



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)

April 19, 2018

Sherrie Nunez, Administrator  
Apex Center  
8211 Ustick Road  
Boise, ID 83704-5756

Provider #: 135079

Dear Ms. Nunez:

On **April 5, 2018**, a survey was conducted at Apex Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes 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.) **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 **April 30, 2018**. Failure to submit an acceptable PoC by **April 30, 2018**, may result in the imposition of civil monetary penalties by **May 22, 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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

- Denial of payment for new admissions effective July 5, 2018
- Civil money penalty

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on October 5, 2018, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009;

Sherrie Nunez, Administrator  
April 19, 2018  
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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/tabid/434/Default.aspx>

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

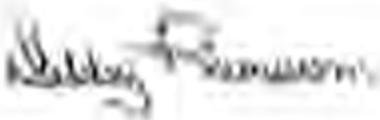
- BFS Letters (06/30/11)

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

This request must be received by **April 30, 2018**. If your request for informal dispute resolution is received after **April 30, 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,



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

dr/lj  
Enclosures

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

PRINTED: 06/27/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/05/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>APEX CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8211 USTICK ROAD</b> <b>BOISE, ID 83704</b>		
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F 000	INITIAL COMMENTS  The following deficiencies were cited during a complaint survey conducted at the facility from April 2, 2018 through April 5, 2018.  The surveyors conducting the survey were:  Brad Perry, LSW, Team Coordinator Linda Kelly, RN Jenny Walker, RN Teresa Kobza, RD Edith Cecil, RN Cecilia Stockdill, RN  Survey Abbreviations: ADL = Activities of Daily Living CM = Centimeter CNA = Certified Nursing Assistant CPR = Cardiopulmonary Resuscitation DON = Director of Nursing IV = Intravenous LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment RN = Registered Nurse TAR = Treatment Administration Record	F 000			
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)  §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced	F 558		6/5/18	

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

TITLE

(X6) DATE

Electronically Signed

04/29/2018

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 558	<p>Continued From page 1</p> <p>by:</p> <p>Based on observation, record review, interview with a resident's interested party, and staff interview, it was determined the facility failed to ensure a resident's call light was within reach for 1 of 9 (#2) residents sampled for call lights. This deficient practice had the potential to cause harm if the resident could not request assistance when needed or experienced an adverse medical event requiring prompt staff attention. Findings include:</p> <p>Resident #2 was admitted to the facility on 8/22/17 with multiple diagnoses, including a history of falls.</p> <p>Resident #2's 2/27/18 significant change MDS assessment documented the resident was moderately cognitively impaired and required extensive two-person assistance for transfers.</p> <p>Resident #2's current falls care plan, dated 8/22/17, directed staff to keep the call light within reach while the resident was in bed.</p> <p>On 4/2/18 at 4:25 PM, Resident #2 was observed awake in his bed with the call light hanging off the left side of the bed. The call light was below the mattress and not within the reach of the resident. The resident's door was wide-opened and the bed and call light could be observed from the hallway. At 4:30 PM, CNA #1 and the Administrator were observed to walk by the resident's room without acknowledging the call light. At 4:32 PM, Resident #2 did not respond when asked about his call light placement. From 4:48 PM to 4:50 PM, two CNAs, a nurse, and another staff member walked by the room without acknowledging the call light. At 5:18 PM, CNA #1</p>	F 558	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Genesis Healthcare Apex Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>Resident Specific:</p> <p>Call light observed to be in place for resident #2 on 4/9/18 by center director of nursing. Social Services evaluated resident for any psychosocial needs related to accessibility of call light with none noted on or before 5/8/18.</p> <p>Other residents with the potential to be affected:</p> <p>Call light audits were completed by members of the IDT on or before 5/8/18 to validate they were accessible to the residents. Corrections were made as indicated through the audits.</p> <p>Systematic Changes:</p> <p>Staff including administrator and CNA #1</p>		

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F 558	Continued From page 2 was asked about the call light placement and she said the call light was out of reach because it was clipped to the blanket which had gotten tangled up. CNA #1 said the resident was able to use the call light when he wanted to.  On 4/3/18 at 4:15 PM, Resident #2's Interested Party said staff should be checking on the resident more often because the resident had several falls since his admission.  On 4/4/18 at 2:20 PM, the DON said Resident #2's call light should have been within reach and staff should have noticed that it was not accessible.	F 558	were re-education was completed by the director of nursing or designee on or before 5/8/18 related to call lights being functional, and accessible to include Residents ability to use them (Button or push pad).  Center IDT will complete random observations/ interviews during partner rounds weekly on units during various shifts related to call light accessibility. Any re-education needed will be completed at time of rounding as indicated.  Ongoing Monitoring:  Beginning the week of 5/7/18, 10 residents will be reviewed for call light accessibility for 4 weeks and monthly for 2 months. Results of these audits will be reviewed by center QAPI team for a minimum of 3 months or until substantial compliance is achieved. Director of nursing will be responsible for compliance.		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)  §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 580		6/5/18	

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F 580	<p>Continued From page 3</p> <p>deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced</p>	F 580			

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F 580	<p>Continued From page 4</p> <p>by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure a resident's physician was notified of her consistent refusal of a physician ordered treatment for dry skin. This was true for 1 of 3 (#4) residents reviewed for timely physician notification. This placed Resident #4 at risk of experiencing dry, itchy, scaly feet without relief. Findings include:</p> <p>Resident #4 was admitted to the facility on 2/7/17 with diagnoses which included gout.</p> <p>An annual MDS assessment, dated 2/7/18, documented Resident #4 was cognitively intact and required extensive assistance of 1-2 staff members for cares.</p> <p>Resident #4's January 2018 Physicians orders documented Resident #4 was to receive Ammonium Lacate Cream 12% two times a day to her feet, ordered 9/15/17.</p> <p>Resident #4's January 2018 MAR documented Resident #4 refused the Ammonium Lacate Cream 31 of 62 opportunities.</p> <p>Resident #4's clinical record did not document the physician was notified when Resident #4 refused the cream consistently.</p> <p>Resident #4's February 2018 Physician orders documented she was to receive Ammonium Lacate Cream 12% two times a day to her feet, ordered 9/15/17.</p> <p>Resident #4's February 2018 MAR documented Resident #4 refused the Ammonium Lacate</p>	F 580	<p>Resident Specific:</p> <p>Resident #4 medication was discontinued on or before 5/8/18 due to refusals. Resident's responsible party and provider were notified of refusals of medications by center licensed nurse on or before 5/8/18. Social Services assessed related to medication and /or Treatment administration on or before 5/8/18.</p> <p>Director of nursing assessed resident #4 on 4/10/18 resident for any concerns or signs of infection related to this resident's medication and/or Treatment administration with none noted.</p> <p>Others residents with the potential to be affected:</p> <p>A review of the last 30 days MARs/TARs was completed by center nurse managers on or before 5/8/18 to identify refusals of medications. Providers and resident representatives were noted as indicated through review. New orders will be followed as received.</p> <p>Systematic Changes:</p> <p>Re-education will be completed with licensed nurses on or before 5/8/18 by the director of nursing or designee regarding how to document the refusals of medications and treatments as well as notifications to providers and resident</p>		

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F 580	Continued From page 5 Cream 52 of 56 opportunities.  Resident #4's clinical record did not document the physician was notified when Resident #4 refused the cream consistently.  Resident #4's March 2018 Physician orders documented Resident #4 was to receive Ammonium Lacate Cream 12% two times a day to her feet, ordered 9/15/17.  Resident #4's March 2018 MAR documented Resident #4 refused her Ammonium Lacate Cream 49 of 58 opportunities.  Resident #4's Ammonium Lacate Cream was discontinued on 3/29/18.  On 4/3/18 at 4:27 PM, LPN #2 stated when a medication was not provided to a resident the protocol was to sign and circle her initials on the MAR. The LPN stated if a resident refused a medication this was same process. LPN #4 stated she would notify the provider if the resident was not consistently taking a medication in the case of refusals. The LPN stated reasons why medications were not provided were when residents were out of the facility, refusals, or the medications were unavailable.  On 4/3/18 at 4:47 PM, the DON stated staff should be documenting refusals of medications in a progress note or on the back of the MAR. The DON stated if a pattern was seen with refusals then the provider should be notified timely.	F 580	representatives.  Licensed nurses will document the explanation of circled initials on the back side of medication and treatment administration records as well as notify providers for any consistent refusals or per orders.  Ongoing Monitoring:  Beginning the week of 5/7/18, members of the nurse management team will review 10 residents weekly for 4 weeks and monthly for 2 months for any noted refusals to validate new systematic changes are affective. Results of these audits will be reviewed by center QAPI team for a minimum of 3 months or until substantial compliance is achieved. Director of Nursing will be responsible for compliance.		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii)	F 659		6/5/18	

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F 659	<p>Continued From page 6</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure the care plan of 1 of 14 (Resident #13) residents sampled for ADL assistance, was followed regarding bed mobility. The deficient practice created the potential for harm if the resident fell or was otherwise injured when not enough support was provided during bed mobility. Findings include:</p> <p>Resident #13 was admitted to the facility on 12/21/17 with diagnoses that included morbid (severe) obesity, edema, diabetes mellitus, neuropathy, and muscle wasting.</p> <p>The most recent MDS assessment, dated 2/19/18, documented Resident #13 was cognitively intact, did not exhibit behaviors, and required extensive assist of 2 for bed mobility and toileting (incontinence care.) The assessment documented Resident #13 had impairment to bilateral lower extremities (legs).</p> <p>Resident #13's care plan, dated 1/24/18, documented Resident #13 required assistance from, or was dependent on, staff for activities of daily living. The care plan directed staff to provide 2 person assist for bed mobility and toileting.</p> <p>A Fall Interview/Witness Questionnaire, dated</p>	F 659	<p>Resident Specific:</p> <p>Resident #13 Discharged on 3/8/18</p> <p>Other residents with the potential to be affected:</p> <p>Residents currently residing in the center care plans will be reviewed by members of nurse managers to validate the correct assistance needed was on the care plan as well as the Kardex on or before 5/8/18. Corrections were made as indicated at the time of review.</p> <p>Systematic Changes and Education : Nursing staff will be re-educated by Director of Nursing or designee on or before 5/8/18 regarding following the care plan for resident's assistance level for safety.</p> <p>Baseline and updated care plans as well as residents with changes in condition will be reviewed by center IDT during care planning meetings and morning clinical meetings by the director of nursing or designee for any changes related to level</p>		

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F 659	Continued From page 7 3/8/18, documented CNA #3 provided personal care to Resident #13 at 4:15 AM. CNA #3 left the room and at approximately 4:25 AM, CNA #3 returned to Resident #13's room and found Resident #13 on the floor, between the bed and the wall.  A facility Fall Investigative Report dated 3/8/18, documented CNA #3 provided incontinence care to Resident #13 at approximately 4:15 AM. The report documented CNA #3 did not have assistance while providing the care because Resident #13 helps and holds on to the rails when she is turned. The report further documented Resident #13 always helped CNA #3 and he could complete cares for Resident #13 by himself.  On 4/3/18 at 3:00 PM, CNA #3 stated that technically Resident #13 was a two person assist, however; she did not like a lot of people in her room. CNA #3 stated he always provided cares for Resident #13 by himself.	F 659	of assistance with ADLS and care plan updates as indicated.  Ongoing Monitoring:  Beginning the week of 5/7/18, members of nursing management will review 10 residents being assisted with bed mobility to validate care plans are followed weekly for 4 weeks and monthly for 2 months to validate care plans are reflective of level of assistance required. Results of these audits will be reviewed by center QAPI committee for a minimum of 3 months or until substantial compliance is achieved. Director of Nursing will be responsible for compliance.		
F 678 SS=G	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)  §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of facility fall investigations and resident records, it was determined the facility failed to initiate basic life support for 1 of 1 sampled resident (#13) who	F 678	Resident Specific:  Resident #13 discharged from facility on 3/8/18	6/5/18	

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F 678	<p>Continued From page 8</p> <p>experienced a life threatening medical emergency. The failure to initiate lifesaving interventions when Resident #13 stopped breathing following a fall may have contributed to her death, and placed all residents who may experience a medical emergency at risk. Finding include:</p> <p>Resident #13 was admitted to the facility in 2015 and readmitted 12/21/17. Diagnoses included morbid (severe) obesity, edema, diabetes mellitus, neuropathy, and muscle wasting.</p> <p>Resident #13's fall risk assessment dated 12/27/17 documented a score of 10 which indicated a high risk for falls.</p> <p>Resident #13's ADL care plan, dated 1/24/18, documented Resident #13 required assistance from, or was dependent on, staff for activities of daily living. The care plan directed staff to provide 2 person assist for bed mobility and toileting (incontinence care.). The care plan stated Resident #13 utilized bilateral 1/4 side rails to enable bed mobility, liked her bed in the high position, and had a trapeze to the bed to increase her independence with bed mobility. The care plan documented staff were to encourage Resident #13's participation while providing ADL care. The trapeze was attached to a single pole with a 3/4 frame to stabilize it on the floor. The bed was positioned within the base of the frame.</p> <p>Resident #13's resuscitation Code Status Care Plan, dated 1/24/18, documented an established advanced directive was in place, full code with aggressive interventions. The interventions</p>	F 678	<p>Other Residents with the Potential to be affected:</p> <p>A review of other residents currently residing in the center will be reviewed for accuracy of code status by center IDT on or before 5/8/18.</p> <p>Systematic Changes and Education:</p> <p>Licensed nurses will be re-educated on or before 5/8/18 by director of nursing or designee regarding following resident <input type="checkbox"/> wishes for code status.</p> <p>Licensed nurses will be educated on or before 5/8/18 to the American Heart Association 2015 CPR guidelines by the Boise Fire Department and members of the nurse management team regarding spinal stabilization and performing CPR with return demonstration.</p> <p>An in-service for licensed staff will be provided by Boise Fire Department on or before 5/8/18 to educate staff how to move equipment and perform CPR during emergency situations.</p> <p>Ongoing Monitoring:</p> <p>Beginning the week of 5/7/18 residents that expire in the facility will be reviewed to validate CPR was initiated as indicated by code status. Quarterly code status drills for each shift will also be conducted to validate CPR is initiated per POST.</p>		

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F 678	<p>Continued From page 9</p> <p>directed staff to activate Resident #13's advanced directives as indicated.</p> <p>A Fall Interview/Witness Questionnaire, dated 3/8/18, documented CNA #3 provided personal care to Resident #13 at 4:15 AM when 2 skin impairments were observed to Resident #13's buttocks. CNA #3 positioned Resident #13 on her back, covered her with her gown, and clipped the call light and bed control to the gown. The questionnaire documented CNA #3 left the room and notified the licensed nurse of the skin impairment at approximately 4:23 AM. At approximately 4:25 AM, CNA #3 returned to Resident #13's room and found Resident #13 on the floor, between the bed and the wall.</p> <p>A Fall Interview/Witness Questionnaire, dated 3/8/18, documented LPN #6 entered Resident #13's room and found her face down on the floor between the bed and the window side wall. It stated Resident #13 was angled under the bed from the top of Resident #13's head and right arm and shoulder. Resident #13's head was wedged between the bed frame and the trapeze legs. LPN #6 determined it was not safe or feasible to move the resident and 911 was called at 4:35 AM and EMS responded at 4:40 AM.</p> <p>On a Fall Interview/Witness Questionnaire, dated 3/8/18, LPN #7 documented that at 4:25 AM, she saw Resident #13 face down by the window and she had blood on her face and right arm. LPN #7 documented staff were "not physically able to move the bed without causing further injury to the resident." LPN #7 documented Resident #13 was nonresponsive when she entered the room and Resident #13 was "wedged under the</p>	F 678	Results of audits and drills will be reviewed by center QAPI committee for a minimum of 3 months or until substantial compliance is achieved. Director of nursing will be responsible for compliance.		

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

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F 678	<p>Continued From page 10</p> <p>bed/trapeze." Resident #13 was "on top of bed/trapeze" and "This LPN was not able to move the bed to safely serve the resident. C-Collar (cervical collar) not found and resident could not be safely moved. 911 called."</p> <p>On a Fall Interview/Witness Questionnaire, dated 3/8/18, LPN #5 documented she observed LPN #6, CNA #3, and CNA #9 around Resident #13 who was lying face down on the window side of the bed. LPN #5, primary nurse for Resident #13, documented she last saw Resident #13 at 1:00 AM when she provided cough medicine and pain medication to her.</p> <p>On 3/9/18 at 1:30 PM, LPN #6 documented that she immediately directed staff to call 911 and to not move Resident #13 due to possible neck injury. Placement of oxygen was not successful due to the angle of the resident. LPN #6 left the room to make copies of the paperwork, leaving CNA #3, LPN #5 and CNA #9 in the room. LPN #6 returned to the room after the arrival of the EMS and Resident #13 was on her back with a towel on her face, after EMS "had called the incident as death." LPN #6's statement documented EMS initiated CPR as staff could not move resident from under bed and firemen assisted EMS personnel in moving Resident #13.</p> <p>On 3/10/18 at 10:30 AM, the DON documented an interview with LPN #5. LPN #5 stated 911 was called, per LPN #7's phone, at 4:28 AM. LPN #5 stated she did not remain with Resident #13 the entire time she was on the floor. LPN #5 stated she went to check on getting the paperwork ready for the EMS, and came right back. LPN #5 stated CNA #3 was under the bed with Resident</p>	F 678			

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F 678	<p>Continued From page 11</p> <p>#13. LPN #5 stated Resident #13 was intermittently breathing at 4:25 AM. LPN #5 stated she asked CNA #3 at approximately 4:30 AM, if Resident #13 was still breathing. CNA #3 stated no. LPN #5 asked when Resident #13 stopped breathing and CNA #3 stated, "about a minute ago." The DON asked LPN #5 if Resident #13 had a pulse. LPN #5 stated initially she did, but at the point when CNA #3 said Resident #13 was not breathing, LPN #5 was not sure if she had a pulse or not. The DON asked how much longer it took for the EMS to arrive, LPN #5 stated, "Up to 5 minutes, it seemed like forever." The DON asked LPN #5 if at any point did she think the risk of moving Resident #13 was greater than the risk of not initiating CPR and LPN #5 stated they could not reach the resident to move her. LPN said Resident #13 was wedged and staff needed additional help from EMS and the Fire Department.</p> <p>The American Heart Association October 2015, CPR guidelines state:</p> <p>a. Recommend that 'because true spinal immobilization is not possible, the term spinal motion restriction is now being used to describe the practice of attempting to maintain the spine in anatomical alignment and minimize gross movement, with or without the use of specific adjuncts such as collars.</p> <p>b. With a growing body of evidence showing more actual harm and no good evidence showing clear benefit, we recommend against routine application of cervical collars by first aid providers.</p>	F 678			

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F 678	<p>Continued From page 12</p> <p>c. For victims with suspected spinal injury, rescuers should initially use manual spinal motion restriction (e.g., placing 1 hand on either side of the patient's head to hold it still) rather than immobilization devices, because use of immobilization devices by lay rescuers may be harmful.</p> <p>d. After activation of the emergency response system, all rescuers should immediately begin CPR for adult victims who are unresponsive with no breathing or no normal breathing (only gasping).</p> <p>e. Occasional gasps do not necessarily result in adequate ventilation. The rescuer should treat the victim who has occasional gasps as if he or she is not breathing</p> <p>On 4/4/18 at 3:00 PM, RN #4 stated the facility followed the American Heart Association guidelines for CPR. RN #4 stated when breathing stops, CPR should be started for residents that chose full code status.</p> <p>On 4/4/18 at 4:10 PM, LPN #5 stated they did not attempt CPR because they could not get to Resident #13. LPN #5 stated it took 7 or 8 people to move the bed.</p> <p>On 4/5/18 at 9:15 AM, LPN #7 stated they did not move Resident #13 because it would have caused more damage to her. LPN #7 stated she was not aware of when Resident #13 stopped breathing.</p> <p>On 4/5/18 at 10:15 AM, the DON stated there were 7 staff working that shift. An investigative</p>	F 678			

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F 678	Continued From page 13 report provided by the facility documented 2 of the CNAs had no interaction with Resident #13 as they were managing call lights during the incident.	F 678			
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 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, review of medical records, policies, and interviews with residents, residents' interested parties, home health agency staff, and facility staff, it was determined the facility failed to ensure professional standards of practice related to medication management for 2 of 14 sampled residents (#4, and #11) Whose care plans were reviewed. This was true when:</p> <p>* Resident #4 did not receive ordered medications and treatments. * Resident #11 was discharged home with expired IV antibiotic medications.</p> <p>These failed practices had the potential to harm residents if they did not receive physician ordered medications. Findings include:</p> <p>1. Resident #11 was admitted to the facility on 7/14/17 with multiple diagnoses, including wedge</p>	F 684	<p>Resident Specific:</p> <p>Resident # 4s medication was discontinued on or before 5/8/18 due to refusals. Resident's responsible party and provider were notified of refusals of medications by center licensed nurse on or before 5/8/18. Social Services assessed resident for any psychosocial needs related to medication and /or Treatment administration on or before 5/8/18.</p> <p>Director of nursing assessed resident #4 on or before 4/9/18 for any concerns or signs of infection related to this resident's medication and/or Treatment administration with none noted.</p> <p>Other Residents with the Potential to be</p>	6/5/18	

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F 684	<p>Continued From page 14</p> <p>compression fracture of the first lumbar (lower back) vertebra.</p> <p>Resident #11's July 2017 Order Summary Report documented 0.9% Sodium Chloride IV solution with Penicillin G Potassium (antibiotic) 15 million units one time a day was ordered on 7/14/17.</p> <p>Resident #11's care plan documented he exhibited or was "at risk for complications of infection related to sepsis" and directed staff to administer the IV antibiotic as ordered.</p> <p>Resident #11's MAR documented the 0.9% Sodium Chloride IV solution with Penicillin G Potassium 15 million units was administered each day from 7/15/17-8/1/17.</p> <p>Resident #11's General Progress Note, dated 8/2/17 at 12:57 PM, documented the resident was discharged to home with home health services, and the resident left the facility with all medications including IV antibiotics.</p> <p>Resident #11's pharmacy Compounding Records documented multiple doses of 0.9% Sodium Chloride IV solution with Penicillin G Potassium 15 million units were compounded on the following dates: 7/14/17, 7/18/17, 7/21/17, 7/24/17, 7/26/17, 7/27/17, and 7/31/17. The pharmacy Compounding Records documented the medication was to be stored in the refrigerator and was stable for four days.</p> <p>On 4/3/18 at 4:28 PM, the pharmacist said Resident #11's 0.9% Sodium Chloride IV solution with Penicillin G Potassium expired four days from the date on the IV bag located above the</p>	F 684	<p>affected:</p> <p>A review of the last 30 days MARs/TARs was completed on 4/16/18 by center nurse managers to identify refusals of medications. Providers and families were notified as indicated through review. New orders will be followed as received.</p> <p>Residents that discharged home within the last 30 days will be interviewed via phone by the director of nursing or designee on or before 5/8/18 to validate that no expired medications were sent home. These residents will be instructed on proper disposal of discharged medications as indicated by the interview.</p> <p>Systematic Changes and Education:</p> <p>Licensed nurses will be re-educated by Director of Nursing or designee on or before 5/8/18 related to validating medications being sent home are not expired.</p> <p>Re-education to LNs by director of nursing or designee on will be completed on or before 5/8/18 related to documentation of the MAR/TARs-Refusals and or circled initials must have supporting explanation as to why the medication or treatment was not administered, MD notification/family notifications and care plan needs will be updated for refusals.</p> <p>Two licensed nurses will begin to validate</p>		

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F 684	<p>Continued From page 15</p> <p>physician's name, which indicated the date the medication was mixed by the pharmacy.</p> <p>On 4/3/18 at 4:40 PM, an interested party said Resident #11 returned home on 8/2/17, and later that day the home health nurse found multiple doses of IV antibiotics that were expired. The interested party said there were five doses of IV antibiotics and one of the doses was still good, so the home health nurse administered the dose that was not expired.</p> <p>On 4/4/18 at 10:05 AM, the home health nurse said on her initial visit to Resident #11's home she found the majority of the IV antibiotic doses that had been sent home with the resident were expired. The home health nurse said there were approximately 5 doses of IV antibiotic, and of those doses one dose was not expired. The home health nurse said she administered the dose of IV antibiotic that was not expired, and she contacted the facility to notify them Resident #11 was sent home with expired IV antibiotics. The home health nurse said she was told by the facility there was nothing they could do because Resident #11 was no longer under their care, and they advised her to contact the physician. The home health nurse said she contacted Resident #11's physician, and it was arranged for the resident to receive outpatient IV antibiotics.</p> <p>On 4/3/18 at 10:45 AM, RN #1 said she was involved in Resident #11's discharge to home and she provided him with the medications he took home. RN #1 said if there were remaining doses of IV antibiotic at the time of discharge she would have sent them home with him. RN #1 said she could not remember for certain, that she</p>	F 684	<p>that any medications sent home are not expired at time of discharge.</p> <p>Ongoing Monitoring:</p> <p>Beginning the week of 5/7/18, IDT will complete audits of 5 residents that discharged home to validate that 2 licensed nurses are verifying medications at time of discharge weekly for 4 weeks, and monthly for 2 months. Also beginning the week of 5/7/18, members of the nurse management team will review 10 residents weekly for 4 weeks and monthly for 2 months for any noted refusals to validate new systematic changes are effective. Results of these audits will be reviewed by center QAPI committee for a minimum of 3 months or until substantial compliance is achieved. Director of Nursing will be responsible for compliance.</p>		

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F 684	<p>Continued From page 16</p> <p>may or may not have sent home remaining IV antibiotics with Resident #11. RN #1 said she would have checked the expiration dates on the medication sent home with Resident #11 and she would not send expired medication home with the resident.</p> <p>On 4/4/18 at 2:45 PM, RN #1 said she could have sent one or "not more than two" doses of IV antibiotic home with Resident #11.</p> <p>On 4/5/18 at 8:30 AM, the DON said the facility would not prepare the 0.9% Sodium Chloride IV solution with Penicillin G Potassium, it was not a medication available in the facility, and they would only obtain it from the pharmacy.</p> <p>On 4/5/18 at 8:20 AM, RN #2 said she received a phone call from a home health agency regarding Resident #11's medication after he was discharged, but she did not recall the details or concerns about the medication.</p> <p>2. Resident #4 was admitted to the facility on 2/7/17 with diagnoses which included gout.</p> <p>The Facility's Medication Administration Policy, dated 11/28/17, documented "For medication refused by patient, circle your initials in the date and time space where that medication is ordered, and document patient's refusals of medication on the back of the MAR."</p> <p>An annual MDS assessment, dated 2/7/18, documented Resident #4 was cognitively intact and required extensive assistance of 1-2 staff members for cares.</p>	F 684			

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F 684	<p>Continued From page 17</p> <p>Resident #4's January 2018 Physician orders documented Resident #4 was to receive Ammonium Lacate Cream 12% two times a day bilateral to her feet, ordered 9/15/17.</p> <p>Resident #4's January 2018 MAR documented Resident #4's Ammonium Lacate Cream was not applied 29 of 62 opportunities. There was no reason given for the missing doses.</p> <p>Resident #4's February 2018 Physician orders documented she was to receive the following:</p> <ul style="list-style-type: none"> <li>* Bacitracin antibiotic ointment for 1 week between 2/15/18 and 2/21/18, ordered 2/15/18.</li> <li>* Bacitracin antibiotic ointment for 1 week between 2/22/18 and 2/28/18, ordered 2/22/18.</li> <li>* Ammonium Lacate Cream 12% two times a day to her feet, ordered 9/15/17.</li> <li>* Tramadol 100 mg by mouth at bedtime for pain, ordered 1/24/18.</li> <li>* Trazodone 50 mg at bedtime for depression, ordered 2/7/17.</li> </ul> <p>Resident #4's February 2018 MAR documented Resident #4 was not administered the medications and ointments ordered by the physicians as follows:</p> <ul style="list-style-type: none"> <li>* Bacitracin antibiotic ointment was not applied on 2/17/18. There was no reason documented for the missing dose.</li> <li>* Bacitracin antibiotic ointment was not applied on 2/25/18 and 2/26/18. There was no reason documented for the missing doses.</li> <li>* Ammonium Lacate Cream was not applied 4 of 56 opportunities. There was no reason documented for the missing doses.</li> </ul>	F 684			

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F 684	Continued From page 18 * Tramadol 100 milligrams (mg) was not administered on 2/25/18. There was no reason documented for the missing dose. * Trazodone 50 mg was not administered on 2/25/18. There was no reason documented for the missing dose.  Resident #4's March 2018 Physician orders documented Resident #4 was to receive Ammonium Lacate Cream 12% two times a day to her feet, ordered 9/15/17.  Resident #4's March 2018 MAR documented Resident #4's Ammonium Lacate Cream was not applied 9 of 58 opportunities. There was no reason documented for the missing doses.  On 4/3/18 at 4:27 PM, LPN #2 stated when a medication was not provided to a resident the protocol was for the staff administering the medication to sign and circle his/her initials on the MAR. The LPN stated if a resident refused a medication the same process was followed. LPN #4 stated she would notify the provider if a resident was not consistently refusing to take a medication. The LPN stated reasons why medications were not provided were when residents were out of the facility, refusals, or the medications were unavailable.  On 4/3/18 at 4:47 PM, the DON stated staff should be documenting refusals of medications in a progress note or on the back of the MAR. The DON stated if a pattern was seen with refusals then the provider should be notified.	F 684			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		6/5/18	

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F 686	<p>Continued From page 19</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.</p> <p>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 and resident interview, and record review, it was determined the facility failed to prevent the development of avoidable pressure ulcers. This was true for 1 of 4 residents (#5) reviewed for pressure ulcers and resulted in harm when Resident #5 developed and/or re-developed skin damage to her left buttocks and her heel. Findings include:</p> <p>Resident #5 was admitted to the facility on 4/16/17 with diagnoses that included chronic pain, sciatica of the left side, and arthritis of the left hip.</p> <p>A quarterly MDS assessment, dated 3/20/18, documented Resident #5 was cognitively intact and required extensive assistance of 2 staff members for all cares. The MDS documented Resident #5 did not have current skin impairments and was not at risk of developing pressures ulcers. The MDS did not document the resident was on a repositioning schedule.</p>	F 686	<p>Resident Affected:</p> <p>Resident had a head to toe skin check on or before 5/8/18 by licensed nurse to validate any skin issues have been investigated, treatments ordered, skin integrity sheet initiated, care plans updated, and notifications completed to provider and family.</p> <p>Other Residents with the potential to be affected:</p> <p>Other residents residing in the center had head to toe skin checks by a licensed nurse on or before 5/8/18 to identify any potential skin issues that have not been previously identified. Treatment orders, implementation of skin integrity sheets, investigations, notifications, and care plans updated at time of skin check as indicated.</p>		

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F 686	<p>Continued From page 20</p> <p>Resident #5's Braden Scale for Predicting Pressure Sore Risk, dated 1/23/18, documented she was at moderate risk for developing pressure ulcers.</p> <p>The April 2018 Order Review History Report, documented Resident #5's skin impairment prevention orders included:</p> <ul style="list-style-type: none"> <li>* Z-guard (skin protectant) to groin and buttock every day and night, ordered 11/12/17.</li> <li>* Pressure redistribution cushion to chair, ordered 4/16/17.</li> <li>* Pressure redistribution mattress to bed, ordered 4/16/17.</li> <li>* Skin Checks on Wednesdays, ordered 4/16/17.</li> </ul> <p>A Resistive to Cares Care Plan, revised 2/14/18, documented Resident #5 refused showers, incontinence care, and bandage changes. The care plan did not direct staff to monitor Resident #5's resistance to care behaviors.</p> <p>A Potential Skin Impairment Care Plan, revised 2/6/18, documented staff were to observe Resident #5's skin while providing activities of daily living (ADL) care and report abnormalities to the nursing staff.</p> <p>a. A Skin Assessment, dated 12/20/17, documented Resident #5's skin was assessed and no skin damage was found.</p> <p>A Skin Assessment, dated 12/27/17, documented Resident #5 had Moisture Associated Skin Damage (MASD) to her buttocks with the skin intact and blanchable.</p>	F 686	<p>Systematic Changes and Education:</p> <p>Center nursing staff will be educated by director of nursing or designee on or before 5/8/18 regarding ensuring that the following have been completed for any identified skin issues; Treatment orders obtained, implementation of skin integrity sheets, investigations, notifications, shower skin checks completed and given to nurse managers, and care plans updated for any newly identified skin issues.</p> <p>Beginning 5/7/18 contracted wound provider will come to center weekly to assist with wound rounds, treatments, and documentation. Additionally, a second skin sweep will be completed by providers with center licensed staff on 5/14/18.</p> <p>Skin checks will be reviewed by center IDT during morning clinical meeting to validate that any new skin issues or those documented as previously noted, have treatment orders obtained, implementation of skin integrity sheets, investigations, notifications, and care plans updated. Corrections will be made at the time of review as indicated.</p> <p>Ongoing Monitoring:</p> <p>Beginning the week of 5/7/18, center nurse managers will review 10 residents weekly to validate that any new skin</p>		

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F 686	Continued From page 21  A Skin Assessment, dated 1/3/18, documented the skin on Resident #5's buttocks was red, blanchable, and intact.  A Skin Assessment, dated 1/17/18, documented Resident #5 had "small open areas to buttocks due to pressure and prolonged exposure to moisture."  A Skin Assessment, dated 2/28/18, documented Resident #5's skin was assessed with no skin damage.  A Skin Assessment, dated 3/7/18, documented Resident #5 had MASD to her buttocks and peri-area with the skin intact and blanchable. The assessment documented z-guard was applied.  A Skin Assessment, dated 3/14/18, documented Resident #5 had MASD to her right groin and peri-area.  A Skin Assessment, dated 3/21/18, documented Resident #5 had an open area of MASD to her left buttock.  Resident #5's ADL Documentation Survey Report 1/1/18 through 4/4/18, documented Resident #5's bed mobility and toilet use during each shift, showed the following:  * Resident #5 refused bed mobility 14 out of 282 opportunities and was not offered bed mobility 77 out of 282 opportunities.  * Resident #5 refused use of the toilet during the shift 41 out of 282 opportunities and was not	F 686	issues have been investigated, treatment orders obtained, skin integrity sheets initiated, notifications completed, and that care plans have been updated. These audits will be reviewed by center QAPI committee monthly for a minimum of three months or until substantial compliance has been achieved. Director of nursing will be responsible for compliance.		

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F 686	<p>Continued From page 22</p> <p>offered the use of the toilet during the shift 123 out of 282 opportunities.</p> <p>On 4/2/18 at 11:00 AM, Resident #5 was observed laying on her back in bed with the head of the bed raised 30-35 degrees. The resident said her incontinence brief was not getting changed often enough. She said, "It happened 3 days last week" and caused a "big sore" on her right calf and a sore on the left side of her "tailbone."</p> <p>An Event Summary Report, dated 4/2/18, documented Resident #5 sustained a skin tear to her right [sic] buttocks. The report documented positioning was a factor in the development of the wounds. The report documented Resident #5 refused cares and "pressure and moisture" were contributing factors.</p> <p>A Skin Integrity Report, dated 4/2/18, documented Resident #5 sustained an "incontinence" related "skin tear" to her "right [sic] gluteal" measuring 0.5 centimeter (cm) by 0.5 cm.</p> <p>Resident #5's Actual Skin Breakdown Care Plan, revised 4/2/18, documented she had skin breakdown on her buttock related to incontinence, limited mobility, fragile skin, and skin tears. The care plan interventions included:</p> <ul style="list-style-type: none"> <li>* Staff were to apply barrier cream with each cleansing.</li> <li>* Staff were to monitor Resident #5 for verbal and non-verbal signs of pain related to wound or wound treatment and medicate as ordered.</li> <li>* Resident #5 was to have a pressure</li> </ul>	F 686			

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F 686	<p>Continued From page 23</p> <p>redistribution surface to her bed and chair as per protocol.</p> <p>* Staff were to assess Resident #5's skin weekly.</p> <p>* Staff were to provide pericare and incontinence care as needed.</p> <p>The care plan did not document how often staff were to encourage Resident #5 to reposition or if they were to encourage her to reposition.</p> <p>On 4/3/18 at 10:00 AM, Resident #5 was observed lying in bed. Resident #5 stated she had received pain medications earlier in the morning and was waiting for staff to come and assist her with the bathroom. Resident #5 stated she had bed sores on her "bottom." Resident #5 stated she had spoken to staff about the bed sores and this was not the first time she had developed sores at the facility. Resident #5 stated she discussed concerns with staff and the issues did not resolve. Resident #5 stated she developed the sores because the facility was not addressing her extreme pain, and due to the pain, she would occasionally refuse cares, such as incontinence care and/or repositioning. Resident #5 stated if the facility provided her better pain management she would be more willing to reposition and allow incontinence care. Resident #5 stated staff would "assume" she was going to refuse cares and staff would "ignore" her.</p> <p>On 4/3/18 at 10:46 AM, Resident #5's left buttock was observed with two open areas, the top area was approximately 1 cm by 0.5 cm wide and the lower area was approximately 1.5 cm by 1 cm wide, both were near the sacrum. The open areas were not covered with a bandage or</p>	F 686			

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F 686	<p>Continued From page 24</p> <p>covering. After completion of incontinence care CNA #7 and LPN #4 positioned Resident #5 on her back with the head of the bed raised to about 30 degrees and did not apply a bandage or a covering to the affected area. CNA #7 stated Resident #5's areas on her left buttock were present since she changed from sleeping in her recliner to sleeping in her bed last week.</p> <p>On 4/3/18 at 11:05 AM, CNA #7 and LPN #4 utilized a drawsheet to move Resident #5 up in bed. CNA #7 placed 2 pillows under Resident #5's lower legs, which floated the resident's heels. CNA #7 and LPN #4 did not encourage or offered to reposition Resident #5 off of her back.</p> <p>On 4/3/18 at 11:10 AM, CNA #7 stated she did not offer or encourage Resident #5 to reposition off of her back. The CNA said she "knows" the resident and the resident "always refuses." The CNA stated, "It's up to her to let us know when she will turn or wants to turn off of her back."</p> <p>On 4/3/18 at 3:43 PM, CNA #3 stated Resident #5 did not often refuse cares such as repositioning or incontinence care with him. CNA #3 stated Resident #5 complained of pain and if she did refuse it was due to increased pain.</p> <p>On 4/3/18 at 5:00 PM, CNA #4 stated Resident #5 had a history of refusing to reposition and have incontinence care completed. CNA #4 stated she did not have issues with Resident #5 refusing often.</p> <p>On 4/4/18 at 9:41 AM, the DON stated Resident #5 had a history of refusals with cares and repositioning. The DON stated she knew there</p>	F 686			

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F 686	<p>Continued From page 25</p> <p>was a problem assessing and monitoring skin issues including pressure ulcers. The DON stated Resident #5's MASD was discovered before the facility completed the Skin Integrity Reports on 4/2/18.</p> <p>On 4/4/18 at 10:38 AM, LPN #3 stated she "discovered" Resident #5's left buttock skin impairment of 3/7/18. The LPN stated she did not complete an investigation into the cause of the skin impairment because she thought another staff member had completed this task prior. LPN #3 stated since she thought another staff member had completed the investigation, she did not initiate a Skin Integrity Report regarding Resident #5's left buttock.</p> <p>On 4/5/18 at 9:56 AM, the DON stated the wound to Resident #5's buttock was on the left-side and pressure "could be a component." The DON stated she needed to assess the area for blood flow before making the determination of the causality of the wound.</p> <p>On 4/6/18 at 8:31 AM, the DON stated the wound to Resident #5's left buttock was one area with an island in between of healing skin.</p> <p>b. Resident #5's heel wound:</p> <p>Resident #5's Actual Skin Breakdown Care Plan, initiated 5/23/17, documented she had skin breakdown related to vascular disease. The care plan documented interventions as:</p> <ul style="list-style-type: none"> <li>* Staff were to evaluate the wound area daily for drainage and infection.</li> <li>* Staff were to monitor Resident #5 for verbal and</li> </ul>	F 686			

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F 686	<p>Continued From page 26</p> <p>non-verbal signs of pain related to wound or wound treatment and medicate as ordered.</p> <p>* Staff were to provide wound treatments as ordered.</p> <p>* Staff were to assess Resident #5's skin weekly.</p> <p>A Physician's Progress Note, dated 10/31/17, documented Resident #5 had venous stasis insufficiency and she had areas on her heels recently healed.</p> <p>On 4/2/18 at 11:00 AM, Resident #5 was wearing non-skid socks on both feet and her heels were in contact with the mattress.</p> <p>On 4/3/18 at 10:00 AM, Resident #5 was wearing non-skid socks on both feet and her heels were in contact with the mattress.</p> <p>On 4/3/18 at 10:38 AM, Resident #5 was observed in bed with her heel in contact with the mattress. CNA #7 removed Resident #5's sock from her left foot and an area of black eschar (dead tissue) was observed on the posterior lateral aspect (back, of her left heel approximately the size of a quarter.</p> <p>On 4/3/18 at 3:04 PM, Resident #5 was observed in bed with her heels in contact with the mattress.</p> <p>Resident #5's ADL Documentation Survey Report 1/1/18 through 4/4/18, documented Resident #5's preventative skin care (protectors heel/elbows) use. The protective skin care was to be documented as "applied" or "not applied" once a shift or three times a day. The ADL report documented:</p>	F 686			

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F 686	Continued From page 27 * Resident #5 refused the heel protectors 4 out of 282 opportunities; * Resident #5 was not provided the heel protectors 94 out of 282 opportunities; and * Heel protectors were not applied 5 out of 282 opportunities.  On 4/5/18 at 10:36 AM, the Regional RN stated there were no other skin impairment investigations completed for Resident #5 other than those previously provided, dated 1/23/18 and 4/2/18.  On 4/6/18 at 8:31 AM, the DON stated she had not started a tracking sheet on Resident #5's left heel as of 4/6/18. The DON stated Resident #5's left heel had a 1 cm by 1 cm area that she measured last week. The DON stated she had not completed a skin integrity report or a Event Summary Report. The DON stated she would re-evaluate Resident #5's heel this week.	F 686			
F 689 SS=G	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 staff interview, observation, and review of a bed manufacturer's manual, facility policy, and resident records, it was determined the facility failed to ensure:	F 689	Resident affected:  Resident # 13 discharged from center on 3/8/18	6/5/18	

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F 689	<p>Continued From page 28</p> <ul style="list-style-type: none"> <li>* Residents were provided the level of supervision necessary to prevent falls.</li> <li>* Care plan interventions to prevent falls were updated as needed and consistently implemented.</li> <li>* Equipment used by residents was assessed for safety prior to use.</li> <li>* Beds were assessed to ensure the bed, bed frame and mattress dimensions were appropriate for the resident's size and weight.</li> </ul> <p>This was true for 3 of 10 residents (#2, #13, and #14) reviewed for accident prevention. Resident #13 was harmed when she passed away following a fall. Resident #2 was at risk of harm when he experienced 19 falls in the facility from 8/28/17 through 3/26/18, and Resident #14 was at risk of harm when equipment to improve her comfort and bed mobility were not assessed for safety. Findings include:</p> <p>1. Resident #13 was admitted to the facility in 2015 and readmitted 12/21/17. Diagnoses included morbid (severe) obesity, edema, diabetes mellitus, neuropathy, and muscle wasting.</p> <p>Resident #13's fall risk assessment, dated 12/27/17, documented a score of 10 which indicated a high risk for falls.</p> <p>Resident #13's Nutritional care plan, dated 1/24/18, documented Resident #13 preferred not to be weighed. Resident #13's most recent weight obtained by facility staff on 12/21/17, was 310 lbs.</p> <p>a. Resident #13's potential risk for skin</p>	F 689	<p>Resident #2s care plan will be reviewed by center IDT on or before 5/8/18 to validate that adequate supervision and prevention are care planned. Resident was observed to have fall prevention measures in place at the bedside as well as documented safety checks by director of nursing on or before 5/8/18. Resident was assessed by LSW on or before 5/8/18 for any psychosocial distress related to care plan not being followed or level of supervision is within resident's needs to prevent falls. Any corrections will be completed at time of review.</p> <p>Other Residents with the potential to be affected:</p> <p>Other residents residing in the center that sustained falls within the last 30 days, care plans were reviewed on or before 5/8/18 by members of the IDT to validate adequate supervision and prevention measures are care planned to decrease risk of falls. Care plans were updated as indicated at time of review.</p> <p>Other residents residing in the center were reviewed for appropriate bed height and assessment of height by the director of nursing or designee on or before 5/8/18. Those found to be an increased risk for falls and or injuries were corrected at time of review or risk vs benefits education was provided to resident or family as indicated for refusals to replace including a device assessment for safety</p>		

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F 689	<p>Continued From page 29</p> <p>breakdown care plan related to limited mobility, diabetes, incontinence, neuropathy, lower extremity edema, lymphedema, and chronic pain, directed staff to assist her to reposition every 2 hours as she allowed with cares and provide a low air loss mattress. The care plan stated Resident #13 utilized bilateral 1/4 side rails and a trapeze to enable bed mobility and liked her bed in the high position.</p> <p>The facility provided the User-Service manual for the Joerns support surface DermaFloat low air loss bed model Resident #13 utilized. The safety information included:</p> <p>* To minimize the risk of falls or injury the resident surface should always be in the lowest practical position when the resident is unattended.</p> <p>* Specialty bed products are designed to reduce/redistribute pressure and the shearing/friction forces on the resident's skin. The risk of gradual movement and/or sinking into hazardous positions of entrapment and/or inadvertent bed exit may be increased due to the nature of these products.</p> <p>An undated Event Summary Report documented Resident #13 had an unwitnessed fall from bed on 3/8/18 at 4:15 AM. Resident #13 was found face down with her head under the bed. The Report documented it was unclear if she had pulled herself up that way while on her knees. The Report further stated staff remained with Resident #13 under the bed providing support. Licensed Nurses remained in the resident's room, attempted to find C-collar (cervical) to</p>	F 689	<p>Other residents residing in the center will be reviewed by members of the nurse management team on or before 5/8/18 to validate that assistive devices have been assessed and that bed rails have maintenance schedules. Corrections were made at time of review as indicated.</p> <p>Systematic Changes and Education:</p> <p>Fall care plans will be reviewed by center IDT after admission and during MDS updates to validate resident specific supervision and preventative measures are in place.</p> <p>New admissions will be placed on every one hour safety checks for the first 72 hours to track and trend any needs, routines, or behaviors.</p> <p>Licensed nurses will be re-educated on or before 5/8/18 by the director of nursing or designee regarding bed height per manufacturers guidelines including assessing and educating those that prefer a different height.</p> <p>Center nursing staff will be re-educated by director of nursing or designee on or before 5/8/18 to validate that the care plan is being followed for level of assistance and that fall prevention and supervision is in place per the care plan.</p> <p>CNAs will be educated by the director of nursing or designee on or before 5/8/18 to</p>		

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F 689	<p>Continued From page 30</p> <p>stabilize her neck, and attempted to provide oxygen support. The Report noted Resident #13's body taken by the County coroner and the exact cause of death was being investigated. The Report documented the facility presumed through investigation and witness statements that Resident #13 slid off the bed.</p> <p>A phone interview documented by the facility as part of its investigation into the fall, dated 3/9/18 at 2:00 PM, documented LPN # 7 stated she was called to the resident's room at 4:25 AM. Resident #13's bed was in the high position and her face was on the bed frame and trapeze (frame.)</p> <p>On 4/3/18 at 4:20 PM, the DON stated there was not a safety assessment addressing Resident #13's use of the bed in the high position, as Resident #13 preferred. The DON stated, "We talked to her about it."</p> <p>b. Resident #13's most recent MDS assessment, dated 2/19/18, documented Resident #13 was cognitively intact and required extensive assistance of 2 people for bed mobility and toileting (incontinence care.) The assessment documented Resident #13 had impaired range of motion to bilateral lower extremities (legs).</p> <p>Resident #13's care plan, dated 1/24/18, documented Resident #13 required assistance from, or was dependent on, staff for activities of daily living. The care plan directed staff to provide 2 person assist for bed mobility and toileting.</p> <p>A Fall Interview/Witness Questionnaire, dated 3/8/18, documented CNA #3 provided personal</p>	F 689	<p>communicate areas of safety needs to include bed size on the alert charting or face to face to a licensed nurse or member of the maintenance department through use of the electronic communication board and/or electronic clinical alerts</p> <p>Nurse Managers will begin to review residents while in bed following admission or with significant weight changes to validate that the bed dimensions are the appropriate size for the resident. Those found not to be will be placed on alternative bed surfaces.</p> <p>Licensed nurses will be re-educated by director of nursing on or before 5/8/18 by director of nursing or designee regarding assessing assistive devices at time of placement.</p> <p>Maintenance director will be re-educated by center administrator on or before 5/8/18 regarding maintaining a maintenance schedule for bed rails.</p> <p>New admission charts will be reviewed by IDT following admission for any identified assistive devices to validate assessment, maintenance schedule, and consents. Corrections will be made at the time of review.</p> <p>Electronic communication and clinical alerts will be reviewed daily during morning stand-up to identify any safety concerns found by nursing staff.</p>		

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F 689	<p>Continued From page 31</p> <p>care to Resident #13 at 4:15 AM. CNA #3 left the room and at approximately 4:25 AM, CNA #3 returned to Resident #13's room and found Resident #13 on the floor, between the bed and the wall. The report documented CNA #3 did not have assistance while providing the care because Resident #13 helps and holds on to the rails when she is turned. The report further documented Resident #13 always helped CNA #3 and he could complete cares for Resident #13 by himself.</p> <p>On 4/3/18 at 3:00 PM, CNA #3 stated that technically Resident #13 was a two person assist, however; she did not like a lot of people in her room. CNA #3 stated he always provided cares for Resident #13 by himself.</p> <p>A Fall Interview/Witness Questionnaire, dated 3/8/18, documented CNA #3 provided personal care to Resident #13 at 4:15 AM when 2 skin impairments were observed to Resident #13's buttocks. CNA #3 positioned Resident #13 on her back, covered her with her gown, and clipped the call light and bed control to the gown. The questionnaire documented CNA #3 left the room and notified the licensed nurse of the skin impairment at approximately 4:23 AM. At approximately 4:25 AM, CNA #3 returned to Resident #13's room and found Resident #13 on the floor, between the bed and the wall.</p> <p>On 3/14/18, the facility documented the measurements of Resident #13's "actual bed," a Joerns low air loss mattress, as 34.5 inches (2 feet 10.5 inches) by 78 inches. The manufacturer's system specifications documented mattress dimensions of 36 inches (3</p>	F 689	<p>Ongoing Monitoring:</p> <p>Beginning the week of 5/7/18, five residents fall care plans will be reviewed for adequate supervision and fall preventions weekly for 4 weeks and monthly for 2 months or until substantial compliance is achieved. Also beginning the week of 5/7/18, 5 new admissions and 5 long term residents will be reviewed weekly for 4 weeks and monthly for 2 months to validate consents, maintenance schedules, and assessments are in place for assistive devices as well a maintenance schedules for bed rails. Results of these audits will be reviewed by center QAPI committee meeting monthly for 3 months or until substantial compliance is sustained. Director of nursing will be responsible for compliance.</p> <p>Beginning the week of 5/7/18, 5 residents will be reviewed weekly for 4 weeks and monthly for 2 months for safe bed height and or associated risk and education Results of these audits will be reviewed by center QAPI committee monthly for 3 months or until substantial compliance sustained. Director of nursing will be responsible for compliance.</p>		

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F 689	<p>Continued From page 32</p> <p>feet) by 80 inches or 42 inches by 80 inches. The Joerns Bed Frames User - Service Manual recommended the use of a mattress with minimum dimensions of 36 inches by 72 inches.</p> <p>The low air loss mattress provided integrated CairRails risk management side air bolsters, two-inch side bolsters that inflate on both sides of the resident along the mattress edge to provide additional support and to provide a gentle reminder to the resident that they are near the edge of the mattress.</p> <p>On 4/3/18 at 3:00 PM, CNA #3 stated that when he turned Resident #13, she would hold on to the side rail. CNA #3 stated that Resident #13 was on a regular size mattress and she took up most of the bed. CNA #3 stated that when he turned Resident #13, her belly hung over the side of the bed. CNA #3 stated the base on the trapeze was wider than the bed.</p> <p>A facility Fall Investigative Report dated 3/8/18, documented CNA #3 provided incontinence care to Resident #13 at approximately 4:15 AM. The report documented CNA #3 did not have assistance while providing the care because Resident #13 helps and holds on to the rails when she is turned. The report further documented Resident #13 always helped CNA #3 and he could complete cares for Resident #13 by himself.</p> <p>On 4/3/18 at 3:00 PM, CNA #3 stated that technically Resident #13 was a two person assist, however; she did not like a lot of people in her room. CNA #3 stated he always provided cares for Resident #13 by himself.</p>	F 689			

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F 689	<p>Continued From page 33</p> <p>On 4/3/18 at 4:45 PM, CNA #8 stated Resident #13 required extensive assist from two staff for bed mobility and incontinence care. CNA #8 stated Resident #13 did not turn or reposition herself. CNA #8 stated the resident preferred to turn to her right side because it was easiest for her. CNA #8 stated Resident #13 needed someone on each side of the bed because her feet would start to slide toward the edge of the bed.</p> <p>On 4/4/18 at 5:00 PM, CNA #7 stated Resident #13 required extensive assist of two staff for bed mobility and incontinence care. CNA #7 stated Resident #13 was difficult to turn because of her pain and did not turn independently. CNA #7 stated Resident #13 did not fit her bed, she was on an air bed, and it did not have bolsters. She said without the second person there, Resident #13 could fall out of the bed.</p> <p>On 4/5/18, the DON stated she had no idea how someone that was on the correct size of bed, never moved independently, and was left positioned on her back, fell out of bed. The DON stated they were waiting for the coroner's report to see if Resident #13 had a heart attack or a seizure. The DON stated, "We don't know what happened."</p> <p>2. Resident #2 was admitted to the facility on 8/22/17 with multiple diagnoses, including a history of falls and Lewy body dementia.</p> <p>The facility's Falls Management policy, dated 3/15/16, directed staff to update the care plan to reflect new interventions.</p>	F 689			

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F 689	Continued From page 34  Resident #2's Events Summary Reports (incident reports) documented the resident had 19 falls in the facility from 8/28/17 through 3/26/18 without major injury. On 9/2/17 and 11/29/17, the resident fell and received minor skin tears to his left elbow and to the back of his left upper arm, respectively.  Resident #2's 8/29/17 admission MDS assessment documented the resident was moderately cognitively impaired, required extensive two-person assistance for transfers, and had two falls without injury since admission.  a. Resident #2's Events Summary Reports documented the resident had 6 falls from 8/31/17 to 10/3/17.  Resident #2's falls care plan, dated 9/22/17, directed staff to not leave the resident unsupervised "in areas such as TV room and dining room."  Resident #2's physician's order, dated 10/1/17, directed staff to conduct safety checks and to monitor the resident's fall precautions every hour. This order remained in place on the physician's Order Summary Report (recapitulation) and TAR as of April 2018.  Resident #2's Event Summary Report, dated 10/4/17, documented the resident was found on the floor in the hallway between the dining and the TV rooms and had no injuries. The root cause of the fall was the resident attempted to transfer or ambulate unassisted in the hallway. New interventions included escorting the resident	F 689			

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F 689	<p>Continued From page 35</p> <p>to and from each meal. This intervention was not initiated on the care plan until 12/18/17.</p> <p>b. Resident #2's Events Summary Reports documented the resident had 2 falls from 10/17/17 to 11/14/17.</p> <p>Resident #2's Event Summary Report, dated 11/15/17, documented the resident was found on the fall mat in his room and had no injuries. A new intervention directed staff to check the resident every half hour between 7:00 PM and 7:00 AM. This intervention was not documented on Resident #2's care plan.</p> <p>c. Resident #2's falls care plan, dated 9/22/17, directed staff to not leave the resident unsupervised "in areas such as TV room and dining room."</p> <p>Resident #2's Event Summary Reports, dated 11/24/17 and 11/29/17, documented the resident was left in his room in his wheelchair unattended, and he fell while trying to self-transfer to his bed, and attempting to throw away a tissue. The resident did not sustain an injury on 11/24/17 and sustained a 5 cm by 0.4 cm skin tear to the back of his left upper arm on 11/29/17.</p> <p>d. Resident #2's falls care plan, dated 9/22/17, directed staff to not leave the resident unsupervised "in areas such as TV room and dining room."</p> <p>Resident #2's Event Summary Report, dated 12/1/17, documented the resident was left in the dining room in his wheelchair unattended and fell without injury. New interventions included</p>	F 689			

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F 689	<p>Continued From page 36</p> <p>escorting the resident to and from each meal. Resident #2's Event Summary Report, dated 10/4/17 documented the same intervention. This intervention was not added to the care plan until 12/18/17.</p> <p>e. Resident #2's Events Summary Reports documented the resident had 3 falls from 1/15/18 to 3/15/18 without injury.</p> <p>Resident #2's Event Summary Report, dated 3/26/18, documented the resident was in his room and rolled out of bed without injury. No new interventions were implemented and staff was re-educated to enter into the resident's room when making rounds.</p> <p>f. Resident #2's Fall Risk assessment, dated 2/11/18, documented the resident was a high fall risk.</p> <p>Resident #2's 2/27/18 significant change MDS assessment documented the resident was moderately cognitively impaired and required extensive two-person assistance for transfers.</p> <p>Resident #2's April 2018 Order Summary Report documented a physician's order, dated 10/1/17, for staff to conduct safety checks and to monitor the resident's fall precautions every hour.</p> <p>Resident #2's current Activities of Daily Living and falls care plan documented the following interventions: *8/22/17-Keep the call light within reach while the resident was in bed. *10/1/17-Keep mobile phone within resident's reach.</p>	F 689			

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F 689	<p>Continued From page 37</p> <p>*11/29/17-Keep the trash can beside the bed to dispose of tissues, etc.</p> <p>*1/11/18-Keep dental picks within reach for easy access.</p> <p>Resident #2's March and April 2018 TARs documented staff performed hourly checks, except on 4/3/18 from 4:00 PM to 7:00 PM.</p> <p>The following observations were made in Resident #2's room:</p> <p>*On 4/2/18 at 4:00 PM, Resident #2 was awake in his bed flossing his teeth with a floss pick and his trash can was 7 feet away near the sink.</p> <p>*On 4/2/18 at 4:25 PM, Resident #2 was observed awake in his bed with the call light hanging off the left side of the bed. The call light was below the mattress and not within the reach of the resident. The resident's door was wide-open and the bed and call light could be observed from the hallway. At 4:30 PM, CNA #1 and the Administrator were observed to walk by the resident's room without acknowledging the call light. At 4:32 PM, Resident #2 did not respond when asked about his call light placement. From 4:48 PM to 4:50 PM, two CNAs, a nurse, and another staff member walked by the room without acknowledging the call light. At 5:18 PM, CNA #1 was asked about the call light placement and said the call light was out of reach because it was clipped to the blanket which had gotten tangled up. CNA #1 said the resident was able to use the call light when he wanted to.</p> <p>*On 4/3/18 from 10:25 AM to 10:50 AM, Resident #2 was observed in his bed asleep and no floss</p>	F 689			

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F 689	<p>Continued From page 38 picks were near the resident.</p> <p>*On 4/3/18 at 12:50 PM, CNA #1 said the resident usually had the floss pick on his tray table next to his bed and she could not find them there. She then searched the room and found a large bag of floss picks in a dresser drawer 10 feet away from the bed. CNA #1 did not place any of the floss picks on the tray table.</p> <p>*On 4/3/18 at 2:55 PM, Resident #2 was in his bed asleep with no floss picks nearby, and the resident's cell phone was on the counter next to the sink 7 feet away.</p> <p>*On 4/3/18 from 4:30 PM to 5:00 PM, Resident #2 was observed in his bed asleep with no floss picks on the tray table or nearby.</p> <p>*On 4/4/18 at 10:15 AM, Resident #2 was in his bed asleep with no floss picks nearby, his trash can was 7 feet away, next to the sink.</p> <p>On 4/3/18 at 4:15 PM, Resident #2's Interested Party said staff should be checking on the resident more often because the resident had several falls since his admission. The Interested Party said staff did not consistently implement the falls care plan.</p> <p>On 4/4/18 at 10:18 AM, LPN #1 said the order for hourly checks for Resident #2 meant that staff were to make sure he was in a safe place.</p> <p>On 4/4/18 at 10:35 AM, CNA #1 said the resident was checked every hour to make sure fall precaution interventions were in place. She said she was not aware of where the trash can should</p>	F 689			

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F 689	<p>Continued From page 39 be located for Resident #2.</p> <p>On 4/4/18 at 1:35 PM, CNA #2 said the resident was checked every hour to make sure fall precaution interventions were in place.</p> <p>On 4/4/18 at 2:20 PM and 4/5/18 at 9:00 AM, the DON said Resident #2 was a high fall risk and said the facility could do a better job making sure the resident remained safe. She said staff did not follow the care plan and left the resident unattended during the 10/4/17, 11/24/17, 11/29/17, and 12/1/17 falls and the new intervention of escorting the resident to and from his meals was not placed on the care plan until 12/18/17. The DON said the intervention to conduct safety checks every 30 minutes from 7:00 PM to 7:00 AM after the 11/15/17 fall was not implemented or placed on the care plan, and that must have been missed by the interdisciplinary team. She said there were no new interventions after the 3/26/18 fall but the staff were re-educated. The DON said she would expect staff to follow the care plan and make sure the resident had his call light, floss picks, cell phone and trash can within reach of the resident.</p> <p>3. Resident #14 was admitted to the facility on 3/29/18 with multiple diagnoses, including pneumonia, morbid obesity, and chronic pain.</p> <p>On 4/2/18 at 12:45 PM, Resident #14 was observed sitting on the right side of the bed, a pad was hanging down over the right side of the bed, and a free-standing trapeze bar was above the bed. Resident #14 stated her family brought a memory foam pad from home to place on top of</p>	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/05/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>APEX CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8211 USTICK ROAD</b> <b>BOISE, ID 83704</b>		
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F 689	<p>Continued From page 40 the facility's mattress.</p> <p>On 4/4/18 at 9:30 AM, Resident #14 was observed sitting on the edge of the right side of bed with her left leg up on the bed and her right foot on the floor. Resident #14's mattress memory foam pad was hanging down the right side of the bed. Resident #14 stated she needed the memory foam pad for comfort to help her sleep and she used the free-standing trapeze bar for bed mobility.</p> <p>On 4/4/18 at 10:25 AM, Resident #14 was observed as she ambulated from the bathroom to her bed, sat on the edge of the right side of the bed, and used the trapeze bar to reposition herself on the edge of the bed. She consented to having her mattress and memory foam pad to be measured. The facility's mattress measured 47 inches wide (3 feet 11 inches). The memory foam mattress pad, which was aligned with the left side of the facility's mattress, measured 2 1/2 inches thick and overlapped the facility's mattress by 14 inches and hung down the right side of the bed to 7 inches above the floor. The base of the free-standing trapeze device was positioned in between the wheels of the bed frame. The trapeze device did not have brakes.</p> <p>Resident #14's care plan, dated 3/29/18, documented Resident #14 utilized a trapeze to enable bed mobility. The care plan did not document the memory foam mattress pad.</p> <p>Resident #14's inventory sheet, dated 3/29/18, documented, "bed pad with cover."</p> <p>On 4/4/18 at 1:40 PM, the DNS stated she was</p>	F 689			

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F 689	Continued From page 41 unaware Resident #14 had a memory foam mattress pad. The DNS stated the mattress pad and trapeze bar device had not been assessed for safety.  The manufacturer's manual for the Free-standing Bariatric Trapeze with base documented, "The trapeze, used in conjunction with a bed, can assist an individual weighing up to 650 lbs. The trapeze is designed to provide support, increase stability and assist the user when repositioning in bed. The trapeze is not designed, however, to support the total body weight of an individual. Use it for assistance only. IMPORTANT, Prior to patient use, be sure that all connections are inspected and secure."	F 689			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing,	F 880		6/5/18	

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F 880	<p>Continued From page 42</p> <p>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> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under 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>	F 880			

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F 880	<p>Continued From page 43</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, record review, policy review, and staff interview, it was determined the facility failed to keep a catheter bag and catheter tubing off the floor and staff failed to perform standard hand hygiene measures to reduce the risk of infection. This was true for 1 of 2 (#2) residents sampled for catheters. This failure created the potential for more than minimal harm by exposing residents to the risk of infection and cross-contamination. Findings include:  The facility's Catheter policy, dated 1/2/14, directed staff to keep catheter bags and tubing off of the floor.  The facility's Hand Hygiene policy, dated 11/28/17, directed staff to perform hand hygiene after any contact with bodily fluids, even when gloves were worn, and after patient care.  Resident #2 was admitted to the facility on 8/22/17 with multiple diagnoses, including neuromuscular dysfunction of the bladder.</p>	F 880	<p>Resident Specific:</p> <p>Resident #2 will be assessed by a licensed nurse on or before 5/8/18 for signs or symptoms of infection related to lack of hand hygiene and catheter bag and catheter tubing on the floor. No signs and symptoms were noted at the time of assessment.</p> <p>Other Residents with the potential to be affected:</p> <p>Other residents residing in the facility with indwelling catheters will be reviewed by members of the nurse management team on or before 5/8/18 to validate that catheter and tubing was not on the floor as well as hand hygiene performed after emptying catheters. Corrections were made at time of review as indicated.</p> <p>Center CNAs completed will complete competencies for hand washing after</p>		

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F 880	<p>Continued From page 44</p> <p>Resident #2's physician order, dated 9/12/17, documented the resident had a foley catheter placed.</p> <p>On 4/2/18 at 5:18 PM, Resident #2 was sitting up in bed in his room when CNA #1 and CNA #2 assisted him with cares. CNA #1 had gloves on and released the catheter clamp and drained the resident's urine into a graduated cylinder. CNA #1 then placed the catheter bag onto the floor with the tubing side face down, with several inches of tubing touching the floor. She took the urine into the bathroom and came out with a different cylinder, turned on the sink faucet and filled the cylinder with water. CNA #1 went back into bathroom, disposed of the urine into the toilet, rinsed that cylinder with the water, then disposed of the water into the toilet and then placed the cylinders into separate plastic bags, which hung from the bathroom door. CNA #1 then removed the gloves and threw them into the trash and immediately put on new gloves and placed the resident's cell phone on the over bed tray table. Using a gait belt, CNA #1 and CNA #2 then assisted Resident #2 to transfer from his bed to his wheelchair. CNA #2 picked up the catheter bag and tubing from the floor and placed it into a cage under the resident's wheelchair. CNA #1 gave the resident his cell phone and both CNAs washed their hands.</p> <p>On 4/2/18 at 5:30 PM, CNA #1 said she placed the catheter bag on the floor so it would not twist during the transfer. She said she did not need to wash her hands after disposing of the urine because she had gloves on and had put on a clean pair of gloves on to replace the first pair.</p>	F 880	<p>emptying catheters and placement of catheter bag and tubing on or before 5/8/18 by the nurse practice educator or designee.</p> <p>Systematic Changes and Education:</p> <p>Center nursing staff will be re-educated by director of nursing or designee on or before 5/8/18 regarding hand hygiene after catheter care and ensuring that catheter tubing and catheter bags are not on the floor to prevent potential infection. Specifically, CNAs re-educated to leave the bags in the bedside basins when transferring residents with catheters.</p> <p>Residents with indwelling catheters will have basins at bedside if in low bed and baskets under wheelchairs to prevent catheters and tubing from touching the floor.</p> <p>Ongoing Monitoring:</p> <p>Beginning the week of 5/7/18, 5 residents with indwelling catheters will be reviewed weekly for 4 weeks and monthly for 2 months during transfers to validate that catheters and tubing are not touching the floor and that hand hygiene is performed following the emptying of the catheter bag. Results of these audits will be reviewed by center QAPI committee for a minimum of 3 months or until substantial compliance is sustained. Director of nursing will be responsible for compliance.</p>		

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F 880	Continued From page 45 On 4/2/18 at 5:40 PM, Resident #2 was in the main dining room eating his dinner meal with his cell phone on the table next to him.  On 4/4/18 at 2:20 PM, the DON said CNA #1 should not have placed the catheter bag and tubing on the floor. She said CNA #1 should not have touched the sink faucet after handling the urine filled cylinder and should have washed her hands prior to putting on a new pair of gloves and should have not handled the cell phone, unless her hands were clean.	F 880			



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January 10, 2019

Sherrie Nunez, Administrator  
Apex Center  
8211 Ustick Road  
Boise, ID 83704-5756

Provider #: 135079

Dear Ms. Nunez:

On **April 2, 2018** through **April 5, 2018**, an unannounced on-site complaint survey was conducted at Apex Center.

Call lights were observed throughout the survey. Infection control practices were observed, including catheters, cleanliness, and hand hygiene. Residents were observed for fall prevention and supervision. Dinner meals were observed.

The clinical record of the identified resident and 13 other residents were reviewed for Quality of Care issues. The facility's Grievance file was reviewed, as well as its Incident and Accident reports, Resident Council minutes, and facility staffing records.

Several residents, family members, CNAs, and nurses were interviewed regarding various Quality of Life and Care issues. The Director of Nursing and the Administrator were interviewed regarding various issues.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007655**

ALLEGATION #1:

The Reporting Party said an identified resident's catheter bag was left on the floor, there was feces on the pillowcase and bathroom grab bars, and staff did not perform hand hygiene after performing pericare.

FINDINGS #1:

The identified resident's catheter bag and tubing were observed on the floor, and staff did not perform hand hygiene after draining the catheter bag. Based on observation and staff interview, it was determined the allegation was substantiated and the facility was cited at F880.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

An identified resident's need for a catheter was not justified

FINDINGS #2:

The clinical records of the identified resident was reviewed and documented medical justification for the use of the catheter. One other resident's record was reviewed for medical justification of a catheter and no concerns were identified.

Several nurses and the Director of Nursing said the resident used a catheter based on various medical conditions.

Based on record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility did not provide adequate supervision to prevent an identified resident from falling and did not investigate falls sufficiently.

FINDINGS #3:

The identified resident and one other resident were observed for fall precautions and supervision. During observations, fall preventions for the identified residents were not implemented consistently.

The identified resident's clinical record and two other residents' records documented fall prevention and supervision was not adequate to provided safety for the residents. The facility's Incident and Accident investigations documented fall precautions were not consistently implemented following falls.

CNAs and nurses said fall preventions were supposed to be monitored to keep residents safe. Two family members said staff did not provide consistent supervision and fall prevention for residents. The Director of Nursing said fall interventions were not always placed in a timely manner or consistently for the identified resident.

Based on observation, record review, family and staff interview, it was determined the allegation was substantiated and the facility was cited at F689 and F558.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

Dinner meals were often not provided to an identified resident until 9:00 PM.

FINDINGS #4:

Dinner, breakfast and lunch were observed to be served in a timely manner. The identified resident was observed to be brought down to the dining room and was served the dinner meal within minutes of arriving.

The facility Grievance file did not document late meals were a concern.

Several residents said there were no concerns with late meals. Several staff said sometimes meals were delayed by several minutes, but never more than that.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Grievances brought to the attention of staff were not resolved.

FINDINGS #5:

The facility's Grievance file was reviewed and documented the facility had addressed the concerns.

Several residents said the facility staff addressed concerns raised by them or their family members in a timely manner. CNAs and nurses said they immediately address concerns when they come up and also forward those onto their supervisors, the Administrator or the Director of Nursing. The Director of Nursing and the Administrator said they address every Grievance and try to resolve them to the best of their ability.

Based on record review, resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility has a lack of staffing.

FINDINGS #6:

Call lights and resident needs were observed to be answered and residents' needs were addressed in a timely manner.

Resident Council minutes were reviewed and call lights and lack of staffing was not an identified concern. Facility staffing records documented the facility was staffed adequately to meet the residents' needs.

Several residents, CNAs and nurses said the facility had enough staff to meet the residents' needs. The Director of Nursing said she had trained CNAs to work smarter to meet the residents' needs,

Sherrie Nunez, Administrator  
January 10, 2019  
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had hired an extra nursing position to monitor and answer call lights to address residents' needs. The Director of Nursing and the Administrator said the facility had enough staff.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj



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January 8, 2019

Sherrie Nunez, Administrator  
Apex Center  
8211 Ustick Road  
Boise, ID 83704-5756

Provider #: 135079

Dear Ms. Nunez:

On **April 2, 2018** through **April 5, 2018**, an unannounced on-site complaint survey was conducted at Apex Center.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007657**

**ALLEGATION #1:**

The facility neglected a resident.

**Findings #1:**

Fourteen individual residents, and all residents in general, were observed for potential signs of neglect during the survey. No signs of neglect were observed.

Staff responses to call lights were observed throughout the survey. The staff were also observed as they provided care, interacted with residents, and responded to residents' needs and requests, which they did in prompt and respectful fashion.

Nine residents were asked about neglect of themselves and/or others. All of them said they were treated with dignity and respect, and none of them verbalized concerns about neglect.

Sherrie Nunez, Administrator  
January 8, 2019  
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Three Certified Nursing Assistants, three nurses, the Director of Nursing Services, and the Administrator were interviewed about neglect. None of the staff verbalized concerns or issues about neglect.

The clinical records of fourteen residents were reviewed for quality of care and quality of life issues, including neglect. There were no concerns or issues about neglect identified in the residents' records.

The facility's Grievance file was also reviewed and there were no complaints of neglect documented.

The clinical record documented the identified resident's cognition was intact, the resident was able to make his/her wishes known and was actively involved in care planning, and participated and progressed with physical therapy.

Based on these findings, it was determined the allegation could not be substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

A resident had too many wounds to count on the lower extremities. At least five of the wounds were necrotic and there was "severe" edema to the bilateral lower extremities. The resident also had a "very severe" pressure ulcer to the coccyx which "was necrotic" and "life threatening."

#### FINDINGS #2:

The resident's clinical record documented he was admitted to the facility with seven unstageable pressure ulcers, including to the coccyx and bilateral lower extremities, and three vascular ulcers to both lower legs. The resident's cognition was intact, he was able to make his needs known and was actively involved in care planning his rehabilitation and discharge to home. As the resident's mobility improved, a heel blister developed when the resident independently chose to wear shoes without socks when there was significant pitting edema in both lower extremities. The resident was educated about the risks for blisters before and after the heel blister developed and he agreed to off loading the heel until the blister resolved. The resident's diuretic medication was increased and the resident agreed to periodically elevate his lower extremities to help reduce the edema. Deficient practice was not identified for this resident. However, deficient practice was identified for other residents and the facility was cited at F 686.

Sherrie Nunez, Administrator  
January 8, 2019  
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CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3:

A resident was dependent on tube feedings for nutrition and lost a significant amount of weight.

Findings #3:

The clinical record documented the identified resident had significant weight loss prior to admission to the facility and continued weight loss after admission to the facility. The weight loss was attributed to the resident's diagnoses and to fluctuating edema. The facility assessed and monitored the resident's weight and edema, and implemented timely interventions, including adjustments to enteral feedings and diuretics.

Based on these findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj



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January 15, 2019

Sherrie Nunez, Administrator  
Apex Center  
8211 Ustick Road  
Boise, ID 83704-5756

Provider #: 135079

Dear Ms. Nunez:

On **April 2, 2018** through **April 5, 2018**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007783**

**ALLEGATION #1:**

Residents were left in soiled briefs and bedding for long periods of time.

**FINDINGS #1:**

The facility was observed for odors throughout the survey. Staff responses to call lights were observed throughout the survey. Facility staff were observed providing care and responding to residents' needs and requests promptly.

The clinical records of four residents were reviewed for quality of care concerns, including bowel and bladder incontinence. Concerns regarding incontinence and staff response time to provide care were not identified. The facility's Grievance files from May 2017 to April 2018 were reviewed. The facility's Incident and Accident reports from May 2017 to April 2018 were reviewed.

Several residents were interviewed and did not express concerns related to being left in soiled briefs for an extended period of time. Nurses, CNAs, and the Director of Nursing were interviewed. They stated they made sure residents received incontinent care routinely and as needed, and if a resident declined, the facility staff would reapproach the resident with other staff to assure residents needs were met in a timely manner.

Sherrie Nunez, Administrator  
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Based on the investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence

ALLEGATION #2:

Residents with feeding tubes are not provided care and the site becomes infected.

FINDINGS #2:

Two residents, including the identified resident, were interviewed regarding nurses providing care to tube feeding sites. The residents did not express concerns regarding care provided by the nurses with the tube feeding site.

Several nurses and the Director of Nursing were interviewed and no concerns were identified regarding the nurses providing care to the tube feeding sites.

Based on the investigative findings, it was determined the allegation could not be substantiated.

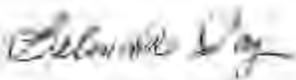
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
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January 17, 2019

Sherrie Nunez, Administrator  
Apex Center  
8211 Ustick Road  
Boise, ID 83704-5756

Provider #: 135079

Dear Ms. Nunez:

On **April 2, 2018** through **April 5, 2018**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007739**

ALLEGATION #1:

Residents did not receive all doses of prescribed medication.

FINDINGS #1:

The clinical records were reviewed for **14 residents**. Staff members were interviewed including five nurses, the DON, and the pharmacist.

The clinical record of one resident documented an IV antibiotic was administered each day as ordered, and multiple Progress Notes documented the IV antibiotic was infusing. There was no documentation a dose of IV antibiotic was missed or held for any reason.

The clinical record of another resident documented four medications had missing doses, as indicated by missing signatures on the MAR and no documentation regarding the reason for the missing dose.

Sherrie Nunez, Administrator  
January 17, 2019  
Page 2 of 3

Based on the investigative findings, it was determined the allegation was substantiated and the facility was cited at F684 as it relates to quality of care pertaining to medications.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #2:**

Residents were discharged home with expired medication.

**FINDINGS #2:**

The clinical records were reviewed for **14 residents**. It was documented a resident was sent home with all remaining medications, including an unspecified number of doses of IV antibiotics.

Staff members were interviewed including five nurses, the DON, and the pharmacist. It was confirmed one resident was sent home with a number of IV antibiotics, although it could not be explained why there were remaining doses of antibiotic. During an interview, a nurse stated she found expired medication in the same resident's home. The clinical record of one resident documented some of the IV antibiotics would have expired during the days immediately following the resident returning home if the IV antibiotic was sent home with the resident.

Based on record review, resident and interested party and staff interviews, it was determined the allegation was substantiated and the facility was cited at F684 as it relates to quality of care pertaining to medication management.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #3:**

The facility accepted residents for whom they could not meet their needs.

**FINDINGS #3:**

Staff members were interviewed including five nurses, the DON, and the pharmacist. The clinical records of **14 residents** were reviewed. General observations were made of residents throughout the facility and staff providing care to residents.

Sherrie Nunez, Administrator  
January 17, 2019  
Page 3 of 3

The clinical record of one resident documented an IV antibiotic was administered each day as ordered, and multiple Progress Notes documented the IV antibiotic was infusing. There was no documentation a dose of IV antibiotic was missed or held for any reason. It was documented a resident was sent home with all remaining medications, including an unspecified number of doses of IV antibiotics. There was no documentation or expressed concerns regarding staff not being able to provide care or administer medications. During an interview, a nurse said she was inserviced by the pharmacy on how to use the equipment for administering an IV antibiotic, and printed instructions were available for all staff to reference as needed. There were no issues or concerns discovered during the survey regarding the facility not being able to meet the residents' needs.

Based on the investigative findings, the allegation could not be substantiated.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

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February 26, 2019

Sherrie Nunez, Administrator  
Apex Center  
8211 Ustick Road  
Boise, ID 83704-5756

Provider #: 135079

Dear Ms. Nunez:

On **April 2, 2018** through **April 5, 2018**, an unannounced on-site complaint survey was conducted at Apex Center. Fourteen residents were observed for Quality of Care issues, medication management, and food concerns. Quality of Care practices were observed, including staff interaction with residents and behavior management. Dinner meals were observed.

The clinical record of fourteen residents were reviewed for quality of care issues and medication management. The facility's grievance file was reviewed, as well as its medication review and social service concerns.

Nine residents, three CNAs, three nurses, and one physician was interviewed regarding various quality of life and care issues. The Director of Nursing and the Administrator were interviewed regarding various issues.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007735**

**ALLEGATION #1:**

Residents required psychiatric assistance and the facility did not meet a resident's mental health needs.

FINDINGS #1:

The clinical record of a resident was reviewed and documented she was receiving non-pharmacological interventions, supplementation, and anti-anxiety medications. The resident's record documented she was consistently seen by a mental health provider who assessed and evaluated her mental health needs. Two other resident's records were reviewed for psychiatric assistance and no concerns were identified.

Several nurses, social services, the mental health provider and the Director of Nursing said the resident had a long history of skin picking from anxiety and the medication treatment and other treatments were consistently monitored and adjusted for effectiveness.

A resident stated they had no concerns with the services received from the mental health provider.

Based on the investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

A resident was to receive medications, treatments, and skin creams and the facility did not provide these to the identified resident.

FINDINGS #2:

A resident's record documented she was to receive multiple medications, treatments, and skin creams. The Medication Administration Record documented these medications were not administered to the resident consistently.

Based on investigative findings, the allegation was substantiated. A deficiency was cited at F580 as it relates to the failure of the facility to ensure the ordering physician was notified when a medication or treatment was not consistently administered. A deficiency was cited at F684 as it relates to the failure of the facility to ensure medications and treatments were provided to a resident per physician orders.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Sherrie Nunez, Administrator  
February 26, 2019  
Page 3 of 3

ALLEGATION #3:

A resident received inappropriate diet restrictions for health needs.

FINDINGS #3:

Dinner, breakfast and lunch were observed to be served in a timely manner.

The facility grievance file did not document issues with salty foods as a concern.

Several residents stated they had to add additional salt to their food because they wanted more flavor. The residents had no concerns with salt restricted diets.

A resident stated the facility had improved on providing her with more food options with less salt.

The facility's menus were reviewed and were appropriate for therapeutic restrictions such as low salt diets.

Based on investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj

Sherrie Nunez, Administrator  
February 26, 2019  
Page 4 of 3



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February 26, 2019

Sherrie Nunez, Administrator  
Apex Center  
8211 Ustick Road  
Boise, ID 83704-5756

Provider #: 135079

Dear Ms. Nunez:

On **April 2, 2018** through **April 5, 2018**, an unannounced on-site complaint survey was conducted at Apex Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007775**

ALLEGATION #1:

Residents were not provided with assistance to toilet or to get dressed in a timely manner.

FINDINGS #1:

Call light response times were monitored in each hall of the facility and staff responded to them within acceptable time frames.

Facility staffing levels were reviewed and were found acceptable. Staff members were interviewed including one CNA, four nurses, the DON, and Registered Dietician.

The clinical records and grievance file were reviewed for one resident. One resident's record documented she was transferred to the hospital on 3/2/18 and did not return to the facility. It was documented in the resident's clinical record that there were concerns regarding staff response times to call lights. The clinical record documented it took 45 seconds for the resident's call light to be answered and she was assisted to the bathroom upon request. The Registered Dietician

stated she answered the resident's call light after dinner, the resident requested assistance to the bathroom, and the Registered Dietician appropriately requested a CNA who was passing by to assist the resident.

The same resident's clinical record documented a nurse assisted the resident to the toilet twice during the night. The clinical record documented a CNA assisted the resident with ADLs including dressing and toileting during the day shift on 3/2/18.

Staff members were interviewed including CNAs, nurses, and the Director of Nursing. A nurse was interviewed who stated a CNA was assigned to remain outside the resident's door during the night. The resident did not turn on her call light during the night until the next morning, on 3/2/18, when she asked for a medication for a migraine.

Based on the investigative findings, it was determined the allegation could not be substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The facility did not provide prescribed medications for residents.

#### FINDINGS #2:

The clinical records of 14 residents were reviewed for medication management. Ordered medications were available for each of the 14 residents.

One resident's clinical record documented she was admitted to the facility with orders for Lyrica (Pregabalin) and Tramadol as needed. The resident received Lyrica as scheduled, and she received no doses of Tramadol. It was documented that Imitrex and Excedrin Migraine were ordered on 3/2/18, and one dose of Excedrin Migraine was administered on 3/2/18. The resident told the nurse she used Excedrin Migraine at home and the Imitrex was discontinued by her physician due to the length of time it had been prescribed.

Staff members were interviewed including four nurses, the Admissions Director, and the Director of Nursing. It was confirmed through the interviews the facility did not receive the necessary prescriptions for Lyrica or tramadol and did not obtain the medications from the pharmacy. The facility attempted to obtain the necessary prescriptions but was unsuccessful. The resident's family member was called and agreed to bring the medications from home. A nurse was interviewed and said she received the medications and logged them in with another nurse.

Based on investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents were told if they went home it would be considered AMA discharge, and residents were transferred to the hospital against their wishes.

FINDINGS #3:

The clinical records of one resident were reviewed. Staff members were interviewed including four nurses, the Director of Nursing, the Administrator, the physician, and Social Worker.

The same resident's clinical record documented her family member requested to have the resident transported home. The clinical record documented the physician spoke to the resident's family member on the phone and provided an order for the facility to transfer the resident to the hospital due to concerns regarding the resident receiving care at home. The clinical record documented the resident expressed she wanted to go home with home health services, and it was explained to her and her family member the facility's physician could not order home health services for her until she was evaluated by the facility's healthcare provider. The clinical record documented the resident and her family member declined to wait for the facility's provider to see the resident. During an interview, the Director of Nursing said the resident agreed with transferring to the hospital in order to be evaluated for possible discharge to home.

Based on investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The Medical Director was not made aware of concerns regarding residents' care.

Sherrie Nunez, Administrator  
February 26, 2019  
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FINDINGS #4:

The clinical records were reviewed for one resident. It was documented the Administrator spoke to the resident's family member on 3/1/18 at 9:54 PM, and the Medical Director spoke to the resident's family member on the phone on the morning of 3/2/18.

Staff members were interviewed including four nurses, the Director of Nursing, the Administrator, the physician, and the Social Worker. The Medical Director spoke to the resident's family member on the phone and was aware of the concerns regarding the resident's care. The Medical Director subsequently provided an order for the resident to be transferred to the hospital and evaluated for discharge to home.

Based on the investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj