



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

March 2, 2018

G. David Chinchurreta, Administrator  
Sunny Ridge  
2609 Sunnybrook Drive  
Nampa, ID 83686-6332

Provider #: 135102

Dear Mr. Chinchurreta:

On **February 23, 2018**, a survey was conducted at Sunny Ridge by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes immediate jeopardy to resident health or safety, as documented on the enclosed CMS-2567, whereby significant corrections are required** You were informed of the immediate jeopardy situation(s) in verbally and in writing on **February 22, 2018**.

On **February 23, 2018**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed at 4:00 pm on **February 23, 2018**. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please**

G. David Chinchurreta, Administrator  
March 2, 2018  
Page 2 of 4

**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 **March 12, 2018**. Failure to submit an acceptable PoC by **March 12, 2018**, may result in the imposition of additional civil monetary penalties by **April 6, 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.
- 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*.

G. David Chinchurreta, Administrator  
March 2, 2018  
Page 3 of 4

Based on the immediate jeopardy cited during this survey:

**F0805 -- S/S: K -- 483.60(d)(3) -- Food In Form To Meet Individual Needs**

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

- Civil money penalty
- Denial of Payment effective May 23, 2018

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 23, 2018**, if substantial compliance is not achieved by that time.

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

If you believe the 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.

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

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

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

- BFS Letters (06/30/11)

G. David Chinchurreta, Administrator  
March 2, 2018  
Page 4 of 4

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

This request must be received by **March 12, 2018**. If your request for informal dispute resolution is received after **March 12, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive style with a large initial 'D'.

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

dr/lj  
Enclosures

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

PRINTED: 03/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/23/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUNNY RIDGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2609 SUNNYBROOK DRIVE NAMPA, ID 83686</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from February 20, 2018 through February 23, 2018. Immediate Jeopardy was identified at:</p> <p>*42 CFR 483.60 [F805]</p> <p>Immediate Jeopardy at F805 was removed prior to the exit conference.</p> <p>The surveyors conducting the survey were: Edith Cecil, RN Team Coordinator Teresa Kobza, RDN, LD</p> <p>Survey Abbreviations:</p> <p>CDM = Certified Dietary Manager CNA= Certified Nursing Assistant DON = Director Of Nursing LN = Licensed Nurse MAR = Medication Administration Record MASD = Moisture Associated Skin Damage MD = Medical Doctor MDS = Minimum Data Set RN = Registered Nurse tsp = teaspoon</p>	F 000			
F 585 SS=D	<p>Grievances CFR(s): 483.10(j)(1)-(4)</p> <p>§483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been</p>	F 585		3/20/18	

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

TITLE

(X6) DATE

Electronically Signed

03/12/2018

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 585	<p>Continued From page 1</p> <p>furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:</p> <p>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;</p>	F 585			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 585	Continued From page 2 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement	F 585			

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F 585	<p>Continued From page 3</p> <p>Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interviews, it was determined the facility failed to identify and handle a resident's verbal request for a change in staff. This was true for 1 of 8 residents (#233) when dissatisfaction with nursing care and the request for a different nurse was not addressed. This created a potential for psychosocial harm if a resident had a grievance and could not get someone to look into it. Findings include:</p> <p>Resident #233 was admitted to the facility on 6/22/17 with diagnoses that included osteomyelitis (infection of the bone) of the left ankle, post-surgical amputation of the 4th and 5th toes of the left foot, and diabetes mellitus type 2.</p> <p>The admission MDS assessment, dated 6/29/17, documented Resident #233 was cognitively intact and was able to make her needs known.</p> <p>A nursing note, dated 7/2/17, documented Resident #233 told an unidentified CNA that she did not like her nurse and that she wanted a new nurse. Resident #233 verbalized she wanted to meet with the supervisor and asked the CNA to send the supervisor in. Resident #233's nurse, LN #2, accompanied by an unidentified LN and CNA, met with Resident #233 and asked her why she wanted a different nurse. Resident #233</p>	F 585	<p>Residents Affected:</p> <p>Resident #233 was discharged on 7/14/17.</p> <p>Other Residents Having the Potential to be Affected:</p> <p>Current residents will be interviewed related to any unresolved grievances by the social services designee on or before 3/20/18.</p> <p>Grievances will be initiated with any follow-up completed as indicated by the resident grievance on or before 3/20/18.</p> <p>System Change/Education:</p> <p>Center staff were re-educated by Practice Development Specialist or designee, on the grievance process, including following up with residents within a timely manner, on or before 3/20/18.</p> <p>Beginning 3/20/18, any resident concerns will be reviewed with the IDT in the morning clinical meeting by the Center Executive Director or designee to track</p>		

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F 585	<p>Continued From page 4</p> <p>stated she did not like her [LN #2.] Resident #233 stated "I wanted my Metformin at dinner and you told me I had to take it by 5:00 PM because it was ordered at 4:00 PM." LN #2 informed the resident that it was not possible to change nurses. Resident #233 stated she did not want to be there and could not get adequate care. LN #2 asked the resident if there was somewhere else she would like to be sent to, and said she would get someone to help her with it.</p> <p>The clinical record did not reflect Resident #233's grievance was communicated to Social Services, the Director of Nursing, or the Administrator.</p> <p>The facility's grievance file from June 2017 through January 2018 were reviewed. There were no grievances completed for Resident #233 during her stay.</p> <p>On 7/20/17 at 10:00 AM, an interested party stated, a nurse that was not very friendly gave Resident #233 the impression, she was hinting but not saying, "why don't you just leave."</p> <p>On 2/23/18 at 12:40 PM, the DON stated, "Residents have the right to leave against medical advice, but we should try to provide comfort to the resident and get them to want to stay."</p> <p>On 2/23/18 at 1:30 PM, the Administrator stated he did not recall meeting with Resident #233 or of any concerns she may have had.</p>	F 585	<p>the progress of the grievance process to ensure timely follow-up.</p> <p>Audits:</p> <p>Beginning 3/20/18, the Center Executive Director or designee will interview 3 residents related to any unresolved concerns or grievances to ensure resident satisfaction with the grievance process.</p> <p>These audits will be completed weekly X4 weeks, and then monthly X2 months. The results will be compiled and reported to the QAPI committee for review monthly X3 months or until substantial compliance is achieved.</p> <p>The Center Executive Director is responsible for monitoring and follow-up.</p>		
F 657 SS=D	<p>Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans</p>	F 657		3/20/18	

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F 657	<p>Continued From page 5</p> <p>§483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure residents' care plans were regularly reviewed and revised as needed. This was true for 1 of 20 residents (#24) reviewed for care plan revisions and created the potential for harm if care was not provided or decisions were made based on inaccurate or outdated information. Findings include:</p>	F 657	<p>F657</p> <p>Residents Affected:</p> <p>Resident #24's care plan will be reviewed by the Center Nurse Executive or designee to ensure that the care plan reflects care and services provided including directions for staff of when to reposition, and how often to offer fluids on or before 3/20/18.</p>		

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F 657	<p>Continued From page 6</p> <p>Resident #24 was admitted to the facility on 3/5/16 with diagnoses that included Alzheimer's disease, dementia, and cognitive communication deficit.</p> <p>A quarterly MDS assessment, dated 2/5/18, documented Resident #24 had a severe cognitive impairment. The MDS documented Resident #24 required extensive assistance of one staff member with bed mobility and with eating and drinking. The MDS documented Resident #24 had Moisture Associated Skin Damage (MASD).</p> <p>a. A Change in Condition note, dated 1/18/18 at 12:22 PM, documented a skin ulcer was discovered on Resident #24.</p> <p>The care plan titled, At Risk for Skin Breakdown, revised 11/6/17, documented staff were to reposition Resident #24 as he would allow. The care plan did not include direction for staff of when to reposition Resident #24.</p> <p>The care plan titled, Actual Skin Breakdown, dated 1/19/18, documented Resident #24 had skin breakdown to his sacral and buttocks area related to excessive moisture and perspiration. The care plan did not include directions for staff of when to reposition Resident #24.</p> <p>A Change in Condition Follow-up Note, dated 1/18/18 at 11:22 PM, documented Resident #24's skin ulcer was on his coccyx and the treatment in progress was re-positioning Resident #24 from side to side. The treatment did not transition onto the care plan to include direction for staff of when to reposition resident #24 or how often.</p>	F 657	<p>Resident #24 will be assessed by the Center Nurse Executive or designee for any adverse effects associated with lack of instruction for positioning, and administration of fluids on or before 3/20/18.</p> <p>Other Residents Having the Potential to be Affected:</p> <p>Center residents care plans will be reviewed by the Center Nurse Executive or designee to ensure that they reflect care and services provided including instructions for positioning and fluid administration as indicated on or before 3/20/18.</p> <p>System Change/Education:</p> <p>Staff responsible for care plan updates and changes will be re-educated on the requirements for care plan revision and updates including instructions for staff related to positioning residents, as well as fluid administration by the Practice Development Specialist or designee on or before 3/20/18.</p> <p>Beginning 3/20/18, Care plans will be reviewed by the Center Nurse Executive or designee prior to the quarterly care conference to ensure that care and services as well as instructions for staff are reflected in the plan of care. Any follow-up will be completed as indicated at the time of the review.</p>		

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F 657	<p>Continued From page 7</p> <p>On 2/21/18 at 9:13 AM, CNA #2 and CNA #5 were observed assisting Resident #24 into bed. Resident #24 was positioned on his back with a pillow wedged under his left side.</p> <p>On 2/21/18 from 9:20 AM through 11:32 AM, Resident #24 was observed positioned on his back with a pillow wedged under his left side. This was also true on 2/21/18 from 1:15 PM through 2:56 PM, on 2/22/18 from 9:02 AM to 10:00 AM, and 2/22/18 from 10:19 AM to 11:42 AM during observations.</p> <p>On 2/21/18 at 2:31 PM, CNA #5 said direction for Resident #24's positioning was he was the last resident up before meals and the first resident to be laid down after meals. Resident #24's clinical record did not include this direction on the care plan.</p> <p>On 2/23/18 at 10:22 AM, the DON stated staff should be repositioning residents minimally every two hours. The DON stated the care plan should be specific for residents' needs.</p> <p>b. The Hydration Care Plan, revised 6/7/17, documented Resident #24 was at risk for dehydration related to immobility, dementia, and his inability to access fluids on his own. The care plan documented staff should offer and encourage fluids of choice. The care plan did not direct staff how often to offer or encourage fluids to Resident #24.</p> <p>On 2/21/18 from 9:06 AM through 11:32 AM, Resident #24 was observed in bed with various staff contacts and staff did not offer him fluids.</p>	F 657	<p>Audits:</p> <p>Beginning 3/20/18, the Center Nurse Executive or designee will audit 3 resident's care plans to ensure that they reflect the care and services provided as well as instructions for staff related to positioning and fluid administration.</p> <p>These audits will be completed weekly x4 weeks and then monthly x2 months. The results of the audits will be reported to the Performance Improvement Committee for review monthly x3 months or until substantial compliance is achieved.</p> <p>The Center Nurse Executive is responsible for monitoring and follow-up.</p>		

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F 657	Continued From page 8 This was also true on 2/21/18 from 1:15 PM through 2:56 PM and on 2/22/18 from 9:02 AM to 11:42 AM during observations.  On 2/22/18 at 2:40 PM, the DON stated residents were provided fluids during meals, med pass, and during cares. The DON stated staff should be in a residents' room at least every two hours and when staff members were in the room, the staff should offer fluids. The DON agreed the care plan did not include direction for staff of when to offer Resident #24 fluids.	F 657			
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was repositioned routinely to prevent skin breakdown for 1 of 3 residents (#24) sampled for skin impairments. The failure to reposition residents placed residents at risk of developing skin damage. Findings include:  Resident #24 was admitted to the facility on 3/5/16 with diagnoses that included Alzheimer's disease, dementia, and cognitive communication deficit.	F 684	Residents Affected:  Resident #24 skin was assessed by the licensed nurse on 3/08/18 with no new skin issues noted, the physician was updated related to resident skin condition and no new orders were received. Resident #24's care plan and Kardex will be updated by the Center Nurse Executive or designee to reflect the frequency of repositioning required on or before 3/20/18.	3/20/18	

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F 684	<p>Continued From page 9</p> <p>A quarterly MDS assessment, dated 2/5/18, documented Resident #24 had a severe cognitive impairment and no behaviors. The MDS documented Resident #24 required extensive assistance of one staff member for bed mobility and had MASD.</p> <p>The care plan titled, At Risk for Skin Breakdown, revised 11/6/17, documented staff were to reposition Resident #24 as he would allow.</p> <p>The February 2018 Order Review History Report, documented Resident #24's skin impairment prevention orders included:</p> <ul style="list-style-type: none"> <li>* Air mattress with bolsters, setting 4th light from the bottom, and check placement and function every shift, ordered 9/29/17.</li> <li>* Twice daily monitor Resident #24's heels and coccyx for skin breakdown, ordered 9/29/17.</li> <li>* Foot cradle on Resident #24's bed, ordered 7/5/17.</li> <li>* Prevalon boots to Resident #24's feet while in bed, ordered 6/29/17.</li> <li>* Pressure-redistribution cushion to chair, ordered 3/5/16.</li> </ul> <p>A Change in Condition note, dated 1/18/18 at 12:22 PM, documented a skin ulcer was discovered on Resident #24.</p> <p>A Physician Order, dated 1/18/18, documented staff were to cleanse a wound to Resident #24's sacrum/buttocks and apply hydrogel and a dressing as needed.</p> <p>The care plan titled, Actual Skin Breakdown,</p>	F 684	<p>Other Residents Having the Potential to be Affected:</p> <p>A review of center residents skin prevention care plans was completed by the center executive director or designee on or before 3/08/18 to ensure that plan reflects turning and repositioning instruction based on resident assessed risk. Follow-up care plan and Kardex updates will be completed by the center executive director or designee on or before 3/20/18.</p> <p>A center care round will be completed by the center nurse executive or designee to ensure that residents are being positioned per the plan or care/ Kardex on or before 3/08/18 any identified issues will be immediately addressed.</p> <p>System Change/Education:</p> <p>Nursing staff were re-educated on the importance of providing positioning and offloading to prevent skin breakdown, and educated on repositioning residents per the plan of care/ Kardex by the Practice development specialist on or before 3/20/18.</p> <p>Beginning 3/20/18, Resident skin at risk care plans/ Kardex will be reviewed by the center nurse executive or designee on admission, and quarterly care plan meeting schedule to ensure that plan of care and Kardex reflects positioning instructions based off of resident assessment.</p>		

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F 684	<p>Continued From page 10 dated 1/19/18, documented Resident #24 had skin breakdown to his sacral and buttocks area related to excessive moisture and perspiration.</p> <p>A Change in Condition Follow-up Note, dated 1/18/18 at 11:22 PM, documented Resident #24's skin ulcer was on his coccyx and the treatment in progress was re-positioning Resident #24 from side to side. The follow-up note did not include direction for staff of when to reposition resident #24 or how often.</p> <p>Resident #24's clinical record did not contain evidence staff members were repositioning Resident #24 from side to side.</p> <p>On 2/21/18 at 9:13 AM, CNA #2 and CNA #5 were observed assisting Resident #24 into bed. Resident #24 was positioned on his back with a pillow wedged under his left side.</p> <p>On 2/21/18 from 9:20 AM through 11:32 AM, Resident #24 was observed positioned on his back with a pillow wedged under his left side. This was also true on 2/21/18 from 1:15 PM through 2:56 PM, on 2/22/18 from 9:02 AM to 10:00 AM, and 2/22/18 from 10:19 AM to 11:42 AM during observations.</p> <p>On 2/21/18 at 2:31 PM, CNA #5 stated direction for Resident #24's positioning was he was the last resident up before meals and the first resident to be laid down after meals.</p> <p>On 2/22/18 at 10:06 AM, LPN #1 provided Resident #24's wound care. The wound was observed with an island dressing covering approximately a 2 cm by 3 cm excoriated area.</p>	F 684	<p>Audits:</p> <p>Beginning the week of 3/20/18, the Center Nurse Executive will audit 3 residents to ensure that their care plans, and Kardex reflect instructions for repositioning residents based off assessment, and that repositioning occurs per the plan of care/ Kardex. These audits will be completed weekly X4 weeks and then monthly X 2 months. The results of these audits will be reported to the performance improvement committee monthly X3 months or until substantial compliance is achieved. The Center Nurse Executive is responsible for monitoring and oversight.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	Continued From page 11 The skin appeared to be sluffed off and was located in the gluteal fold on the right side near his coccyx. LPN #1 stated Resident #24 had excessive perspiration and tended to have acidic bowel movements, which predisposed him to increased skin impairment risk.	F 684			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)  §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;  §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;  §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to	F 692		3/20/18	Residents Affected:

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F 692	<p>Continued From page 12</p> <p>ensure residents received nutritional and hydration interventions to prevent unplanned weight loss and dehydration. This was true for 2 of 5 residents (#s 21, and 24) reviewed for weight loss and hydration concerns. a) Resident #21 had the potential for harm when he experienced a 7.67% weight loss in less than one months, and b) Resident #24 had potential for harm when he was not provided with fluids and/or assistance to consume them. Findings include:</p> <p>1. Resident #21 was admitted to the facility on 8/16/17 with diagnoses that included irritable bowel syndrome.</p> <p>A quarterly MDS assessment, dated 2/4/18, documented Resident #21 had a moderate cognitive impairment. The MDS documented Resident #21 experienced weight loss.</p> <p>The February 2018 Order Review History Report, documented Resident #21 received a regular/liberalized diet, ordered on 11/14/17 and supplements twice daily, ordered on 1/23/18.</p> <p>The care plan titled, Nutrition at Risk, revised 2/13/18, documented Resident #21's nutrition was at risk related to recent diagnosis of the flu, weight loss, and decreased appetite. The care plan interventions, dated 9/14/17, documented Resident #21 required and received fortified meals items, staff were to offer him snacks, staff were to provide house supplements, and Resident #21 required supervision and cueing with meals.</p> <p>A Nutrition Progress Note, dated 1/23/18,</p>	F 692	<p>Resident #21 was discharged from the center on 3/3/18.</p> <p>Resident #24 will be assessed by the Registered Dietitian on or before 3/20/18 to ensure that resident dietary requirements and fluid needs are met. Follow up will be completed as indicated by the review by the registered dietitian or designee on or before 3/20/18.</p> <p>Resident #24's care plan and Kardex will be reviewed and updated by the center nurse executive or designee on or before 3/08/18 to ensure that instructions for resident assistance with meals, and fluids including when staff should offer fluids in place. Follow-up will be completed as indicated by the review on or before 3/20/18.</p> <p>Resident #24 was assessed by Registered Dietician or designee for signs or symptoms of malnutrition, dehydration or other adverse effect associated with alleged non-compliance on or before 3/20/18 with no adverse effect noted. The refrigerator was stocked with thickened fluids by the dietary manager on 3/9/18.</p> <p>Other Residents Having the Potential to be Affected:</p> <p>Residents who require assistance and or those on thickened liquids, and those residents who require nutritional supplementation will be reviewed by the</p>		

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F 692	<p>Continued From page 13 documented Resident #21 received fortified potatoes with his meals.</p> <p>A General Progress Note, dated 1/26/18 documented Resident #21's was positive for influenza A&amp;B.</p> <p>A Nutritional Assessment, dated 2/13/18, documented Resident #21 had lost weight in the month and the weight loss "could" be attributed to the flu, Lasix order, and decreased intake. The assessment documented Resident #21's admit weight was 182.8 pounds and his current weight was 168.1 pounds. The assessment documented Resident #21 agreed to consume supplements twice daily, increasing his supplementation if needed, and consume his fortified potatoes.</p> <p>A Weight Flow Sheet, dated 1/30/18 through 2/22/18, documented the following weights for Resident #21 included:</p> <ul style="list-style-type: none"> <li>* 1/30/18 - 177.2 pounds</li> <li>* 2/5/18 - 171.2 pounds</li> <li>* 2/10/18 - 171.4 pounds</li> <li>* 2/15/18 - 168.3 pounds</li> <li>* 2/20/18 - 167.4 pounds</li> <li>* 2/22/18 - 163.6 pounds This was a 7.67% weight loss in less than one month.</li> </ul> <p>The 2/1/18 through 2/22/18 Activities of Daily Living (ADL) Record, Nutrition Amount Eaten at meal, documented Resident #21:</p> <ul style="list-style-type: none"> <li>* consumed less than 25% of his meals for 26 of 66 opportunities;</li> <li>* refused meals 11 of 66 opportunities;</li> <li>* was not offered a meal 2 of 66 opportunities;</li> </ul>	F 692	<p>registered dietitian to ensure that hydration and nutritional needs are being met on or before 3/20/18.</p> <p>Follow-up including assessment, physician notification, dietary communication, care plan and Kardex updates will be completed by the registered dietitian or designee on or before 3/20/18.</p> <p>The dietary manager or designee will review residents <input type="checkbox"/> who require nutritional interventions and or thickened liquids on or before 3/20/18 to ensure that tray cards, food liquids and supplies are available and on hand.</p> <p>A dining room review will be completed by the center nurse executive or designee to ensure that meals, supplements, and liquids are provided as ordered, on or before 3/20/18. Any follow-up will be completed at the time of the review.</p> <p>System Change/Education:</p> <p>Nursing staff and those who assist with dining were re-educated by Practice Development Specialist on ensuring that residents receive liquids and dietary supplementation per order on or before 3/20/18.</p> <p>The dietary department was re-educated on or before 3/20/18 by the Regional Dietary Manager, ensuring that dietary supplementation and thickened fluids are</p>		

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F 692	<p>Continued From page 14</p> <p>* was not offered a supplement or a meal alternative when he consumed less than 25% of his meal 39 of 39 opportunities.</p> <p>On 2/22/18 at 11:57 AM, Resident #21 was observed in the dining room and not eating his lunch meal. Resident #21's meal tray consisted of BBQ pulled pork, boiled red potatoes, sliced carrots, dinner roll, peach crisp, and milk. The lunch meal tray did not contain fortified potatoes.</p> <p>On 2/22/18 at 12:00 PM, Resident #21 was observed removed from the dining room without a supplement offered or an alternative meal offered.</p> <p>Resident #21's 2/22/18 Lunch Meal Ticket documented he refused the meal.</p> <p>On 2/22/18 at 12:08 PM, the CDM examined Resident #21's uneaten meal and could not locate the fortified potatoes.</p> <p>On 2/22/18 at 12:16 PM, Cook #1 stated she had not provided the fortified potatoes to Resident #21 during the current meal service. Cook #1 stated she had not been providing the fortified potatoes lately because Resident #21 did not like gravy.</p> <p>On 2/22/18 at 12:17 PM, the CDM was observed notifying Cook #1 that she needed to provide the fortified foods to residents if the Dietitian (RD) had recommended it. The CDM stated if Resident #21 was not eating a fortified food item, then the cook should notify the CDM and the CDM would notify the RD. The CDM stated residents should be offered an alternative meal</p>	F 692	<p>provided per the physicians order.</p> <p>Beginning 3/20/18 the dietary manager or designee will review trays prior to meal service to ensure that supplements, nutritional interventions are provided on the trays per order.</p> <p>Beginning 3/20/18 the dietary manager or designee will check/ stock the nursing pantry to ensure that thickened fluids are available to staff 3X a day.</p> <p>Audit:</p> <p>Beginning 3/20/18, an audit of 3 residents will be completed by the Center Nurse Executive or designee to ensure that meals are provided as ordered. These audits will be completed weekly X 4 weeks and then monthly X2 months.</p> <p>The results of the audits will be reported to the performance improvement committee for review monthly X3 months or until substantial compliance is achieved.</p> <p>The Center Nurse Executive is responsible for monitoring and follow-up.</p>		

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F 692	<p>Continued From page 15</p> <p>item and or a supplement if they eat less than 25% of meals or refuse meals. The CDM stated other foods could be fortified if Resident #21 did not want the potatoes. The CDM stated, "The cook should have notified myself and I would have notified the RD," prior to stopping the fortified foods.</p> <p>On 2/22/18 at 5:37 PM, Resident #21 was in the small dining room with LN #2 observed sitting next to Resident #21. LN #2 was not observed cueing Resident #21 or reminding him to take alternating bites of foods and liquids. LN #2 was observed intermittently assisting other residents' needs throughout the meal service.</p> <p>On 2/23/18 at 12:36 PM, the CDM stated she contacted the RD and the RD was not aware Resident #21 was not receiving the fortified potatoes.</p> <p>2. Resident #24 was admitted to the facility on 3/5/16 with diagnoses that included Alzheimer's disease, dementia, oropharyngeal dysphagia, and cognitive communication deficit.</p> <p>A quarterly MDS assessment, dated 2/5/18, documented Resident #24 had a severe cognitive impairment and no behaviors. The MDS documented Resident #24 required extensive assistance of 1 staff member with eating and drinking needs.</p> <p>The February 2018 Order Review History Report, documented Resident #24's current dietary orders were as follows:</p> <p>* Pureed diet texture with "spoon thickened</p>	F 692			

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F 692	<p>Continued From page 16 (pudding) liquids," ordered 2/14/18. * Strict aspiration precautions, ordered 1/30/18. * 1/2 tsp bites with foods and liquids, ordered 1/30/18.</p> <p>The care plan titled, Impaired Swallowing, dated 2/5/18, documented Resident #24 coughed during meals. The care plan documented staff were to provide Resident #24 with a puree diet texture and spoon thick liquids. The care plan documented Resident #24 required one staff members assistance with meals and fluid intake.</p> <p>The care plan titled, Hydration, revised 6/7/17, documented Resident #24 was at risk for dehydration related to immobility, dementia, and his inability to access fluids on his own.</p> <p>According to the Nutrition Care Manual "Methods for Estimating Fluid Requirements" from the Academy of Nutrition and Dietetics, adults within Resident #24's age range should consume 25 ml per kilogram of body weight per day. Using this calculation method, Resident #24 needed a total daily fluid intake of 1602 ml's.</p> <p>The 2/1/18 through 2/21/18 ADL Record, Fluid Intake, documented Resident #24's total fluid intake for each day with meals. Resident #24 received the highest total fluid intake of 480 ml on 2/4/18, 2/6/18, 2/7/18, 2/12/18, 2/13/18, 2/15/18 - 2/18/18. Resident #24 received the lowest total fluid intake of 240 ml on 2/1/18, and 2/14/18. Resident #24's average fluid intake for the dates above was 382.8 ml's.</p> <p>The 2/1/18 through 2/21/18 ADL Record, Bladder Voiding, documented Resident #24's total fluid</p>	F 692			

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F 692	Continued From page 17 output for each day. Resident #24's highest total fluid output of 800 ml's occurred on 2/1/18 and 2/21/18. Resident #24's lowest total fluid output of 150 ml's occurred on 2/4/18. Resident #24's average fluid output for the dates above was 573.8 ml's.  On 2/21/18 from 9:06 AM through 11:32 AM, Resident #24 was observed in bed with multiple staff contacts and staff did not offer him fluids. This was also true on 2/21/18 from 1:15 PM through 2:56 PM and on 2/22/18 from 9:02 AM to 11:42 AM during observations.  On 2/22/18 at 2:40 PM, the DON stated residents were provided fluids during meals, med pass, and during cares. The DON stated staff should be in a residents' room at least every two hours and offer fluids when they were in the room. The DON stated spoon thick fluids were located in the residents' refrigerator on the unit.  On 2/22/18 at 2:55 PM, the DON accompanied the surveyor to the residents' refrigerator. The DON stated she could not locate spoon thick liquids in the residents' refrigerator. The DON stated she would call the kitchen to prepare spoon thick liquids.	F 692			
F 805 SS=K	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3)  §483.60(d) Food and drink Each resident receives and the facility provides-  §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by:	F 805		3/20/18	

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NAME OF PROVIDER OR SUPPLIER  <b>SUNNY RIDGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2609 SUNNYBROOK DRIVE NAMPA, ID 83686</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 805	<p>Continued From page 18</p> <p>Based on observation, staff interview, record review, policies and recipes, it was determined the facility failed to ensure physician-ordered pureed diets and thickened liquids were the appropriate consistency when served to residents. This was true for 1 of 2 sampled residents (#24) with orders for thickened liquids and diet texture alterations. Resident #24 was in immediate jeopardy (IJ) of serious harm, impairment, or death when: a. Resident #24 was provided nectar thick liquids rather than spoon thick (pudding-like) liquids; b. Resident #24 received pureed food items inconsistent with physician orders; and c. Resident #24 was positioned inappropriately during liquid intake and after meals. On 2/22/18 at 7:26 pm, the facility's Administrator and DON were notified verbally and in writing of the IJ situation. Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>* Ensure physician orders were followed regarding therapeutic diets and thickened liquids, which increased residents' risk of aspiration or choking on beverages or food.</li> <li>* Ensure the food prepared and delivered to residents was consistent with physician's dietary orders prior to residents eating or drinking food and/or beverages.</li> <li>* Ensure thickened liquids were provided at the consistency ordered by the physician.</li> <li>* Ensure aspiration precautions were implemented.</li> </ul> <p>The combined effect of the above failed systems placed Resident #24, and all other residents on</p>	F 805	<p>Residents Affected:</p> <p>Resident #24 was assessed by LN for any adverse effect related to receiving the incorrect fluid consistency/ diet texture, or lack of aspiration precautions on or before 2/22/18. No adverse effects were noted.</p> <p>Other Residents Having the Potential to be Affected:</p> <p>A dining room audit was completed by the center nurse executive or designee to ensure that meal textures, liquid consistencies are provided as ordered on or before 2/22/18.</p> <p>A post-meal round was completed by the center nurse executive or designee to ensure that residents <input type="checkbox"/> with ordered aspiration precautions were administered as ordered.</p> <p>A tray audit will be completed by the Regional dietary manager on 2/22/18 to ensure that trays were prepared per MD order. Any concerns were immediately addressed.</p> <p>System Change/Education:</p> <p>Nursing and kitchen staff will be re-educated by the speech therapist or designee on or before 3/20/18 related to diet textures and fluid consistencies.</p> <p>Dietary staff completed a fluid thickness and diet texture preparation competency</p>		

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F 805	<p>Continued From page 19</p> <p>thickened liquids and/or altered textured diets, at immediate risk for serious harm, impairment, and/or death.</p> <p>Findings include:</p> <p>The Idaho Diet Manual for Health Care Facilities, 11th edition, 2015, documented the ideal puree consistency should resemble whipped topping or mashed potatoes and occasionally pureed foods may be a thinner consistency to meet an individual's needs. In addition, the Idaho Diet Manual documented that foods with high water content must be drained or have additional fluid thickened to the correct consistency. The Idaho Diet Manual referenced the National Dysphagia Diet: Standardization for Optimal Care guidelines.</p> <p>The National Dysphagia Diet: Standardization for Optimal Care 2002, documented a pureed diet was for people who had moderate to severe dysphagia with poor oral phase abilities and reduced ability to protect their airways. A puree diet consists of pureed, homogenous, and cohesive foods and should be "pudding-like."</p> <p>The American Speech-Language-Hearing Association at <a href="http://www.asha.org/public/speech/swallowing/Swallowing-Disorders-in-Adults">http://www.asha.org/public/speech/swallowing/Swallowing-Disorders-in-Adults</a>, documented a 2004 study that identified signs and symptoms of swallowing disorders included coughing during that or right after eating or drinking, wet or gurgly sounding voice during or after eating or drinking, extra effort or time needed to chew or swallow, and food or liquid leaking from or getting stuck in the mouth. The study noted treatments for those</p>	F 805	<p>administered by the regional dietary manager or designee on or before 3/20/18.</p> <p>On or before 3/20/18 the dietary manager or designee will review completed trays prior to meal service to ensure that fluids and meals textures/ thickness are administered per order.</p> <p>On or before 3/20/2018, dining will be supervised by a staff member who has been trained and deemed competent on diet textures and fluid consistencies to ensure that food and fluids are screened prior to service to residents.</p> <p>On or before 3/20/18 nursing staff will validate fluid consistency and diet texture prior to resident consuming food or fluids.</p> <p>Dietary staff was educated on preparation of altered diet textures, and thickened liquids by the area dietary manager on or before 2/23/2018.</p> <p>Dietary staff completed/passed a competency administered by the area dietary manager on thickening liquids, and preparation of altered diet textures on 2/23/2018.</p> <p>Beginning 2/23/2018 the dietary manager or designee who has demonstrated competency will complete a validation of diet textures, and thickened liquid consistency before meals or fluids are provided to nursing staff for distribution to</p>		

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F 805	<p>Continued From page 20</p> <p>with swallowing disorders included positioning and strategies to help the individual swallow more effectively.</p> <p>The facility's 11/28/16 Dysphagia Diet -Liquids Policy and Procedure (P&amp;P) documented "nectar-like" liquids were fluids that poured like buttermilk, "honey-like" liquids were fluids that poured like honey or tomato sauce, and "spoon thick" liquids were fluids that held their shape on a spoon like pudding. The P&amp;P documented "nectar-like" and "honey-like" fluids were commercially bought and "spoon thick" liquids were prepared and served by the kitchen.</p> <p>The above standards of practice were not followed. Examples include:</p> <p>1. Resident #24 was admitted to the facility on 3/5/16 with diagnoses that included Alzheimer's disease, dementia, oropharyngeal dysphagia, and cognitive communication deficit.</p> <p>A quarterly MDS assessment, dated 2/5/18, documented Resident #24 had a severe cognitive impairment and no behaviors. The MDS documented Resident #24 was being followed by the Speech Language Pathologist (SLP) as of 1/30/18.</p> <p>The February 2018 Order Review History Report documented Resident #24's current and discontinued dietary orders were as follows:</p> <p>i. Active:</p> <ul style="list-style-type: none"> <li>* Pureed diet texture with "spoon thickened (pudding) liquids," ordered 2/14/18.</li> <li>* Strict aspiration precautions, ordered 1/30/18.</li> </ul>	F 805	<p>residents.</p> <p>Nursing staff was educated by the Practice Development Manager on aspiration precautions, diet textures, and liquid consistencies, and screening food and fluids prior to administration to residents to ensure that meals texture and liquid consistency are consistent with physician orders on or before 2/23/2018.</p> <p>Audit:</p> <p>Beginning 3/20/18 the center nurse executive or designee will audit 5 residents with altered diet texture/ thickened liquids to ensure that resident received texture/ thickness per order. These audits will be completed weekly X4 weeks, and then monthly x2 until substantial compliance is achieved.</p> <p>On or before 3/20/18 the dietary manager or designee will review completed trays prior to meal service to ensure that fluids and meals textures/ thickness are administered per order.</p> <p>On or before 3/20/18 nursing staff will validate fluid consistency and diet texture prior to resident consuming food or fluids.</p> <p>On or before 3/20/18, Physician orders for diet texture and fluid consistency will be reviewed by the Center Nurse Executive or designee to ensure that care plan and Kardex, are updated to reflect current orders weekly X4 weeks, and then monthly x2 months until substantial</p>		

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F 805	<p>Continued From page 21</p> <p>* 1/2 tsp bites with foods and liquids, ordered 1/30/18.</p> <p>ii. Discontinued:</p> <p>* Pureed diet texture with "honey thick liquids," ordered 1/30/18 and discontinued 2/14/18.</p> <p>* Pureed diet texture with "nectar-like" liquids, ordered 8/28/17 and discontinued 1/30/18.</p> <p>The care plan titled, Impaired Swallowing, dated 2/5/18, documented Resident #24 coughed during meals. The care plan documented staff were to provide Resident #24 with a puree diet texture and spoon thick liquids. The care plan documented Resident #24 was to be upright at 90 degrees when swallowing food or drink and required one staff member to assist with meals. The care plan documented staff were to stop assisting Resident #24 with food or liquids if he started coughing.</p> <p>The care plan titled, Nutrition at Risk, revised 9/22/17, documented Resident #24 was nutritionally at risk related to dysphagia and dementia. The care plan documented Resident #24 required 1/2 tsp bites when eating. The care plan documented staff were to follow strict aspiration precautions. The care plan did not define what strict aspiration precautions meant.</p> <p>On 2/21/18 at 8:55 AM, Resident #24 was being assisted with his breakfast meal by the LSW (who was also a CNA). Resident #24 started coughing and his cough had a wet vocal quality to it.</p> <p>On 2/21/18 at 8:59 AM, the LSW stopped assisting Resident #24 with his breakfast meal.</p>	F 805	<p>compliance is achieved.</p> <p>On or before 3/20/18, an audit/observation of residents with aspiration precautions will be completed by the center nurse executive or designee to ensure that residents <input type="checkbox"/> are provided aspiration precautions per physicians order weekly X4 weeks and then monthly x2 months until substantial compliance is achieved.</p> <p>Center Nurse Executive is responsible for monitoring and follow-up.</p>		

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

PRINTED: 03/19/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/23/2018</b>
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F 805	<p>Continued From page 22</p> <p>On 2/21/18 at 9:13 AM, CNA #2 and CNA #5 assisted Resident #24 into bed. Resident #24 was positioned on his back with a pillow wedged under his left side. The head of the bed was elevated to approximately 30 degrees or less.</p> <p>On 2/21/18 at 9:20 AM, Resident #24 was observed coughing and his cough had a wet vocal quality to it.</p> <p>On 2/21/18 from 9:20 AM through 11:21 AM, Resident #24 coughed intermittently.</p> <p>On 2/21/18 at 2:29 PM, LN #2 administered medications to Resident #24. Resident #24's head of bed was elevated to approximately 60 degrees. Resident #24 was coughing after LN #2 administered the medications. The LN lowered the bed to approximately 15 degrees or less after administering the medications.</p> <p>On 2/21/18 at 2:31 PM, Resident #24 was in bed and was coughing with wet vocal quality.</p> <p>On 2/22/18 from 8:33 AM to 8:47 AM, Resident #24 was being assisted with his breakfast meal by CNA #8. Resident #24 was observed coughing while CNA #8 continued to provide Resident #24 with food. CNA #8 did not stop assisting Resident #24 with his breakfast meal when he was coughing. At 8:48 AM, Resident #24 was moved to his room.</p> <p>On 2/22/18 at 9:02 AM, CNA #8 and CNA #6 assisted Resident #24 into bed. Resident #24 was positioned on his back with a pillow wedged under his left side. The head of the bed was</p>	F 805			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 805	<p>Continued From page 23</p> <p>elevated to approximately 15 degrees or less. Resident #24's neck was slightly hyper-extended.</p> <p>On 2/22/18 from 9:11 AM through 10:06 AM, Resident #24 remained in the same position until LN #1 looked at his wound.</p> <p>On 2/22/18 at 2:40 PM, the SLP stated Resident #24 did not open his mouth very wide and he required small 1/2 tsp bite sizes while eating. The SLP stated Resident #24 was safest on pureed diet texture and spoon thick (pudding-like) liquids. The SLP stated Resident #24 coughed during meals which was what alerted her to needing an assessment. The SLP stated when diet changes occurred she filled out an order for the physician to sign. The SLP stated she would then fill out a diet change request for the kitchen and lastly, she would change the order in the facility's online medical records. The SLP stated Resident #24 should be on "standard aspiration precautions." The SLP stated the care plan did not define aspiration precautions because, "Staff know what aspiration precautions are." The SLP stated in "normal" circumstances residents would remain upright for minimally 30 minutes after meals. The SLP stated Resident #24 had MASD to his coccyx and he was the last one up before meals and the first one down after meals. The SLP stated when Resident #24 was assisted in bed directly after meals, he should be elevated to approximately 45 degrees or more for at least 30 minutes. The SLP stated Resident #24 should be elevated to 90 degrees for all food and beverage intake. The SLP stated she had educated staff on residents' swallowing needs or aspiration precautions on a 1:1 basis. The SLP stated she would search for any educations she had</p>	F 805			

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F 805	<p>Continued From page 24</p> <p>provided to staff in regards to Resident #24's diet requirements.</p> <p>On 2/22/18 at 2:50 PM, the DON stated aspiration precautions meant residents should be provided the safest diet order as specified by the SLP and/or physician. The DON stated residents should be left up-right in a chair for minimally 30 minutes after meals and if they were placed in bed before the 30 minutes, then the bed should be elevated to minimally 45 degrees. The DON stated residents should be sitting up-right for all food and beverage intake.</p> <p>The Resident Alert - "Diet: Pureed &amp; Nectar Thick liquids," dated 9/1/17, documented Resident #24 required "Aspiration precautions and feeding strategies, verbal cue patient during meals: 1) to clear his throat, 2) to swallow again (second dry swallow), 3) give nectar liquid every 1-2 bites, 4) feed slowly, 5) 1/2 tsp bites, 6) if pt [patient] coughs stop feeding until cough stops &amp; voice is clear." The facility could not provide evidence further diet change educations were provided to staff regarding Resident #24's diet changes to honey and then spoon thick liquids. On 2/22/18 at 2:55 PM, the DON stated sometimes there was a lack of communication between therapy and nursing when residents' diets were changed.</p> <p>2. On 2/22/18 at 2:55 PM, the DON stated she could not locate spoon thick liquids in the residents' refrigerator. The DON stated she would call the kitchen to prepare spoon thick liquids.</p> <p>On 2/22/18 at 3:05 PM, CNA #1 was observed pouring nectar thick water into a cup and entered</p>	F 805			

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F 805	<p>Continued From page 25</p> <p>Resident #24's room. As surveyor entered the room, Resident #24's head of bed was raised approximately 20 degrees and CNA #1 had her hand behind his neck which hyper-extended his neck. She had the cup tilted towards his open mouth and a drop of the nectar thick liquids entered his mouth. CNA #1 was asked to stop providing the fluids and was asked what fluids she was providing Resident #24, CNA #1 stated, "Nectar thick water." When asked what Resident #24's orders documented CNA #1 stated, "Nectar thick." CNA #1 attempted to provide additional fluids and was stopped and asked to check the order. LN #1 was asked to come and assist CNA #1. LN #1 examined the fluids in the cup and stated, "This is wrong." LN #1 verified Resident #24's diet order, care plan, and Kardex with CNA #1, which all documented spoon thick liquids. CNA #1 stated, "Well, I messed up." CNA #1 stated the fluids on Resident #24's dinner meal tray were consistently nectar thick. CNA #1 stated Resident #24 received nectar thick liquids "all the time." CNA #1 stated she had not checked Resident #24's care plan or Kardex before providing Resident #24 with fluids.</p> <p>On 2/22/18 at 3:11 PM, DA #1 was carrying Resident #24's thickened liquids towards the residents' refrigerator that she had prepared. The thickened liquids were dropped off with LN #1. The liquids were observed dripping readily off of a spoon and swished easily around the cup. LN #1 stated the liquids were not spoon thick viscosity, and were not appropriate for Resident #24.</p> <p>On 2/22/18 at 3:15 PM, the CDM in Training was shown the thicken liquids prepared for Resident</p>	F 805			

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F 805	<p>Continued From page 26</p> <p>#24. The CDM in Training was asked what spoon thick liquids meant and she was "not sure." The CDM in Training was asked what pudding thick liquids meant and she stated, "Like pudding." The CDM in Training stated she did not realize spoon thick and pudding thick liquids were the same thickness. The CDM in Training was asked if the fluids in the cup were spoon thick or pudding-like and she stated, "No." The CDM in Training left with the beverages to add more instant thickener.</p> <p>On 2/22/18 at 4:53 PM, Cook #2 stated she though spoon thick liquids viscosity was between nectar and honey thick liquids. Cook #2 stated she did not realize spoon thick and pudding thick liquids were the same thickness.</p> <p>On 2/22/18 at 4:58 PM, the facility provided copies of the instant food thickener and a second document of a different food thickener directions. The label on the instant food thickener used in the facility directed staff to stir the liquid for 10-20 seconds and allow it to sit for 1-4 minutes until the right consistency was reached.</p> <p>The facility provided a second instant food thickener label which contained directions for a product not stocked in the facility. The directions directed staff to use different amounts of food thickener and directed staff to stir for 15-30 seconds and allow fluids to sit for 1-5 minutes. The CDM in Training stated staff utilized the directions on the second instant food thickeners label to prepare thickened liquids. The CDM in Training did not realize there was a difference between the two documents and the amount of thickener needed.</p>	F 805			

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F 805	<p>Continued From page 27</p> <p>3. Resident #24's dinner meal was the incorrect consistency and viscosity.</p> <p>The Puree Chicken and Dumpling recipe and the Puree French Cut Green Beans recipe documented staff were to prepare per recipe, place the needed portions into a food processor, and blend until smooth. The recipe documented if the mixture was too thick, staff were to add low sodium broth and if the mixture was too thin, staff were to add instant food thickener. The recipe documented the food should resemble a soft whipped cream consistency.</p> <p>On 2/22/18 at 5:17 PM, the CDM in Training was assessing the temperatures of the food. When the CDM in Training assessed the temperature of the Puree Chicken and Dumplings, the thermometer's probe was inserted into the puree, and the puree did not cling to the probe and readily dripped off of the tip. The puree was observed thin and did not appear like whipped topping or mashed potatoes. The Puree French Green Beans appeared like apple sauce consistency when temperature was obtained.</p> <p>On 2/22/18 at 5:29 PM, the CDM in Training plated Resident #24's dinner meal with the Puree Chicken and Dumplings and the Puree French Cut Green Beans.</p> <p>On 2/22/18 from 5:37 to 5:49 PM, CNA #1 set Resident #24's dinner meal up in front of the resident. CNA #1 provided Resident #24 with 1/2 tsp bites inconsistently throughout the observation. CNA #1 was asked if the pureed food was the correct consistency and she stated,</p>	F 805			

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F 805	<p>Continued From page 28</p> <p>"No." CNA #1 was observed using a spoon in the green beans and the puree dribbled off the spoon. CNA #1 used a fork to stir the Chicken and Dumplings, and when she lifted the fork out of the puree, it readily dripped off of the fork. CNA #1 stated the way the food was prepared was how it was "always" prepared. CNA #1 stated in the past she had sent the food back, however, nothing changed. CNA #1 was asked if she was going to continue providing Resident #24 with food even when she was aware that it was the wrong consistency, and CNA #1 stated, "Yes."</p> <p>On 2/22/18 at 6:02 PM, the CDM provided a test tray of the Puree Chicken and Dumplings and the Puree French Cut Green Beans. The Chicken and Dumplings dripped readily off the spoon, and the green beans were not a homogenous, and cohesive food that was "pudding-like." The CDM stated some puree foods would be "thinner depending on the water content," and agreed Resident #24's puree should be minimally spoon thick or pudding-like because of his thickened liquid order. When asked if the purees were the correct consistency, she stated, "The Chicken and Dumplings appears barely off." The CDM stated the consistency of the French Cut Green Beans was "fine." When asked if Resident #24 should be consuming the puree she stated, "No." The CDM was asked to remove the puree from Resident #24's plate and she did so. The CDM stated the CDM in Training should have noticed the incorrect consistency when she was plating the food. The CDM stated she would then expect nursing staff to not serve the food to the resident if they noticed the food was the incorrect consistency.</p>	F 805			

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F 805	<p>Continued From page 29</p> <p>On 2/22/18 at 6:09 PM, the DON was shown the pureed food items and stated the purees were thin and were not the correct consistency.</p> <p><b>NOTIFICATION AND REMOVAL OF IMMEDIATE JEOPARDY:</b></p> <p>On 2/22/18 at 7:26 PM, the facility's Administrator and DON was notified verbally and in writing of the IJ situation, and of the need to formulate and implement a plan of removal.</p> <p>On 2/23/18 at 4:00 PM, the facility provided evidence that an acceptable plan to remove the immediacy had been developed and implemented. Resident #24 was evaluated by the nursing for signs and symptoms of aspiration. All residents with orders for a pureed diet and/or thickened liquids were assessed and evaluated for aspiration precautions and records assessed for accurate orders, care plans, and Kardex. The removal plan included re-education of dietary staff on following recipes, ensuring thickened liquids were correct, and ensuring pureed foods were of pudding-like consistencies. The removal included the dietary manager or designee were educated to ensure the trays were appropriately assessed prior to distribution to the nursing staff. The nursing staff were educated on thickened liquids and ensuring pureed foods were of pudding-like consistencies and to return incorrect consistency foods and beverages to the kitchen. The nursing staff was educated on aspiration precautions.</p> <p>The above actions were verified and the Immediate Jeopardy removed prior to the survey exit conference completed on February 23, 2018.</p>	F 805			

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F 812 SS=E	<p>Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§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.</p> <p>§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 and interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen. This affected 3 of 4 (#'s 2, 21, and 24) sampled residents and had the potential to affect all residents who dined in the facility. This failure created the potential for harm if residents contracted food-born illnesses or contagious diseases. Findings include:</p> <p>Dishware Washing: On 2/22/18 at 2:07 PM, the Dishwasher was observed during the dishwashing process</p>	F 812	<p>Residents Affected:</p> <p>Resident #21 discharged on 3-3-18. Residents #2 and #24 will be assessed by CNE or designee on or before 3-20-18 for signs and symptoms of food-borne illnesses.</p> <p>Other Residents Having the Potential to be Affected:</p> <p>The dining manager did a dishwashing and meal-prep, and tray-line observation as well as a kitchen inspection for any</p>	3/20/18	

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F 812	Continued From page 31 wearing a disposable apron. The Dishwasher cleaned the soiled dishes and sent them through the dishwasher. The Dishwasher entered the clean dishware side of the area without removing her apron, which was splashed with food particles and water. The Dishwasher removed clean dishes from the tray and rested the clean dishes against her chest to carry them towards their storage area.  The CDM, present during the observation, stated this was not the correct procedure for handling clean dishware. She stated the Dishwasher should not allow dishes to touch her soiled apron. The CDM had the Dishwasher re-sanitize the dishes.	F 812	noted cross-contamination on or before 3/20/2018. Any identified issues were immediately addressed.  System Change/Education:  Dietary staff was re-educated by regional dietary manager or designee on machine ware washing, as well as ensuring good infection control practices, and avoiding cross-contamination on or before 3-20-18.  Dietary staff completed machine ware competencies by dietary manager or designee by 3-20-18.  Audit:  Beginning the week of 3/20/2018 Sanitation audits will be completed by dietary manager or designee on or before 3-20-18 2x per week for X4 weeks then 1x per week for two months.  Results will be reported to the QAPI Committee monthly x3 months or until substantial compliance is achieved. The dietary manager is responsible for compliance.		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		3/20/18	

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F 880	<p>Continued From page 32 diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> <li>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</li> <li>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</li> <li>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</li> <li>(iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> <li>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</li> <li>(B) A requirement that the isolation should be the least restrictive possible for the resident under</li> </ul> </li> </ul>	F 880			

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F 880	<p>Continued From page 33</p> <p>the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 3 residents (#2, #21, and #24) when staff failed to perform effective hand hygiene during resident cares. The facility failed to practice universal precautions when catheter bags were observed on the floor in residents' rooms (Resident #21 and #24); kitchen employees did not perform appropriate hand hygiene; and for 1 random residents observed during a meal service in the dining room. These failures created the potential for the spread of infection among residents. Findings include:</p>	F 880	<p>Residents Affected:</p> <p>Residents #2 and #24 were assessed for signs or symptoms of infection on 3/20/18 with none noted.</p> <p>Resident #21 discharged from the center on 3/03/18.</p> <p>Other Residents Having the Potential to be Affected:</p> <p>An infection control round will be completed by the center nurse executive or designee on or before 3/20/18</p>		

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F 880	<p>Continued From page 34</p> <p>The Center for Disease Control (CDC) recommended the following procedure for hand hygiene with soap and water:</p> <ul style="list-style-type: none"> <li>* Wet hands first with water,</li> <li>* Apply the recommended amount of anti-bacterial soap,</li> <li>* Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers,</li> <li>* Rinse hands with water and use disposable towels to dry, and</li> <li>* Use towel to turn off the faucet.</li> </ul> <p>The CDC guidelines also documented other entities had recommended cleaning hands with soap and water for approximately 20 seconds and documented either amount of time was acceptable.</p> <p>The facility's Hand Hygiene - Infection Control Policies and Procedures, dated 11/28/17, documented staff should "Perform hand hygiene: 1.1 before resident care; 1.2 before an aseptic procedure; 1.3 after any contact with blood or other body fluids, even if gloves are worn; 1.4 after patient care; and 1.5 after contact with the patient's environment."</p> <p>The above standards of practice and facility policy and procedure, was not followed. Examples include:</p> <p>Hand Hygiene Observations and Interviews</p> <p>1. On 2/20/18 at 11:34 AM, CNA #7 was observed touching his/her face and then</p>	F 880	<p>observing for any infection control concerns or handwashing concerns Follow up with be completed by the center nurse executive at the time of the review 3/20/18.</p> <p>System Change/Education:</p> <p>Center staff including kitchen and nursing staff were re-educated by the practice development specialist or designee on hand hygiene on or before 3/20/18.</p> <p>Nursing and dietary staff completed a hand hygiene competency administered by the practice development specialist or designee on or before 3/20/18.</p> <p>Nursing staff were re-educated on catheter care and infection control by the Practice Development Specialist or designee on or before 3/20/18. Nursing staff will complete a post-test to validate competency on or before 3/20/18.</p> <p>Audit:</p> <p>Beginning 3/20/18 an audit of 3 hand hygiene observations, and 3 catheter management observations will be completed by the center nurse executive or designee to ensure that infection control measures are followed.</p> <p>These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the QAPI committee monthly X3 months</p>		

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F 880	<p>Continued From page 35</p> <p>delivering 1 random residents tray with no hand hygiene.</p> <p>2. On 2/21/18 at 8:45 AM, CNA #2 and CNA #3 were observed assisting Resident #21 into bed with a Hoyer lift. Resident #21's urinary drainage bag was placed on the floor while the Hoyer sling was being readjusted under the resident. CNA #3 did not perform hand hygiene after acquiring the urinary drainage bag off of the floor.</p> <p>3. On 2/21/18 at 9:13 AM, CNA #2 and CNA #5 were observed assisting Resident #24 into bed. Resident #24's urinary drainage bag was placed on the floor while the sit to stand sling was placed on the resident. After Resident #24 was assisted into bed, his bed lowered to low position, and the urinary drainage bag was touching the floor.</p> <p>4. On 2/21/18 at 9:53 AM, CNA #7 was observed assisting Resident #2 with cares. After CNA #7 finished performing pericare he/she changed their gloves and replaced the gloves with fresh gloves without first performing hand hygiene.</p> <p>5. On 2/21/18 at 11:28 AM, CNA #2 and CNA #3 were observed assisting Resident #21 out of bed with a Hoyer lift. Resident #21's urinary drainage bag was placed on the floor while Resident #21 was being adjusted in his wheelchair. The urinary drainage bag was on the floor for 10 seconds before CNA #2 placed the urinary drainage bag on the wheelchair.</p> <p>6. On 2/21/18 at 11:32 AM, CNA #2 and CNA #3 were observed assisting Resident #24 out of bed with a sit to stand machine. Resident #24's</p>	F 880	<p>or until substantial compliance is achieved. The center nurse executive is responsible for monitoring and follow-up.</p>		

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F 880	<p>Continued From page 36</p> <p>urinary drainage bag was placed on the floor while Resident #24 was being adjusted in his wheelchair. The urinary drainage bag was on the floor for 5 seconds before CNA #3 placed the urinary drainage bag on the wheelchair.</p> <p>7. On 2/21/18 2:20 PM, LN #2 was observed holding a cup of medication for Resident #21 and with the other hand she moved Resident #21's urinary drainage bag lower down on the bed. When she finished moving the urinary drainage bag, LN #2 then continued to administer the medication without hand hygiene.</p> <p>8. On 2/21/18 from 2:25 to 2:49 PM, Resident #24 was resting in bed with his bed in low position, and the urinary drainage bag was touching the floor.</p> <p>On 2/21/18 at 2:50 PM LN #3 stated the urinary drainage bag should never touch the floor.</p> <p>On 2/21/18 at 2:56 PM, the Infection Control Specialist RN observed Resident #24's urinary drainage bag on the floor and stated, there should be a basin to place the urinary drainage bag in while the bed was in low position. The Infection Control Specialist RN stated she would correct the issue.</p> <p>9. On 2/22/18 at 9:02 AM, CNA #6 and CNA #8 were observed assisting Resident #24 out of his wheelchair and into bed after the breakfast meal. The CNAs changed Resident #24's briefs while he was standing up in the sit to stand lift. CNA #6 did not change his/her gloves, or perform hand hygiene throughout the observation until he/she had completed their task.</p>	F 880			

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F 880	Continued From page 37  10. On 2/22/18 at 5:15 PM, DA #1 was observed washing her hands. The DA turned the water on, put soap in her hand and rubbed her hands together for 2 seconds, and then rinsed her hands under running water. DA #1 turned the water off with her clean hand and then dried her hands.  On 2/23/18 at 9:04 AM, the Infection Control Specialist RN stated the observations described above were inappropriate forms of hand hygiene. The RN stated during cares staff should perform hand hygiene, prior to assisting residents, before transitioning from dirty to clean, and after cares were completed. The RN stated gloves should be changed when transitioning from dirty to clean and hand hygiene as well performed. The RN stated staff should wash their hands for a minimum of 20 seconds with soap and water and if hand sanitizer was used then until their hands were dry. The RN stated if staff touched their body, then they should perform hand hygiene before assisting residents with food.	F 880			