minutes after he took his pills they were found on the floor "half dissolved." Resident #205's Incident Report, dated 1/20/18 at 4:20 AM, and Incident Note, dated 1/20/18 at 4:20 AM, documented an un-witnessed fall in the dining room. Resident #205 was found by a CNA sitting on the floor, and his left hand was holding onto the rail next to the dining room. The resident said he was "trying to go over there" as he pointed toward the medication cart. Resident #205 denied hitting his head. He was assisted from the floor with a Hoyer (mechanical) lift. Other information in the Incident Report documented the resident "did not sleep all night. He was moving back and forth in the north dining room...He did rest in the recliner with the CNA next to him for about less than 10 min[utes]. He	F 689			

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F 689	Continued From page 39 was incontinent of bowel when found him sitting on the floor." The Incident Note documented Current Care Plan Interventions included "stand by assist with transfer. Closer observations." New Care Plan Interventions included "continue to do closer observations." On 1/25/18 at 4:51 PM, the DON said Resident #205 was recently moved to the East hall and that he was not the same as when he came in for the initial tour of the facility prior to admission. The DON said the resident fell on the first night in the facility and was moved to this hall closer to the nurse's station. The DON said she did not "see from the documentation what was done to prevent the falls." The facility did not provide documentation of increased supervision or other interventions aimed at preventing additional falls.	F 689			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure staff changed residents' oxygen humidifiers and cannulas (tubing that delivers oxygen) per physician orders. This was true for 1 of 2 sample residents	F 695	F <input type="checkbox"/> 695 - D <input type="checkbox"/> the facility failed to ensure staff changed residents' oxygen humidifiers and cannulas per physician orders. What corrective action(s) will be accomplished for those residents found to	2/23/18	

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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - LEWISTON			STREET ADDRESS, CITY, STATE, ZIP CODE 821 21ST AVENUE LEWISTON, ID 83501		
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F 695	<p>Continued From page 40 (#50) reviewed for respiratory care. This failure created the potential for harm from respiratory infections due to the growth of pathogens (organisms that cause illness) in oxygen humidifiers and cannulas. Findings include:</p> <p>The facility's Policy and Procedure for Oxygen Therapy-Respiratory Care, reviewed 1/15, documented "Change masks and cannula as needed and in accordance with the facility's equipment changeover schedule."</p> <p>Resident #50 was admitted on 9/25/17 with multiple diagnoses, including COPD and chronic atrial fibrillation (irregular heart rhythm).</p> <p>Resident #50's quarterly MDS assessment, dated 12/26/17, documented he received oxygen therapy while a resident.</p> <p>Resident #50's Order Summary Report, Active Orders As Of 1/1/18, documented the following:</p> <ul style="list-style-type: none"> * Oxygen at 2 liters to keep oxygen saturation levels above 90% every evening and night. * Change oxygen tubing on the first and third Tuesday and as needed each month. <p>Resident #50's MAR, dated 1/1-1/31/18, documented oxygen was administered every evening and night shift 1/1/8-1/23/18 and evening shift on 1/24/18.</p> <p>On 1/22/18 at 2:11 PM, Resident #50's oxygen humidifier and cannula were labeled 1/3. The resident said he wore it at night and he did not know when they last changed it.</p>	F 695	<p>have been affected by the deficient practice.</p> <p>Resident #50's oxygen humidifier/tubing was immediately replaced when it was noted that it was outdated. The resident did not suffer any adverse effects as a result of this deficiency.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>Any resident who utilizes oxygen humidifiers/tubing, cannulas has the potential to be affected by the deficient practice. A facility-wide room check was conducted to ensure no other residents had outdated humidifiers/oxygen tubing/cannulas. No other resident was identified.</p> <p>What measure will be put into place or why systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>Licensed nursing staff were inserviced related to need to ensure physician orders were completed as written. They were also instructed to ensure that oxygen tubing, etc. is changed out as ordered and is properly dated and bagged.</p> <p>The Medical Records Supervisor audits the eMar q week and provides a list of the missing medications/treatments to the RN Mgr for follow-up <input type="checkbox"/> this includes orders for oxygen tubing.</p> <p>Humidifier/Oxygen tubing/cannula change schedule has been changed to match community standards. Based on this</p>		

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F 695	Continued From page 41 On 1/24/18 at 2:50 PM, the DON said oxygen tubing and water should be changed 2 times per month, every other Tuesday. The DON said Resident #50's oxygen humidifier and cannula was last changed on 1/3/18 and should have been changed on 1/16 by night shift.	F 695	change schedule, the following day the RN Mgr/Designee will conduct a room audit to ensure supplies were changed and dated/bagged. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The DNS/Designee will conduct room audits to ensure humidifiers, oxygen tubing, etc. is timely dated, as ordered. This audit will be conducted weekly x 4, then monthly x 3. Results of the audit will be presented to the monthly QA/PI meeting. When corrective action will be completed:02/23/18		
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		2/23/18	

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F 755	<p>Continued From page 42</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, the facility failed to remove expired medications from the medication cart and Pyxis (a medication dispensing system). This was true for one of two medication carts reviewed and one random resident (#105), and had the potential to affect any resident who received medication from the Pyxis. This failure created the potential for harm should the residents receive expired medication with decreased efficacy. Findings include: Resident #105 was admitted on 1/3/18 with multiple diagnoses including malignant neoplasm (cancer) of the liver, lung, and larynx (throat), and COPD. Resident #105's MAR, dated 1/1-1/31/18, documented "MOUTHWASH SOLUTION: MIX 10 MLS (milliliters) of each in a cup: viscous lidocaine (a topical anesthetic), Benadryl elixir, Mylanta-Swish and swallow 30 minutes before meals and at HS (bedtime)..." The mouthwash</p>	F 755	<p>F <input type="checkbox"/> 755 E <input type="checkbox"/> the facility failed to remove expired medications from the medication cart and Pyxis <input type="checkbox"/> this failure created the potential for harm should the residents receive expired medication with decreased efficacy What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were administered the expired medications and the medications were immediately removed and discarded upon discovery. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken. All residents who are administered medications have the potential to be affected by the deficient practice. A thorough inspection of the Pyxis, medication carts, and medication room</p>		

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F 755	<p>Continued From page 43</p> <p>solution was documented as given each day on 1/3-1/9/18.</p> <p>On 1/26/18 at 8:30 AM, the West Hall medication cart contained a bottle of diphenhist (Benadryl elixir). The medication bottle was labeled for Resident #105 with directions consistent on the MAR. The label on the diphenhist bottle documented an expiration date of 12/17 and the bottle was opened on 1/3/18. RN #1 said she would not use that medication bottle and she did not think Resident #105 was getting that medication. RN #1 said the pharmacy checks for expired medications monthly and "we check all the time."</p> <p>On 1/26/18 at 9:31 AM, the Pyxis contained a bottle of Polyethylene Glycol (a laxative) that was labeled with an expiration date of 4/16, and a tube of Nystatin cream (a topical anti-fungal) with an expiration date of 2/17. Pharmacy staff said the expired medications should not be used, and they monitor for expired medications randomly and print a report once a week to check expiration dates.</p> <p>Resident #105 received multiple doses of a medication that expired the previous month, and the Pyxis contained two medications that were expired and available to be dispensed.</p>	F 755	<p>was conducted to ensure no other expired medications were available for use. None were identified.</p> <p>What measure will be put into place or why systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>The Pyxis has a computer system that generates a monthly (or on-demand) list of medications and their expiration dates. For some reason this particular medication had dropped off the list. This list will still be generated by the Pharmacist, however in addition the Pharmacist will conduct an on-sight inspection of the medications in the Pyxis system for expiration dates. All medications (except as identified below) will be removed and discarded if within 90-days of their expiration date. Costly medications (as identified by the Pharmacist) will be pulled/discarded if within 30-days of their expiration date. This report/updated by the Pharmacist and then provided to the Administrator on a monthly basis.</p> <p>The medication carts will be inspected by the Staff Development Coordinator/RN Sr. q month and a report of findings will be provided to the DNS for review.</p> <p>Licensed nurses were inserviced related to the need to ensure medications that are expired are removed from the medication cart/medication room/Pyxis and discarded.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.\</p>		

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F 755	Continued From page 44	F 755	The DNS/Designee will conduct weekly audits x 4, then monthly audits x 3 to ensure there are no expired medications in the Pyxis, Medication Carts and/or Medication Rooms. The results of this audit will be presented to the monthly QA/PI Committee. When corrective action will be completed: 02/23/18		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions when a staff member was	F 812	F <input type="checkbox"/> 812 <input type="checkbox"/> F <input type="checkbox"/> the facility failed to ensure food was prepared and served under sanitary conditions when a staff member was observed in the kitchen without facial	2/23/18	

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F 812	<p>Continued From page 45</p> <p>observed in the kitchen without facial hair restraints. This affected 14 of 14 sampled residents (#s 3, 8, 9, 14, 16, 26, 28, 32, 38, 43, 50, 53, 155, and 205) and had the potential to affect all residents who dined in the facility. This failure created the potential for contamination of food and exposed residents to potential disease-causing pathogens. Findings include:</p> <p>The 2013 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, documented, "(A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food..."</p> <p>The facility's Personnel Policy, dated 2015, documented food service personnel were required to wear hairnets.</p> <p>On 1/22/18 at 1:38 PM, the CDM (Certified Dietary Manager) was observed throughout the kitchen, without a facial hair restraint to cover his goatee beard and mustache.</p> <p>On 1/24/18 at 11:45 AM, the CDM was observed throughout the kitchen, without a facial hair restraint to cover his goatee beard and mustache.</p> <p>On 1/24/18 at 12:11 PM, the CDM delivered a covered container of soup to the steam table in the main dining room. The steam table had uncovered food ready to be served, as the CDM reached over the uncovered food and placed the</p>	F 812	<p>hair restraints and had the potential to affect all residents who dined in the facility.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>No residents were noted to be affected by the deficient practice. No visible hair was found in the food on the steam table where the deficient practice occurred. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>All residents, who consume meals prepared by the kitchen staff have the potential to be affected by the deficient practice. Kitchen staff immediately ensured hairnets/facial nets were donned while they were in the kitchen.</p> <p>What measure will be put into place or why systemic changes you will make to ensure that the deficient practice does not recur.</p> <p>Kitchen staff orientation includes the requirement to ensure all hair/facial hair is covered with a net while in the kitchen. A sign was posted immediately inside the kitchen entrance, by the hairnets, notifying staff of the need/requirement to don a hair net/facial net when entering the kitchen.</p> <p>The kitchen staff was inserviced by the Registered Dietician related to the need to ensure hair/facial hair is covered/netted while in the kitchen.</p>		

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

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F 812	<p>Continued From page 46</p> <p>container in the steam table. His facial hair was unrestrained and was directly over the uncovered food.</p> <p>On 1/24/18 at 1:45 PM, the CDM was in the kitchen without a facial hair restraint to cover his goatee beard and mustache. The CDM said anyone coming into the kitchen should wear a hair restraint and said his beard and mustache were fine, because he kept the facial hair short. He said he required those with a longer beard or mustache to either wear a facial restraint or to shave. He said he leaned over the steam table to deliver the hot soup and did not deliver the soup on the side with the sneeze guard, because he did not want to potentially burn staff who were standing near that side of the steam table.</p> <p>On 1/24/18 at 2:10 PM, the CDM said he had reviewed the regulations and said he should have been covering his facial hair while in the kitchen.</p>	F 812	<p>6. How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p> <p>The Registered Dietician has the above requirement as part of her sanitation safety inspection. She will conduct this inspection weekly x 4, then monthly thereafter and submit a copy of the findings to the Administrator. The Administrator will include this report in the QA/PI monthly meeting.</p> <p>When corrective action will be completed: 02/23/18</p>		