



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
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May 4, 2018

Michael Littman, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. Littman:

On **April 20, 2018**, a survey was conducted at Lacrosse Health & Rehabilitation 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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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 **May 14, 2018**. Failure to submit an acceptable PoC by **May 14, 2018**, may result in the imposition of penalties by **June 8, 2018**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 25, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 19, 2018**. A change in the seriousness of the deficiencies on **June 4, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **July 19, 2018** includes the following:

Denial of payment for new admissions effective **July 20, 2018**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **October 20, 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; 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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 19, 2018** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

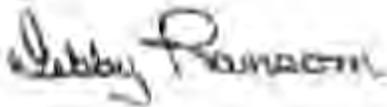
- BFS Letters (06/30/11)

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

This request must be received by **May 14, 2018**. If your request for informal dispute resolution is received after **May 14, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/20/2018
NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint investigation survey conducted April 16, 2018 to April 20, 2018. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Brad Perry, LSW Linda Kelly, RN Edith Cecil, RN Presie Billington, RN Cecilia Stockdill, RN Wendi Gonzales, RN Teri Hobson, RN Survey Abbreviations: ADL = Activities of Daily Living ADON = Assistant Director of Nursing CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DON = Director of Nursing LMSW = Licensed Master Social Worker LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams PEG = Percutaneous Endoscopic Gastrostomy PRN = As needed RT = Respiratory Therapist r/t = related to	F 000			
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	F 580		5/21/18	

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

TITLE

(X6) DATE

Electronically Signed

05/09/2018

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 580	Continued From page 1 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 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (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. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §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	F 580			

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F 580	<p>Continued From page 2</p> <p>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 by:</p> <p>Based on record review, review of hospital and Fire Department patient records, and staff interview, it was determined the facility failed to ensure a resident's physician and daughter who served as the resident's emergency contact person, were notified of significant changes in the resident's clinical condition and transfer to the emergency room (ER). This was true for 1 of 2 (#72) sample residents reviewed for hospitalizations. The deficient practice placed Resident #72 at risk of harm due to lack of physician involvement and lack of advocacy and support from her daughter when she was unable to make decisions for herself due to decreased level of consciousness. Findings include:</p> <p>Resident #72 was admitted to the facility on 2/24/16 with diagnoses that included chronic kidney disease and diabetes mellitus type 2.</p> <p>Resident #72's admission record, dated 2/24/16, documented Resident #72 was her own responsible person and her daughter was the emergency contact person.</p> <p>The Minimum Data Set assessment, dated 1/17/18, documented Resident #72 was cognitively intact.</p> <p>Physician orders documented Resident #72's physician was contacted on 3/18/18 at 2:20 AM</p>	F 580	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident # 72 is no longer at the facility.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>Residents residing at the facility have the potential to be affected by this deficient practice. Residents who have transferred to acute care in the last 30 days have been reviewed to ensure MD/representative notification.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Licensed nurses were in-serviced on notification of MD and family with change of condition/transfers to acute care by DON.</p>		

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F 580	Continued From page 3 and ordered staff to obtain labs, and provide fluids and oxygen therapy. A Progress Note, dated 3/18/18 at 3:35 AM, documented Resident #72 was non-responsive. The Fire Department's patient record dated 3/18/18, documented Resident #72 was transported to the ER at 10:57 AM. A hospital history and physical dated 3/18/18 at 2:37 PM, documented Resident #72 was admitted to the hospital with the diagnoses of sepsis related to a urinary tract infection and acute metabolic encephalopathy (chemical abnormalities, resulting in adverse brain function). A hospital Intensive Care Unit Nursing Note, dated 3/19/18 at 8:21 AM, documented contact with Resident #72's daughter to obtain Resident #72's usual health status. On 4/19/18 at 3:00 PM, the DON stated the facility did not have documentation Resident #72's physician and daughter were notified of her transfer to the ER.	F 580	How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained: Audits of residents transferring to acute care will be done daily Monday through Friday X 12 weeks to ensure compliance by Medical Records Manager. Findings will be reviewed at QAPI monthly X 3 for further educational opportunities. Person responsible for compliancel DON or disgreee will be responsible for compliance. Dates when corrective action will be completed:		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,	F 583		5/21/18	

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F 583	<p>Continued From page 4</p> <p>and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' clinical records remained confidential. This was true for 1 of 3 residents (#50) sampled for isolation precautions. This deficient practice had the potential to place Resident #50 at risk of embarrassment and/or diminished sense of self-worth when the resident's personal health information was available to seen by the public. Findings include:</p>	F 583	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident # 50 is no longer on isolation.</p> <p>Staff # OT has been in-serviced on confidentiality with resident medical records.</p>		

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F 583	<p>Continued From page 5</p> <p>On 4/17/18 at 6:45 PM, an isolation cart was observed in 500 Hall, outside Resident #50's room. A sign posted to the left of the Resident's door directed visitors to report to the nurses' station prior to entering. A double-sided facility form titled "Droplet Precautions" was laying on top of the isolation cart. The sheet provided the following information:</p> <ul style="list-style-type: none"> * Common conditions for the isolation * Limit visitors to those already exposed * Handling of dishes, utensils, equipment, supplies, and management of linen * Direction for Personal Protective Equipment, order of/and donning and removal * Private room or, if unavailable, room with a resident that has the same organism but no other infection * Direction for room cleaning * Precautions during transport <p>At 6:58 PM, the Infection Control nurse, LPN #1 stated the facility followed the CDC (Centers for Disease Control and Prevention) guidelines. LPN #1 stated the Droplet Precautions direction was per CDC guidelines. LPN #1 stated it is not appropriate for others to know a resident's diagnoses and that the 500 Hall was a busy hall and had residents and visitors using the hallway. LPN #1 stated the Droplet Precautions sheet was supposed to be in the top drawer of the isolation cart. LPN #1 stated she had provided an inservice approximately 3 weeks ago and recently inserviced OT #1.</p> <p>On 4/18/18 at 4:30 PM, OT #1 stated she was aware of the isolation precautions for Resident #50. OT #1 stated LPN #1 inserviced her on the precautions needed for entering the room but did</p>	F 583	<p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>There are no residents in the facility at this time requiring isolation precautions.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Staff were in-serviced by the infection control specialist on confidentiality of residents' records including that PPE instructions are to be placed in a closed drawer of the isolation cart.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained:</p> <p>Resident with isolation precautions as part of their POC will be audited daily Monday through Friday X 12 weeks by the infection control specialist to ensure PPE instructions are confidentially maintained.</p> <p>These audits will be presented at QAPI monthly X 3 to identify further educational opportunities.</p> <p>Who will be responsible for compliance.</p> <p>Infection Control Specialist or designee will be responsible for compliance.</p>		

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F 583	Continued From page 6 not provide direction as to what to do with the Droplet Precautions sheet. OT #1 stated the sheet was in the top drawer of the isolation cart. She stated she took it out and looked at it and put it back in the drawer. OT #1 stated she inserviced a CNA that was on the unit, but did not remember if she put the sheet back in the drawer or not. Resident #50's preferences/quality of life care plan, dated 11/15/17, documented the intervention "it is important to the resident to have privacy."	F 583	Dates when corrective action will be completed:		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		5/21/18	

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F 657	<p>Continued From page 7 or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and record review, it was determined the facility failed to develop and implement comprehensive resident-centered care plan, and include residents' representatives in the development of the care plan. This was true for 2 of 18 residents (#25 and #73) reviewed for care plans and created the potential for residents to receive inappropriate or inadequate care. Findings include:</p> <p>1. Resident #73 was admitted to the facility on 7/16/17 with diagnoses that included COPD, dementia, and anxiety disorder.</p> <p>A quarterly MDS assessment, dated 4/2/18, documented Resident #73 had a severe cognitive impairment. required extensive staff assistance with bed mobility, and was at risk for pressure ulcers.</p> <p>The care plan for activities of daily living and mobility documented Resident #73 required the assistance of staff for repositioning and turning. The care plan did not include direction for staff of when to reposition Resident #73.</p> <p>On 4/16/18 at 10:46 AM, Resident # 73, was observed in bed sleeping, lying on his back, and a Bilevel Positive Airway Pressure (BiPap) mask was in place.</p>	F 657	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #73 has had his careplan/care directives reviewed and updated as indicated and is receiving care as per his careplan including his positioning schedule. Resident and his POA have reviewed and signed off on his care plan.</p> <p>Resident #25 has had his careplan/care directives reviewed and updated as indicated and is receiving care as per his careplan including discharge planning. Redident and his POA have reviewed and signed off on his careplan.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>Residents residing at the facility have the potential to be affected by this deficient practice.</p> <p>Residents have had their careplans reviewed and updated as indicated. Careplans are resident centered.</p>		

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F 657	<p>Continued From page 8</p> <p>On 4/17/18 at 8:30 AM, 9:02 AM, 10:30 AM, 10:42 AM and 11:30 AM, Resident #73 was observed in bed sleeping, lying on his back, and a BiPap mask was in place.</p> <p>On 4/18/18 at 2:41 PM, LPN #1 said Resident #73 should be repositioned at least every two hours. She said it was in the care plan but the care plan did not indicate how often the resident should be repositioned.</p> <p>2. Resident #25 was re-admitted to the facility on 2/2/17 with multiple diagnoses, including traumatic subdural hemorrhage (bleeding around the brain) and Type 2 diabetes mellitus.</p> <p>The facility's policy and procedure regarding resident/family conferences documented the following:</p> <ul style="list-style-type: none"> * The facility would encourage the resident and/or family/representative to attend care conferences. * Encourage the resident/family/representative to express preferences regarding care. * Ensure notification of the resident and resident representative of the next scheduled Resident Care Conference" and document the notification using a Social Services Progress Note. <p>A Progress Note, dated 10/20/17 at 1:08 PM, documented Social Services spoke to Resident #25's mother, who desired for the resident to be discharged and moved to California.</p>	F 657	<p>Residnets have had or have a scheduled care conference in accordance to the MDS schedule to ensure resident/family involvement.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Interdisciplinary team involved in care planning have been in-serviced by the DON on resident centered care planning and the need for residnet/representative involvement in the developement of individual careplans/care conference.</p> <p>Care conference schedule will be established in accordance with MDS schedule and reviewed during the morning clinical meeting.</p> <p>Clinical follow up in the afternoon will confirm that the established care conferences were scheduled with resident/family involvement in accordance with the MDS schedule.</p> <p>Refusals of care conference participation by the resident or family will be documented in the medical record.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained:</p> <p>Careplans will be audited using the MDS</p>		

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F 657	Continued From page 9 On 4/17/18 at 5:19 PM, Resident #25's representative said the care plan had not been discussed with her in about two years and she had not been contacted about the resident's condition since he stopped falling out of bed some time ago. On 4/17/18 at 5:53 PM, the Director of Social Services said care conferences should be done every three months and she talked to Resident #25's family in October 2017. She said she would look for additional documentation of the most recent care conference. On 4/19/18 at 9:18 AM, the DON said Social Services was in charge of inviting the family and scheduling care plan conferences. The facility did not provide additional documentation regarding care conference meetings occurring for Resident #25.	F 657	schedule by the unit managers Monday through Friday X 12 weeks to ensure accuracy and resident/representative involvement. Care Conferences will be audited by MDS using the MDS schedule Monday through Friday X 12 weeks to ensure completion and resident/representative involvement. Audits will be reviewed at QAPI monthly X 3 for further educational/corrective opportunities. Who is responsible for compliance. DON or designee will be responsible for compliance. Dates when corrective action will be completed:		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his	F 676		5/21/18	

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F 676	<p>Continued From page 10</p> <p>or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...</p> <p>§483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:</p> <p>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,</p> <p>§483.24(b)(2) Mobility-transfer and ambulation, including walking,</p> <p>§483.24(b)(3) Elimination-toileting,</p> <p>§483.24(b)(4) Dining-eating, including meals and snacks,</p> <p>§483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, it was determined the facility failed to implement comprehensive resident-centered care plans related to oral/dental care. This was true for 1 of 18 (#19) sample residents whose care plans were reviewed. This failure placed Resident #19 at risk of harm when assistance was not provided with oral care. Findings include:</p> <p>1. Resident #19 was admitted to the facility on 5/1/17 with multiple diagnoses, including failure to thrive and malnutrition.</p>	F 676	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #19 has had dental care assistance as needed.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:</p>		

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F 676	<p>Continued From page 11</p> <p>Resident #19's quarterly MDS assessment, dated 2/3/18, documented she was cognitively intact and required one person physical assistance with personal hygiene. The assessment area pertaining to oral/dental status was blank.</p> <p>Resident #19's care plan directed staff to do the following: * Provide one staff assistance with personal hygiene. * Monitor, document and report to the physician any signs or symptoms of oral/dental problems. * Provide mouth care as directed on the ADL/Mobility care plan.</p> <p>Resident #19's Physician's Telephone Orders, dated 2/17/18, documented she was referred for dental extractions, three visits for dental cleaning, and approximately four appointments for fillings.</p> <p>Resident #19's Request for Appointment and Transportation documented she was scheduled for a dental cleaning on 2/27/18 at 2:15 PM and on 4/5/18 at 8:00 AM.</p> <p>On 4/19/18 at 10:11 AM, Resident #19 said she did not know when her last dental appointment was prior to February 2018, but she thought it was in 2016. Resident #19 said the facility staff did not assist her to brush her teeth and that she could do it herself. Resident #19 said the dentist wanted to pull multiple teeth due to the poor condition of her teeth at her appointment in February 2018.</p> <p>On 4/19/18 at 11:21 AM, CNA #1 said she had never observed Resident #19 brushing her teeth,</p>	F 676	<p>Residents requiring assistance with oral care are at risk to be affected by this deficient practice.</p> <p>Residents requiring assistance with dental care have been evaluated and are receiving identified assistance to complete oral care as needed.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Unit Managers have been in-serviced by the DON on resident dental care needs and documentation requirements for dental care.</p> <p>Residents requiring assistance with dental care have been reviewed and have directions and frequency of oral care added to the care directive kardex.</p> <p>Aides have been in-serviced on oral/dental care and how to locate individual resident care needs on the care directive kardex.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained:</p> <p>Residents needing assistance with dental care will be audited randomly by the Unit Managers daily Monday through Friday X 12 weeks to ensure</p>		

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F 676	Continued From page 12 they did not routinely offer or assist her with oral care, and she was able to do it herself. On 4/19/18 at 2:22 PM, Resident #19 said staff did not assist her to brush her teeth, that her toothpaste and toothbrush were in her dresser drawer and she could use them although "I don't as often as I should," and staff rarely reminded her and never offered to assist her to brush her teeth. On 4/19/18 at 2:37 PM, LPN #1 said residents should have teeth brushed at least once per day. There was no documentation the facility assisted Resident #19 with brushing her teeth or provided oral care as per the care plan.	F 676	assistance/completion of dental care. Audits will be reviewed at QAPI at QAPI monthly X 3 for further corrective opportunities. Who will be responsible for compliance. DON or designee will be responsible for compliance. Dates when corrective action will be completed:		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interviews, it was determined the facility failed to ensure professional standards of practice related to medication management, tube feedings, care of residents who are diabetic, and monitoring of pressure relief mattresses, were followed for 2 of 18 sample residents (#25	F 684	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #25 is receiving medication and treatments as per MD order with accurate	5/21/18	

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F 684	<p>Continued From page 13 and #39) whose MARS were reviewed. This failed practice created the potential for harm when residents did not receive ordered medications and treatments. Findings include:</p> <p>The facility's policy and procedure regarding documentation, dated January 2017, documented the facility would provide "ongoing documentation of the resident's health status to include observations, assessments, interventions, and clinical outcomes... to ensure the appropriate information is available to all interdisciplinary team members regarding treatment interventions and responses."</p> <p>1. Resident #25 was re-admitted to the facility on 2/2/17 with multiple diagnoses, including traumatic subdural hemorrhage (bleeding around the brain) and Type 2 diabetes mellitus.</p> <p>Resident #25's care plan documented he required tube feeding due to a swallowing disorder. The care plan directed staff to administer tube feeding and water flushes and to administer medications as ordered.</p> <p>Resident #25's clinical record documented the following:</p> <p>* A physician's order on 2/16/17 for Lantus (insulin) 100 units/ml (milliliters) inject 18 units in the morning and at bedtime. The 2018 MARs did not document the Lantus was given on 1 of 39 opportunities in April, 2 of 62 opportunities in March, and 4 of 56 opportunities in February.</p> <p>* A physician's order on 6/8/17 to check the blood sugar every morning. The 2018 MARs did not</p>	F 684	<p>documentation in the Medication and Treatment record.</p> <p>Resident #39 is receiving medications and treatments per MD order with accurate documentation in Medication and Treatment record.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>Residents have had their MD orders and Medication/Treatment records reviewed for accuracy. Medication/Treatment documentation is complete.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Licensed Nurses have been in-serviced by the DON on the policy for complete and accurate documentation of Medication/Treatment records.</p> <p>Medication/Treatment records will be reviewed between "off going" Licensed Nurse and "oncoming" Licensed Nurse during shift report to correct any missed documentation.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained:</p>		

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F 684	<p>Continued From page 14</p> <p>document the blood sugar was checked on 2 of 20 opportunities in April and 2 of 31 opportunities in March.</p> <p>* A physician's order on 2/2/17 for Baclofen (a muscle relaxant) 10 mg tablet give one-half tablet (5 mg) by tube three times per day. The 2018 MARs did not document the Baclofen was administered on 4 of 60 opportunities in April, 1 of 93 opportunities in March, and 3 of 84 opportunities in February.</p> <p>* A physician's order on 3/7/18 for hydrocodone-acetamin (pain medication) 5-325 mg give one tablet by tube three times per day. The 2018 MARs did not document the hydrocodone was given on 4 of 58 opportunities in April, 2 of 93 opportunities in March, and 1 of 84 opportunities in February.</p> <p>* A physician's order on 2/2/17 to monitor if the pain program was effective, and if no, to provide a pain rating. The 2018 MARs did not document the pain program effectiveness was monitored on 7 of 58 opportunities in April, 5 of 93 opportunities in March, and 5 of 56 opportunities in February.</p> <p>* A physician's order on 3/8/18 for tube feeding formula Glucerna 1.5 at 75 ML/HR (milliliters per hour) times 20 hours. The 2018 MARs did not document the Glucerna was turned on or off at the appropriate times on 15 of 38 opportunities in April and 11 of 62 opportunities in March.</p> <p>* A physician's order on 2/2/17 to flush with 250 MLs of water every 4 hours for a total of 1500 MLs. The 2018 MARs did not document the</p>	F 684	<p>Medication/Treatment records will be audited Monday through Friday X 12 weeks by the Unit Managers to ensure completeness of documentation. Audits will be reviewed at QAPI monthly X 3 for further corrective action/opportunities.</p> <p>Who will be responsible for compliance.</p> <p>DON or designee will be responsible for compliance.</p> <p>Dates when corrective action will be completed:</p>		

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F 684	<p>Continued From page 15</p> <p>water flush was administered on 14 of 116 opportunities in April, 14 of 186 opportunities in March, and 14 of 168 opportunities in February.</p> <p>* A physician's order on 2/2/17 to flush with 30 MLs of water before/after medication and 15 MLs between each medication. The 2018 MARs did not document the water flush was administered on 8 of 38 opportunities in April, 6 of 67 opportunities in March, and 4 of 56 opportunities in February.</p> <p>* A physician's order on 2/2/17 to replace the tube feeding syringe and tubing every 24 hours. The 2018 MARs did not document the syringe and tubing were changed on 2 of 19 opportunities in April and 4 of 31 opportunities in March.</p> <p>* A physician's order on 2/2/17 to check for placement/patency of the feeding tube before instilling formula, water, or medications. The 2018 MARs did not document the placement/patency of the feeding tube was checked on 5 of 38 opportunities in April, 2 of 62 opportunities in March, and 2 of 56 opportunities in February.</p> <p>* A physician's order on 2/2/17 to monitor the feeding tube site and clean the site every shift and as needed. The 2018 MARs did not document the tube site was cleaned on 6 of 38 opportunities in April, 3 of 62 opportunities in March, and 2 of 56 opportunities in February.</p> <p>* A physician's order on 2/2/17 for the Licensed Nurse to provide diabetic nail care each week. The 2018 MARs did not document the diabetic</p>	F 684			

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F 684	<p>Continued From page 16</p> <p>nail care was provided on 2 of 3 opportunities in April and 1 of 5 opportunities in March.</p> <p>On 4/17/18 at 6:24 PM, LPN #2 said if a medication was not signed on the MAR then it meant the medication was not given.</p> <p>On 4/17/18 at 6:44 PM, LPN #1 said if it was not documented that a medication was given then it was not done and the MAR should be signed for those medications that were given.</p> <p>2. Resident #39 was admitted to the facility on 3/21/2016 with multiple diagnoses, including chronic pain, long term use of anticoagulants (blood thinners), and hypertension (high blood pressure).</p> <p>Resident #39's care plan directed staff to administer medications as ordered and to monitor/document side effects and effectiveness.</p> <p>Resident #39's clinical record documented the following:</p> <p>* A physician's order on 3/21/16 for lisinopril (blood pressure medication) 30 mg one tablet every morning: Hold if systolic blood pressure (top number) is below 100. The 2018 MARs did not document the systolic blood pressure on 7 of 18 opportunities in April, 2 of 31 opportunities in March, and 1 of 28 opportunities in February.</p> <p>* A physician's order on 3/21/16 for metoprolol ER (blood pressure medication) 50 mg tab give one tablet twice a day: Hold if systolic blood pressure is below 100 or heart rate is below 60. The 2018 MARs did not document the heart rate</p>	F 684			

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F 684	<p>Continued From page 17</p> <p>on 5 of 35 opportunities in April, 6 of 62 opportunities in March, and 10 of 56 opportunities in February 2018. The 2018 MARs did not document the systolic blood pressure on 3 of 35 opportunities in April, 3 of 62 opportunities in March, and 7 of 56 opportunities in February.</p> <p>* A physician's order on 3/21/16 to monitor if the pain program was effective, and if no, to provide a pain rating. The 2018 MARs did not document the pain program effectiveness was monitored on 4 of 34 opportunities in April, 8 of 62 opportunities in March, and 7 of 56 opportunities in February.</p> <p>* A physician's order on 4/14/16 for the Licensed Nurse to provide diabetic nail care weekly. The 2018 MARs did not document diabetic nail care was provided on 2 of 3 opportunities in April, 4 of 4 opportunities in March, and 2 of 4 opportunities in February.</p> <p>* A physician's order on 3/9/18 for wound care and dressing change every other day or as needed to a wound on the coccyx (tailbone area). The 2018 MARs did not document the wound care and dressing change were done on 1 of 7 opportunities in April and 5 of 12 opportunities in March.</p> <p>* A physician's order on 2/8/18 to monitor for signs and symptoms of abnormal bleeding or bruising every shift. The 2018 MARs did not document signs and symptoms of abnormal bleeding were monitored on 1 of 34 opportunities in April, 5 of 62 opportunities in March, and and 7 of 61 opportunities in February.</p>	F 684			

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F 684	Continued From page 18 * A physician's order on 3/21/16 for weekly skin assessments. The 2018 MARs did not document the weekly skin assessment was performed on 2 of 3 opportunities in April, 2 of 4 opportunities in March, and 1 of 4 opportunities in February. * A physician's order on 2/7/18 to monitor side effects of Seroquel (anti-psychotic medication) every shift. The 2018 MARs did not document the side effects of Seroquel were monitored on 1 of 34 opportunities in April and 5 of 62 opportunities in March. * A physician's order on 2/9/18 to check the air mattress for proper inflation every shift. The 2018 MARs did not document the air mattress was checked on 1 of 34 opportunities in April, 10 of 62 opportunities in March, and 7 of 36 opportunities in February. On 4/19/18 at 9:18 AM, the DON said the expectation was for staff to document on the MAR, and if it was not documented then it was not done. The DON said if a medication was not given it should be circled and the reason should be documented.	F 684			
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and	F 687		5/21/18	

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F 687	<p>Continued From page 19</p> <p>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by:</p> <p>2. Residents who are diabetic did not receive daily inspections of their feet as directed on their care plans. Examples include:</p> <p>a. Resident #25 was re-admitted to the facility on 2/2/17 with multiple diagnoses, including traumatic subdural hemorrhage (bleeding around the brain) and Type 2 diabetes mellitus.</p> <p>Resident #25's annual MDS assessment, dated 2/10/18, documented short term and long term memory problems, required extensive assistance with bed mobility, and was totally dependent on others for assistance with transfers.</p> <p>Resident #25's care plan directed staff to inspect his feet daily for "open areas, sores, pressure areas, blisters, edema (swelling) or redness" and report any of these to the physician.</p> <p>There was no documentation of Resident #25's feet being inspected daily as directed by the care plan.</p> <p>On 4/17/18 at 10:28 AM, LPN #2 disconnected Resident #25's tube feeding and flushed his feeding tube with water. LPN #2 did not inspect Resident #25's feet.</p> <p>On 4/18/18 at 8:53 AM, LPN #2 said she looked at Resident #25's feet when flushing his feeding tube, then said she looked at his feet during</p>	F 687	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #25 has had diabetic nail care provided.</p> <p>Resident #39 has had nail care and foot inspection completed.</p> <p>Resident #3 has had MD evaluation of her feet and careplan for circulatory status care planned.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>Residents with diabetes/circulatory compromise have been evaluated and have required nail care and evaluations as indicated.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Licensed Nurses have been in-serviced on nail care and foot inspections for residents with diabetes and or circulatory</p>		

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F 687	<p>Continued From page 20</p> <p>weekly skin checks. LPN #2 said she would document checking Resident #25's feet if there was something abnormal, and otherwise she did not document checking his feet.</p> <p>b. Resident #39 was admitted to the facility on 3/21/2016 with multiple diagnoses, including Type 2 diabetes mellitus.</p> <p>Resident #39's annual MDS assessment, dated 2/26/18, documented a moderate cognitive impairment, one stage 3 pressure ulcer was present, she required extensive assistance with bed mobility, and was totally dependent on others for assistance with transfers.</p> <p>Resident #39's care plan directed staff to inspect her feet daily for "open areas, sores, pressure areas, blisters, edema (swelling) or redness" and report any of these to the physician.</p> <p>There was no documentation of Resident #25's feet being inspected daily as directed by the care plan.</p> <p>On 4/18/18 at 10:01 AM, LPN #1 said she personally did not do daily foot inspections for residents who are diabetic, but if it was on the care plan it should be done. LPN #1 said it would be a standard of care to do foot checks for residents who are diabetic, but they did not document it.</p> <p>Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure residents received foot care necessary to maintain good foot health and prevent complications from residents' medical</p>	F 687	<p>compromise by the DON.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained:</p> <p>Treatment records will be audited weekly X 12 by the Unit Managers to ensure foot inspection and nail care for residents with diabetes and or circulatory compromise as per careplan.</p> <p>Who will be responsible for compliance.</p> <p>DON or designee will be responsible for compliance.</p> <p>Dates when corrective action will be completed:</p>		

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F 687	<p>Continued From page 21</p> <p>conditions. adequate circulation to a resident's feet by elevating her lower extremities in accordance with professional standard of practice related to peripheral vascular disease. This was true for 3 of 18 (#3, #25 and #39) sample residents whose care plans were reviewed. This deficient practice placed Resident #3 at risk of foot pain, foot ulcers, infection, or other complications related to peripheral vascular disease. This failure placed Residents #25 and #39, each with a diagnosis of diabetes mellitus, at risk of undetected skin breakdown of the feet, when foot inspections were not completed consistent with their care plans. Findings include:</p> <p>1. Resident #3 was admitted to facility on 3/01/11 with diagnoses that included paraplegia (paralysis below the waist) and aphasia (difficulty communicating). The quarterly Minimum Data Set (MDS) assessment, dated 4/13/17, documented Resident #3 was cognitively intact, unable to speak, and usually understood conversation.</p> <p>On 4/16/18 at 10:43 AM, Resident #3 was observed in a reclining wheelchair with her feet in an elevated position. Resident #3's feet were exposed and normal in color.</p> <p>On 4/17/18 at 9: 45 AM, Resident #3 was observed in a reclining wheelchair with her feet in a dependent position. Resident #3's feet were exposed and observed with dark purple discoloration.</p> <p>On 4/17/18 at 10:02 AM, LPN #4 stated that Resident #3 oversaw her own care. LPN #4</p>	F 687			

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F 687	Continued From page 22 stated "she likes her feet like that." On 4/17/18 at 10:07 AM, Resident #3 was asked if she was aware that her feet were dark purple. Resident#3 shook her head no and displayed a surprised look on her face. When asked if she had been educated about the circulation of her feet, she again shook her head no. On 4/18/18 at 2:52 PM, the DON observed Resident #3 sitting in the reclining wheelchair. Resident #3's feet were dark purple in color. The DON stated Resident #3 oversaw her own care and had a diagnosis of peripheral vascular disease. The DON stated elevating the lower extremities put too much pressure on her coccyx. On 4/19/18 at 3:18 PM, the facility was unable to provide documentation of diagnosis for peripheral vascular disease. The care plan did not direct staff to the care or positioning of Resident #3's feet.	F 687			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interviews, it was determined	F 695	What corrective action will be accomplished for those residents found to	5/21/18	

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F 695	<p>Continued From page 23</p> <p>the facility failed to ensure staff changed and dated residents' oxygen tubing per physician orders and facility policy. This was true for 3 of 10 sample residents (#5, #12, and #72) reviewed for oxygen use. This failure created the potential for harm from respiratory infections due to the growth of pathogens (organisms that cause illness) in oxygen humidifiers and cannulas. Findings include:</p> <p>The facility's Policy and Procedure for disposable equipment change schedule, revised 7/2016, documented the facility required respiratory supplies to be routinely changed or cleaned to prevent nosocomial infections. The procedure directed nasal cannulas and oxygen supply tubing be changed weekly and as needed. The procedure directed all disposable supplies be dated upon opening, "This includes oxygen tubing."</p> <p>Oxygen supply tubing and nasal cannulas were not changed consistent with the above policy and physician orders: Examples include:</p> <p>a. Resident #12 was admitted to the facility on 3/4/15 with a diagnosis of COPD and respiratory failure.</p> <p>A physician's order, dated 6/1/15, directed staff to change, label, and date Resident #12's oxygen tubing every week.</p> <p>On 4/16/18 at 10:00 AM, Resident #12 was observed sitting in his room at bedside with oxygen therapy in place. The oxygen tubing connected to the portable oxygen tank was not dated. An E cylinder oxygen tank was in a rolling</p>	F 695	<p>have been affected by the deficient practice:</p> <p>Resident #5 and Resident #12 have their oxygen tubing changed weekly and tubing is dated.</p> <p>Resident #72 is no longer at the facility.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>Residents utilizing oxygen therapy have their tubing changed weekly and the tubing is labeled.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Licensed Nurses have been inserviced on the policy and procedure for oxyben tubing changes.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained:</p> <p>Residents utilizing oxygen will be audited weekly X 12 to ensure tube changes and dating is in compliance with policy and procedure. Audits will be reviewed at QAPI monthly X 3 for further codrrective opportunities.</p>		

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F 695	<p>Continued From page 24</p> <p>cart at bedside with oxygen tubing wrapped around the tank. The oxygen tubing was not dated.</p> <p>Resident #12's April 2018 Treatment Administration Record (TAR) directed staff to change the oxygen tubing every Sunday on nightshift. Facility staff initials were documented on the TAR for April 1st and 8th to indicate the tubing had been changed.</p> <p>b. Resident #72 was readmitted to the facility on 3/26/18 with a diagnosis of COPD.</p> <p>A physician's order, dated 3/24/18, directed staff to change, label, and date Resident #72's oxygen tubing every week.</p> <p>On 4/16/18 at 1:15 PM, Resident #72 was observed lying on her bed. An oxygen concentrator was observed in her room but not in use. Extension tubing was connected to the oxygen concentrator, and the tubing was not dated. A nebulizer machine was sitting on the nightstand. The oxygen tubing connected to the nebulizer was not dated.</p> <p>Resident #72's April 2018 TAR directed staff to change the oxygen tubing every Sunday on nightshift. Facility staff initials were documented on the TAR for April 1st to indicate the tubing had been changed. Facility staff initials documented on the TAR for April 8th were circled with "N/A" written. The was documentation on the back of the TAR, dated 4/1/18, that Resident #72 refused to use the oxygen.</p> <p>On 4/17/18 at 10:30 AM, the DON removed the</p>	F 695	<p>Who is responsible for compliance.</p> <p>DON or designee is responsible for compliance.</p> <p>Dates when corrective action will be completed:</p>		

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

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F 695	Continued From page 25 oxygen tubing from Resident #72's room. c. Resident #5 was readmitted to the facility on 4/5/18 with diagnosis of pneumonia and COPD. A physician's order, dated 4/5/18, directed staff to change Resident #5's oxygen tubing every Sunday and label. On 4/17/18 at 9:00 AM, Resident #5 was observed in his room with oxygen in place. The oxygen tubing was connected to an oxygen concentrator delivering oxygen to Resident #5 through a nasal cannula. The oxygen tubing was not dated. Resident #5's April 2018 TAR directed staff to change the oxygen tubing every Sunday on nightshift and there were no staff initials documented on the TAR. On 4/17/18 at 10:30 AM, the DON stated oxygen tubing was changed weekly on nightshift. LPN #1 and the Regional Vice President of Clinical Services were also present. LPN #1 stated oxygen tubing was changed every Sunday on nightshift and documented on the TAR. The Regional Vice President of Clinical Services stated oxygen tubing should be documented on the TAR and oxygen tubing should be labeled with the date it was changed.	F 695			
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure	F 725		5/21/18	

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F 725	<p>Continued From page 26</p> <p>resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, Resident Council Minutes, facility grievances, and resident and staff interview, it was determined the facility failed to ensure there was sufficient staffing to provide for the needs of the residents. This was true for 12 of 13 residents in the group interview (#5, #9, #18, #21, #23, #24, #30, #32, #41, #55, #60, and #75), 2 of 18 sample residents (#11 and #21), and 3 random residents (#41, #66, and #84).</p> <p>This deficient practice created the potential for physical and psychosocial harm if call lights were not answered in a timely manner and/or residents experienced a delay in care. Findings include:</p>	F 725	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Residents #5,9,18,21,23,24,30,32,41,55,60,75,66 and 84 have been interviewed to ensure care needs met.</p> <p>How will you identify other residents who have the potential to be affected by the</p>		

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F 725	Continued From page 27 Resident Council Meeting minutes, dated 1/4/18, documented concerns of not enough staff on the 600 unit (Ventilator unit), long call light wait times, and staff answering their call lights and say they would be right back and would not come back. A Resident Council grievance, dated 1/4/18, documented facility staff were educated regarding answering call lights in a timely manner and to take care of residents' needs when call lights were answered. Resident Council Meeting minutes, dated 2/1/18, documented the Administrator, at the time, had discussed hiring new staff. A grievance for Resident #5, dated 2/28/18, documented the resident said there was not enough staff. The grievance was resolved and the Administrator, at the time, was to follow-up with the resident weekly about staffing concerns. A grievance for Resident #18, dated 4/3/18, documented there were not enough staff on the 600 unit, had to wait a long time for his catheter bag to be emptied, and that the CNAs worked hard to meet the resident's needs. The grievance was resolved and CNAs were to check on the resident's needs more often. Resident Council Meeting minutes and a grievance for Resident #41, dated 4/5/18, documented staff would answer her call light, turn it off, say they would be right back and would not come back. The grievance was resolved and staff were to give the resident a time when they were to be back, if they could not immediately	F 725	same deficient practice and what corrective action will be taken: Through the resident advocate system, residents will be interviewed/evaluated for appropriate care delivery and call light response to ensure needs are being met. Any negative findings were corrected through the facility Concern/Grievance process. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Care needs/acuity were re-evaluated and additional aide hours were added to enhance care delivery. Facility will continue with recruitment/retention measures to promote hiring and retention of staff through current Performance Improvement Plan. Recruitment/Retention efforts will be shared with Resident Council monthly to improve communication with residents. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained: 20 Residents will be interviewed randomly throughout the day Monday through Friday X 12 weeks by assigned care advocates to ensure residents needs are		

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F 725	<p>Continued From page 28 meet her needs.</p> <p>A grievance for Resident #5, dated 4/6/18, documented the resident had to wait for up to an hour for his call light to be answered. The grievance was resolved and a caring advocate was to follow-up with the resident daily about concerns.</p> <p>A grievance for Resident #66, dated 4/13/18, documented the resident wanted to lay down and staff answered her call light, turned it off, said they would be right back and did not come back. The grievance was resolved and staff were to assist her per her requests.</p> <p>The facility staffing records, dated 4/1/18 through 4/17/18, documented the daily census ranged between 86 and 89 residents and the 600 unit had 3 CNAs working on the day shift for each of those dates.</p> <p>A facility CNA Daily Sheet for 4/19/18, documented 18 out of 21 residents on the 600 unit required 2 person assistance with either transfers and/or bed mobility.</p> <p>On 4/16/18 at 1:40 PM, Resident #21 said she had several incontinent episodes because it took about 40 minutes for staff to answer her call light and the facility did not have enough staff.</p> <p>On 4/17/18 at 1:15 PM, during the Group Interview, 12 out of 13 residents (#5, #9, #18, #21, #23, #24, #30, #32, #41, #55, #60, and #75) said it could take up to an hour for their call lights to be answered. Resident #41 said after lunch was a busy time and it took too long for staff to</p>	F 725	<p>being met. Audits will be reviewed through QAPI monthly X 3 for further corrective actions/opportunities.</p> <p>Who will responsible for compliance.</p> <p>Executive Director or designee will be responsible for compliance.</p> <p>Dates when corrective action will be completed:</p>		

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F 725	<p>Continued From page 29</p> <p>answer her call light. Resident #18 said the 600 unit did not have enough staff and the CNAs at night had to work really hard to take care of the residents' needs.</p> <p>On 4/17/18 at 11:27 AM and 4:13 PM, Resident #84 (who resided in the 600 unit) said call lights can sometimes take up to an hour to be answered and that had happened several times over the past few weeks. He said when his ventilator alarm went off, staff were in there within a minute, but the call lights took longer.</p> <p>On 4/17/18 at 4:21 PM, Resident #84 turned on his call light. At 4:30 PM, RT #2 entered the resident's room and said she was looking for another Respiratory Therapist. RT #2 did not ask the resident if he needed anything, washed her hands and left the room. At 4:32 PM, the call light was still on and CNA #2 came into the room and repositioned the pillow at the resident's request. After CNA #2 left the room, Resident #84 said that was a quicker than normal response time.</p> <p>On 4/17/18 at 9:45 AM, RN #2 said there were not enough CNAs on the 600 unit. CNA #3 said when staff call in, then they had to work short. CNA #2 said when staff call in, it usually takes 25 minutes to answer residents' call lights. CNA #2 said 3 CNAs on the 600 unit are not enough during the day shift, due to the residents' high acuity level.</p> <p>On 4/17/18 at 5:53 PM, RN #3 said there were not enough staff on the 600 unit at night to meet the high acuity levels of the residents.</p> <p>On 4/18/18 at 10:30 AM, Resident #11 said it</p>	F 725			

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F 725	<p>Continued From page 30</p> <p>took longer for staff to answer call lights during the day shift because it was a busier shift and he had to remind staff more often to reposition him during that time of day.</p> <p>On 4/18/18 at 2:36 PM, CNA #4 said there were not enough staff on the 600 unit due to the high number of residents who needed 2 person assistance with repositioning, transfers, and incontinent care.</p> <p>On 4/18/18 at 2:52 PM, CNA #5 said there needs to be more CNAs on all shifts on the 600 unit because it can take 30 to 45 minutes to answer call lights and it was hard to meet all the residents' needs, including repositioning and incontinence care.</p> <p>On 4/19/18 at 9:10 AM, CNA #9 said there were not enough staff throughout the facility. CNA #9 said when call ins happen, then it got chaotic and call lights took longer to get answered and assist the residents' needs.</p> <p>On 4/19/18 at 9:58 AM, CNA #10 said there were not enough staff when staff called in. CNA #10 said there were no penalties when staff called in frequently.</p> <p>On 4/19/18 at 2:15 PM, the Administrator and DON said they started to look at staffing issues about 3 weeks ago as part of their Quality Assessment and Performance Improvement plan. The DON said each resident was given an acuity assessment score which was based on the residents' needs. She said the assessments scored the residents on the 600 unit but did not have a question specifically related to ventilator</p>	F 725			

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F 725	Continued From page 31 needs. The Administrator said the facility used agency and float pool CNAs, but he would like to increase wages to retain and maintain permanent CNA staff, who know the residents' needs better than the agency staff. The DON said she and Human Resources were monitoring the number of individual staff call ins. She said when call ins happened, shower aides were pulled to the floor and other staff members were shifted around until another staff member could be found to come in to the facility. The DON said the 600 unit needed at least one more CNA during the day to meet the residents' needs and she was just told about this need by the 600 unit staff that week.	F 725			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		5/21/18	

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F 758	<p>Continued From page 32</p> <p>drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, it was determined the facility failed to: a) ensure residents receiving PRN lorazepam (anti-anxiety medication) had clear indications for use of the medications and clinical rationale supporting the continued use of the medications beyond 14 days and b) residents receiving Trazodone (anti-depressant) were monitored for effectiveness of the medication for insomnia. This was true for 2 of 5 residents (#73 and #69) reviewed for unnecessary medications. This</p>	F 758	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #73 has had his order for Ativan reviewed by MD and was updated as indicated. There is documentation supporting PRN use within 14 days in the medical record.</p>		

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F 758	<p>Continued From page 33</p> <p>deficient practice had the potential for harm should residents received psychotropic medications that are unwarranted and used for excessive duration. Findings include:</p> <p>1. Resident #73 was readmitted to the facility on 7/16/17 with diagnoses that included COPD, dementia and anxiety.</p> <p>A quarterly MDS assessment, dated 4/2/18, documented Resident #73 had a severe cognitive impairment and received psychotropic medications.</p> <p>Resident #73's care plan documented, he had depression and anxiety and his behaviors included yelling out, becoming verbally abusive, physically aggressive, and sexually inappropriate towards staff.</p> <p>A physician's order dated 2/19/18, documented Resident #73 was to receive lorazepam 0.5 mg tablet, orally once a day as needed for anxiety. There was no documentation in Resident #73's medical record to support the continuation of Lorazepam beyond 14 days.</p> <p>On 4/19/18 at 11:15 AM, LPN #1 said Resident #73 behaviors included yelling out and becoming verbally abusive and physically aggressive to staff whenever he was anxious. LPN #2 said they hold a Mind Over Meds meeting every month attended by the Medical Director, DON, Unit Managers, LMSW and the Pharmacist. LPN #2 said she was aware of the new regulatory requirement regarding the use of PRN psychotropic medications and she would look for the physician's documentation supporting the use</p>	F 758	<p>Resident #69's Medication record was corrected and shows the number of hours slept each shift to evaluate for continued use of trazadone as indicated.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>Residents with prn psychotropics have been reviewed and are not greater than 14 days use without MD evaluation for continued use or discontinuation.</p> <p>Residents utilizing hypnotics are being monitored for hours of sleep each shift to evaluate and ensure need for ordered hypnotic by MD.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Licensed Nurses have been in-serviced on the prn use of pyychotropic medications including Ativan.</p> <p>Licensed Nurses have been in-serviced on the required assessments to monitor hours of sleep with the use of hypnotics.</p> <p>Psychotropic Medication meeting will be increased to 2 times a month for the purpose of reviewing the use of psychotropic medication use including PRN Ativan and monitoring for the effectiveness of hypnotics including</p>		

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F 758	<p>Continued From page 34 of the PRN lorazepam beyond 14 days.</p> <p>On 4/19/18 at 2:16 PM, LPN #1 said she did not find further physician's documentation supporting the need for the use of lorazepam beyond 14 days.</p> <p>On 4/19/18 at 3:30 PM, the LMSW said Resident #73 started on PRN lorazepam on 8/30/16, and she did not believe it was discussed during their last monthly meeting.</p> <p>2. Resident #69 was readmitted to the facility on 3/21/18 with multiple diagnoses, including insomnia.</p> <p>Resident #69's physician's order, dated 3/21/18, documented an order for 50 mg of Trazodone to be taken at bedtime for insomnia.</p> <p>Resident #69's care plan, dated 3/26/18, documented the resident had trouble falling and staying asleep and directed staff to evaluate the ongoing need for medications.</p> <p>Resident #69's MARs, dated 3/21/18 to 4/17/18, documented the resident received the Trazadone nightly. Resident #69's medical record did not include documentation her hours of sleep were being tracked to determine the effectiveness of the Trazodone.</p> <p>On 4/18/18 at 2:55 PM, the ADON said the Trazadone was for insomnia and Resident #69's hours of sleep were not being monitored.</p> <p>On 4/19/18 at 9:58 AM, Resident #69 said he was able to sleep at night.</p>	F 758	<p>trazadone has been in-serviced to facility Nursing Managers and Social Service director.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained:</p> <p>Social Service Director will audit Medical records weekly X 12 to ensure PRN medications are not given greater than 14 days without MD consideration and documentation.</p> <p>Social Service Director will audit the medical records of residents utilizing hypnotics to ensure hours of sleep are being documented daily Monday through Friday X 12 weeks to monitor the effectiveness and/or adverse side effects of hypnotic medication use.</p> <p>Who will be responsible for compliance.</p> <p>DON or designee will be responsible for compliance.</p> <p>Dates when corrective action will be completed:</p>		

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F 842 SS=D	<p>Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)</p> <p>§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <ul style="list-style-type: none"> (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <ul style="list-style-type: none"> (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to 	F 842		5/21/18	

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F 842	<p>Continued From page 36</p> <p>coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure accurate and complete clinical records were maintained for each resident. This was true for 1 of 20 sample residents (#39) whose records were reviewed. This created the potential for harm should inappropriate care and/or treatment be</p>	F 842	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #39's Medication Record has been corrected.</p>		

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F 842	<p>Continued From page 37</p> <p>provided based on inaccurate information in the resident's clinical record. Findings include:</p> <p>Resident #39 was admitted to the facility on 3/21/2016 with multiple diagnoses, including hypertension (high blood pressure) and chronic kidney disease.</p> <p>A physician's order, dated 4/17/2018 at 12:13 PM, documented an order to check Resident #39's blood pressure twice a day for one week.</p> <p>Resident #39's MAR, dated 4/17/18, documented blood pressure once daily for 7 days then notify the physician.</p> <p>On 4/18/18 at 3:07 PM, LPN #1 said the blood pressure order was transcribed incorrectly on the MAR as once a day, and she would talk to the nurse who transcribed the order and ask her to correct it.</p> <p>On 4/19/18 at 9:29 AM, the DON said the order for blood pressure on the MAR was a transcription error when it was transcribed as once a day on the MAR.</p>	F 842	<p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>Residents residing at the facility have the potential to be affected by thi deficient practice. Residents MD orders have been compared to the Medication record for accuracy and corrections made if identified.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Licensed Nurses were in-serviced on transcribing orders to the medication record per policy by the DON.</p> <p>50% of MD orders will be reviewed during afternoon follow up Nurse Management meeting daily Monday through Friday to ensure MD orders are accuragely transcribed on the medication record by the unit managers.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained:</p> <p>Medication Records will be audited against MD orders randomly X 12 weeks for accuracy of transcription by the Unit Managers. Audits will be reviewed at QAPI monthly X 3 for further corrective</p>		

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F 842	Continued From page 38	F 842	action. Who is responsible for compliance. DON or designee will be responsible for compliance. Dates when corrective action will be completed:		
F 880 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include,</p>	F 880		5/21/18	

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F 880	<p>Continued From page 39</p> <p>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> <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</p>	F 880			

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F 880	<p>Continued From page 40</p> <p>IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 of 3 (#69) residents sampled for catheters. A tube feeding syringe was undated and the graduate cylinder was not changed in a timely manner. This was true for 1 of 4 (#29) residents sampled for tube feeding. A wedge cushion was dropped on the floor and was put back on the resident's bed. This was true for 1 of 3 (#11) residents sampled for isolation precautions. The facility's failure created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include:</p> <p>1. Resident #69 was readmitted to the facility on 3/21/18, with multiple diagnoses, including obstructive uropathy (calculus in the bladder), Parkinson's disease, frequent urinary tract infections, and neurogenic bladder.</p> <p>The facility's Indwelling urinary catheter (Foley) care and management policy and procedure document, dated 2017, directed staff to make sure the catheter was properly secured and assessed daily, and the drainage bag was to be kept below the level of the patient's bladder and off the floor.</p> <p>The Centers for Disease Control and Prevention (CDC) website, updated October 24, 2016, documented recommendations for proper techniques for urinary catheter maintenance to not rest the catheter bag on the floor.</p>	F 880	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #69's catheter is secured properly and not touching the floor.</p> <p>LN #1 has been in-serviced on proper handling of linens and bed pillows.</p> <p>Resident #29 has a new graduate cylinder and syringe in place. LN #2 has been in-serviced on policy and procedure for chaging feeding tube syringes and graduate cylinder.</p> <p>How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>Residents utilizing tube feedings have been evaluated and have syringes and cylinders changed per policy and procedure in place</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Staff have been in-serviced on infection control policy and procedure including care of foley bag and tubing placement and the handling of linens and pillows by</p>		

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F 880	Continued From page 41 Resident #69's physician's order, dated 3/21/18, documented the resident had an indwelling Foley catheter placed. Resident #69's care plan, dated 3/21/18, directed staff to ensure catheter tubing and drainage bag are placed below the level of the bladder and anchored to prevent tension or trauma. On 4/16/18 at 9:51 AM, Resident #69 was lying in a low bed with a catheter drainage bag in a privacy bag on the left side of the bedframe touching the vinyl floor and fall mat. On 4/16/18 from 12:24 PM to 12:34 PM, Resident #69 was in a wheelchair ambulating without assistance in the dining room. The catheter was in a privacy bag and tubing was dragging beneath the wheelchair on the vinyl floor. The resident stepped on the catheter bag and said, "Ouch". Three staff members then walked by without stopping to assist the resident. At 12:35 PM, the DON assisted the resident in the dining room and placed the catheter bag on the wheelchair. On 4/16/18 at 1:59 PM, 4/17/18 at 9:06 AM, and 4/18/18 at 8:24 AM and 2:41 PM, Resident #69 was lying in a low bed with a catheter drainage bag in a privacy bag on the left side of the bedframe touching the vinyl floor and fall mat. On 4/18/18 at 10:05 AM, After CNA #8 performed peri care for Resident #69, emptied the catheter and left the catheter bag in a privacy bag, which hung on the left side of the bedframe and touching the vinyl floor and fall mat.	F 880	the infection control specialist. Licensed Nurses have been inserviced on the changing of feeding tube syringes and labeling and dating of equipment per policy and procedure by the infection control specialist. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained: Random audits will be done by the infection control specialist to ensure foley bag/tubing placement is correct 3 X weekly X 12 weeks. Feeding tube syringes and cylinders will be audited daily Monday through Friday X 12 weeks to ensure equipment is changed per policy. Audits will be reviewed at QAPI monthly X 3 for further corrective measures as indicated. Who will be responsible for compliance. DON or designee will be responsibl for compliance. Dates when corrective action will be completed:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/20/2018
NAME OF PROVIDER OR SUPPLIER LACROSSE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 210 WEST LACROSSE AVENUE COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 42</p> <p>On 4/18/18 at 2:43 PM, CNA #7 said catheter tubing should not be loose to avoid tugging or pulling of the catheter during transfers.</p> <p>On 4/18/18 at 2:49 PM, LPN #3 said the catheter drainage bag was in a privacy bag and the bag was touching the floor mat. She said it would be too high if it was moved up on the bed and she kicked the privacy bag with her foot.</p> <p>On 4/18/18 at 2:55 PM, the ADON said the catheter tubing should not be dragged on the floor and the privacy bag should be kept off of the floor and off the fall matt. The ADON said LPN #3 should not have kicked the privacy bag due to infection control concerns.</p> <p>2. Resident #11 was readmitted to the facility on 9/7/17 with multiple diagnoses, including acute on chronic respiratory failure and CRPA (carbapenem-resistant pseudomonas aeruginosa) for which isolation was in place.</p> <p>04/18/18 4:10 PM, RN#1 was observed as she completed wound care then picked up a small wedge cushion that had fallen to the floor and placed it back on Resident #11's bed. CNA #2, who was also in the room, quickly removed the wedge cushion off the resident's bed and said she would replace the pillow case on the wedge cushion.</p> <p>04/19/18 9:47 AM, RN #1 said she should not have placed the wedge cushion on Resident 11's bed after it had been on the floor.</p> <p>3. On 4/17/18 at 4:25 PM, LPN #2 was observed</p>	F 880			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/20/2018
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F 880	<p>Continued From page 43</p> <p>as she prepared to administer Resident #29's medication via a PEG tube. LPN #2 washed her hand with soap and water, and then washed a graduate cylinder that was on the counter near the sink with a syringe inside. The LPN then filled the graduate cylinder to about half full of water and proceeded to give Resident #29's medications via his PEG tube. The graduate cylinder was observed to have a date of 3/25/18 and labeled with the resident's name. The syringe did not have a date nor the resident's name. After the medications were administered via the PEG tube, LPN #2 was asked how often the change the graduate cylinder is changed. LPN #2 said she was not sure when they change the graduate cylinder but she said the syringe should be change daily, and should be dated and labeled with the resident's name, and put inside a plastic bag. LPN #2 said she threw the plastic bag away.</p> <p>On 4/18/18 at 9:15 PM, the DON said the facility did not have a policy on how often to change the graduate cylinder but the syringe was to be changed daily, dated and labeled. The DON said when she called the corporate nurse she was advised to change the graduate cylinder monthly and it should be dated and labeled with the resident's name on it.</p>	F 880			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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January 8, 2019

Michael Littman, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. Littman:

On **April 20, 2018**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. The complaint investigation survey was conducted at the facility April 16, 2018 through April 20, 2018.

Facility staff were observed providing care with several residents throughout the survey and did so appropriately.

The clinical records of seven residents were reviewed for quality of care concerns, including skin and wound care. The facility's Grievance files from December 2017 to April 2018 were reviewed. Resident Council meeting minutes from January 2018 to April 2018 were reviewed. The facility's Incident and Accident reports from January 2018 to April 2018 were reviewed.

Several residents were interviewed regarding quality of care concerns. Several nurses, CNAs, and management staff were interviewed regarding quality of care concerns. The Director of Nursing was interviewed.

The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007818

Michael Littman, Administrator
January 8, 2019
Page 2 of 2

Allegation #1:

Residents do not receive care with skin and wounds.

Findings #1:

Seven residents' records, including that of the identified resident, were reviewed. No concerns regarding skin and wounds were identified.

Four residents were interviewed, including the identified resident, and no concerns were identified regarding skin and wound care. Several nurses and CNAs were interviewed. They said they made sure residents received showers, wound care per physician orders, and weekly skin assessments. The Director of Nursing was identified and no concerns were identified.

Based on 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

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February 26, 2019

Michael Littman, Administrator
Lacrosse Health & Rehabilitation Center
210 West Lacrosse Avenue
Coeur d'Alene, ID 83814-2403

Provider #: 135042

Dear Mr. Littman:

On **April 16, 2018** through **April 20, 2018**, an unannounced on-site complaint survey was conducted at Lacrosse Health & Rehabilitation Center. The clinical records of three residents were reviewed. Four staff members were interviewed. Two residents and one resident's family member were interviewed. General observations were made of residents throughout the facility and staff providing care throughout the survey.

The complaint allegations , findings and conclusions are as follows:

Complaint #ID00007774

ALLEGATION #1:

Residents are not provided necessary care and services pertaining to incontinence in a timely manner.

FINDINGS #1:

Multiple observations were completed for three residents. Residents were not found to be left soiled for extended periods of time and appropriate incontinence care was provided. Upon resident interview, there were no concerns expressed regarding receiving incontinence care or assistance to the toilet in a timely manner.

Michael Littman, Administrator
February 26, 2019
Page 2 of 3

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents are not provided necessary care and services pertaining to bathing and grooming.

FINDINGS #2:

The clinical records of three residents were reviewed. Four staff members were interviewed. Two residents and one resident's family member were interviewed. The shower logs were reviewed for one resident. General observations were made of residents throughout the facility and staff providing care to residents.

Multiple observations were completed for three residents. Residents were found to be appropriately groomed except times when the resident refused, and showers were given according to schedule with a rare exception. Upon resident interview, there were no concerns expressed regarding receiving showers or assistance with grooming. Upon general observation of residents throughout the facility, residents appeared appropriately groomed and cared for.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents are not provided necessary care and services to maintain acceptable oral/dental health.

FINDINGS #3:

The clinical records of three residents were reviewed. Four staff members were interviewed. Multiple observations were completed for three residents.

One resident's clinical record documented she required multiple dental appointments for dental cleanings and fillings.

During an interview, one resident said the facility staff did not offer to assist her to brush her

Michael Littman, Administrator
February 26, 2019
Page 3 of 3

teeth and the dentist wanted to pull multiple teeth due to their poor condition. One facility staff member said she had never observed the same resident brushing her teeth and they did not routinely offer or assist her with oral care.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F676 related to activities of daily living.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

If you have 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