



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

May 21, 2018

Tamara Gillins, Administrator
Syringa Chalet Nursing Facility
PO Box 400
Blackfoot, ID 83221-4925

Provider #: 135111

Dear Ms. Gillins:

On **May 3, 2018**, a survey was conducted at Syringa Chalet Nursing Facility 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 a widespread deficiency 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.

Tamara Gillins, Administrator
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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 31, 2018**. Failure to submit an acceptable PoC by **May 31, 2018**, may result in the imposition of penalties by **June 23, 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 **June 7, 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 **August 1, 2018**. A change in the seriousness of the deficiencies on **June 17, 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 **August 1, 2018** includes the following:

Denial of payment for new admissions effective **August 1, 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 30, 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 **August 1, 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:

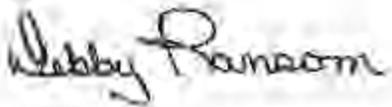
- BFS Letters (06/30/11)

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

This request must be received by **May 31, 2018**. If your request for informal dispute resolution is received after **May 31, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



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

DR/lj
Enclosures

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2018
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NAME OF PROVIDER OR SUPPLIER SYRINGA CHALET NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET BLACKFOOT, ID 83221
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted April 30, 2018 to May 3, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Teresa Kobza, RDN, LD Wendi Gonzales, RN</p> <p>ABBREVIATIONS:</p> <p>ADLs = Activities of Daily Living ADON = Assistant Director of Nursing CNA = Certified Nursing Assistant DNS = Director of Nursing Services LPN = Licensed Practical Nurse MDS = Minimum Data Set RD = Registered Dietitian RN = Registered Nurse SLP = Speech Language Pathologist</p>	F 000		
F 604 SS=E	<p>Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)</p> <p>§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property,</p>	F 604		6/7/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/31/2018
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 604	<p>Continued From page 1</p> <p>and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents were free from restraints, including bed and chair alarms, beds against the wall, and bed U-rails (rail in the shape of an upside down U). The facility failed to identify the medical need for the restraint, ensure the least restrictive restraint was used, and re-evaluate the ongoing need for the restraint. This was true for 5 of 8 (#5, #6, #14, #15, and #20) residents sampled for restraints. This had the potential for physical harm if restraints were improperly used, and psychosocial harm if the resident experienced a psychological decline due to feelings of being restricted in movement.</p> <p>Findings include:</p> <p>1. Resident #5 was admitted to the facility on 10/24/13 and readmitted on 2/13/18 with multiple</p>	F 604	<p>F604 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All safety measures for residents #5, #6, #14, #15 and #20 were assessed, consents and physician orders obtained, and care plans updated as applicable. There are no safety measures used as restraints.</p> <p>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? All safety measures were assessed for all other residents, consents and physician orders obtained, care plans updated as applicable. There are no safety measures used as restraints.</p>		

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F 604	<p>Continued From page 2</p> <p>diagnoses, including dementia and encephalopathy.</p> <p>The readmission MDS assessment, dated 2/20/18, documented Resident #5 was severely cognitively impaired, required the assistance of 2 people for transfers, and was at risk for falls.</p> <p>On 4/30/18 at 4:47 PM, Resident #5's bed was positioned with the right-side of the bed against the wall.</p> <p>On 5/1/18 at 10:30 AM, Resident #5 was observed in bed with a U-rail on the left-side of the bed and right-side of the bed was against the wall.</p> <p>On 5/2/18 at 12:15 PM, the DNS stated Resident #5's bed was against the wall due to the size of the room and to ensure there was sufficient space for the Hoyer lift needed to assist Resident #5 with transfers. The DNS stated Resident #5 used the U-rail for bed mobility.</p> <p>Resident #5's clinical record did not include assessments, care plans, consents, or physician orders for the bed against the wall and the U-rail.</p> <p>2. Resident #6 was admitted to the facility on 1/18/18 with multiple diagnoses, including schizoaffective disorder.</p> <p>The admission MDS assessment, dated 1/25/18, documented Resident #6 was severely cognitively impaired and was independent with transfers.</p> <p>On 5/2/18 at 2:00 PM, Resident #6's left-side of</p>	F 604	<p>What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? A new "Safety Measures Assessment" note was created in CPRS (the electronic medical record). It will be used to assess all safety measures initiated on admission or with a change of condition. This "Safety Measures Assessment" note will also be completed with every MDS to re-evaluate the need/appropriateness of all safety measures. Additionally, this note prompts licensed nursing to obtain consent and physician orders prior to the use of any safety measure and to update the care plan as applicable. In-services held 5/30/18 and 6/5/18.</p> <p>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained? All safety measure assessments, consents, physician orders, and care plans audited weekly with each new admission, change in condition, and with every MDS for 4 months. Audit results reported at the Quarterly QA/PI Meeting.</p>		

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F 604	<p>Continued From page 3</p> <p>the bed was against the wall. The DNS stated Resident #6 wanted her bed against the wall to have more space in her room.</p> <p>Resident #6's clinical record did not include assessments, care plans, consents, or a physician order for the bed against the wall.</p> <p>3. Resident #14 was readmitted to the facility on 4/12/18 with multiple diagnoses, including dementia.</p> <p>The annual MDS assessment, dated 3/6/18, documented Resident #14 was severely cognitively impaired, required the assistance of 2 people for transfers, and was at risk for falls.</p> <p>On 4/30/18 at 4:33 PM, Resident #14 was observed sitting in his wheelchair with an alarm attached to the back of the wheelchair. The left-side of Resident #14's bed was against the wall with a floor mat on the right-side of the bed.</p> <p>On 5/1/18 at 9:45 AM, Resident #14 was observed in bed, alarm sounding, and staff were answering the alarm promptly.</p> <p>Resident #14's clinical record did not include assessments, consents, or physician orders for the alarms and the bed against the wall.</p> <p>On 5/3/18 at 10:36 AM, the DNS was unable to provide assessments, consents, or physician orders for Resident #14's bed to be against the wall and alarms to his wheelchair and bed.</p> <p>4. Resident #20 was admitted to the facility on 9/15/16 with multiple diagnoses, including</p>	F 604			

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F 604	<p>Continued From page 4 schizoffective disorder.</p> <p>A quarterly MDS assessment, dated 2/6/18, documented Resident #20 was cognitively intact and required one person assistance with transfers.</p> <p>On 5/2/18 at 12:00 PM, the DNS, ADON, and the Administrator observed Resident #20's bed was against the right-side of the wall and a U-rail on the left-side of her bed. The DNS stated Resident #20 wanted her bed positioned against the wall and used the U-rail for bed mobility.</p> <p>On 5/2/18 at 4:34 PM, the MDS Nurse stated Resident #20's bed against the wall was not a restraint, as Resident #20 was able to get out of bed on the left-side. The MDS Nurse stated Resident #20 used the U-rail for bed mobility. The MDS Nurse was unable to provide assessments for Resident #20's bed to be against the wall and the U-rail.</p> <p>Resident #20's clinical record did not include assessments, care plans, consents, or physician orders for the bed against the wall and the U-rail attached to the bed.</p> <p>5. Resident #15 was readmitted to the facility on 11/16/15, with multiple diagnoses, including chronic kidney disease, Type II Diabetes with retinopathy, vascular dementia, schizoffective disorder, and mild mental retardation.</p> <p>Resident #15's annual MDS assessment, dated 9/12/17, documented the resident was severely cognitively impaired, required the assistance of two people for transfers, and was at risk for falls.</p>	F 604			

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F 604	Continued From page 5 Resident #15's physician's order, dated 4/16/18, documented the need for a low bed with a mattress on floor next to bed related to falls, and pressure alarm while in bed for safety. The order did not include a requirement for her bed to be against the wall. Resident #15's care plan, dated 3/5/18, directed staff to provide a low bed with mattress on floor next to bed related to falls, and a pressure alarm while in bed for safety. The care plan did not reference a need for her bed to be against the wall. Resident #15's clinical record did not include an assessment, consent, or physician's order for the bed against the wall. On 5/2/18 at 3:47 PM, Resident #15's bed was observed next to the wall. The ADON and DNS stated there was not an order, care plan, or assessment for Resident #15's to be against the wall. The ADON and DNS indicated the beds were next to the walls because of the physical setup of the bedrooms. They said if the beds were moved, it would cause a problem for other residents in the room, and interfere with access to the bathroom and the door. They said the beds against the walls were not used to create a restraint for the residents.	F 604			
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		6/7/18	

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F 656	Continued From page 6 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 656			

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F 656	<p>Continued From page 7</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to develop and implement comprehensive resident-centered care plans. This was true for 5 of 8 (#5, #6, #14, #15, and #20) residents sampled for restraints. The residents' care plans did not address the beds against the walls, alarms, and bed U-rails (rail in the shape of an upside down U). This failure created the potential for residents to experience adverse events related to the use of potentially restrictive interventions that were not included in their care plans. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 10/24/13 and readmitted on 2/13/18 with multiple diagnoses, including dementia and encephalopathy.</p> <p>The readmission MDS assessment, dated 2/20/18, documented Resident #5 was severely cognitively impaired, required the assistance of two people for transfers, and was at risk for falls.</p> <p>On 4/30/18 at 4:47 PM, Resident #5's bed was positioned with the right-side of the bed against the wall.</p> <p>On 5/1/18 at 10:30 AM, Resident #5 was observed in bed with a U-rail on the left-side of the bed and the right-side of the bed was against the wall.</p> <p>Resident #6's care plan, target date 5/22/18, did not include the bed against the wall and the U-rail.</p> <p>On 5/2/18 at 12:15 PM, the DNS stated Resident</p>	F 656	<p>F656 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The care plans for residents #5, #6, #14, #15, and #20 have been updated to reflect current safety measures.</p> <p>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? All other residents have been assessed for safety measures with care plans updated as applicable.</p> <p>What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? A new "Safety Measures Assessment" note was created in CPRS (See F604). It prompts licensed nurses to update the care plan with any safety measures identified. In-services held 5/30/18 and 6/5/18.</p> <p>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained? Care plans audited weekly with each new admission, change in condition, and with every MDS for 4 months. Audit results reported at Quarterly QA/PI Meeting.</p>		

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F 656	<p>Continued From page 8</p> <p>#5's bed was against the wall due to the size of the room and to ensure there was sufficient space for the Hoyer lift needed to assist Resident #5 with transfers. The DNS stated Resident #5 used the U-rail for bed mobility. The DNS was unable to provide a care plan for Resident #5's bed against the wall and the U-rail.</p> <p>2. Resident #6 was admitted to the facility on 1/18/18 with multiple diagnoses, including schizoaffective disorder.</p> <p>The admission MDS assessment, dated 1/25/18, documented Resident #6 was severely cognitively impaired and was independent with transfers.</p> <p>On 5/2/18 at 2:00 PM, the left-side of Resident #6's bed was against the wall. The DNS stated Resident #6 wanted her bed against the wall for more space in her room.</p> <p>Resident #6's care plan, target date 5/3/18, did not include the bed against the wall.</p> <p>3. Resident #14 was admitted to the facility on 4/12/18 with multiple diagnoses, including dementia.</p> <p>The annual MDS assessment, dated 3/6/18, documented Resident #14 was severely cognitively impaired, required the assistance of two people for transfers, and was at risk for falls.</p> <p>On 4/30/18 at 4:33 PM, Resident #14 was observed sitting in his wheelchair. The left-side of Resident #14's bed was against the wall.</p>	F 656			

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F 656	<p>Continued From page 9</p> <p>Resident #14's care plan, target date 6/7/18, did not include the bed against the wall.</p> <p>On 5/3/18 at 10:36 AM, the DNS was unable to provide a care plan for the bed against the wall.</p> <p>4. Resident #20 was admitted to the facility on 9/15/16 with multiple diagnoses, including schizoaffective disorder.</p> <p>A quarterly MDS assessment, dated 2/6/18, documented Resident #20 was cognitively intact and required one person assistance with transfers.</p> <p>On 5/2/18 at 12:00 PM, the DNS, ADON, and the Administrator observed Resident #20's bed was against the right-side of the wall and a U-rail was on the left-side of the bed. The DNS stated Resident #20 wanted her bed positioned against the wall and used the U-rail for bed mobility.</p> <p>On 5/2/18 at 4:34 PM, the MDS Nurse stated Resident #20's bed against the wall was not a restraint, as Resident #20 was able to get out of bed on the left-side. The MDS Nurse stated Resident #20 used the U-rail for bed mobility not as a restraint.</p> <p>Resident #20's care plan, target date 5/15/18, did not include the bed against the wall and the U-rail.</p> <p>5. Resident #15 was readmitted to the facility on 11/16/15, with multiple diagnoses, including chronic kidney disease, Type II Diabetes with retinopathy, vascular dementia, schizoaffective disorder, and mild mental retardation.</p>	F 656		

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F 656	Continued From page 10 Resident #15's annual MDS assessment, dated 9/12/17, documented she was severely cognitively impaired, required the assistance of two people for transfers, and was at risk for falls. Resident #15's physician order, dated 4/16/18, documented she was to have a low bed with a mattress on floor next to bed related to falls, and a pressure alarm while in bed for safety. The order did not include a requirement for Resident #15's bed to be positioned against the wall. Resident #15's care plan, dated 3/5/18, did not include information about her bed being against the wall. On 5/2/18 at 3:47 PM, Resident #15's bed was observed next to the wall. At that time, the ADON and DNS stated there was not a care plan addressing Resident #15's bed being against the wall. They said the bed against the wall was not intended to serve as a restraint, but rather to make more space in the room.	F 656			
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:	F 684		6/7/18	

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F 684	<p>Continued From page 11</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents received neurological assessments following unwitnessed falls. This was true for 1 of 5 residents (#15) reviewed for falls. This deficient practice placed Resident #15 at risk of harm if neurological changes resulting from a fall went undetected. Findings include:</p> <p>1. Resident #15 was readmitted to the facility on 11/16/15, with multiple diagnoses, including chronic kidney disease with anemia, Type II Diabetes with retinopathy, thrombocytopenia, hypertension, insomnia, vascular dementia, schizoaffective disorder, and mild mental retardation.</p> <p>The facility's fall and accident prevention dated 8/10/17, did not direct staff to complete neurological assessments of residents following a fall or accident.</p> <p>Resident #15's annual MDS assessment, dated 9/12/17, documented she was severely cognitively impaired, required the assistance of two people for transfers, and was at risk for falls.</p> <p>Resident #15's physician order, dated 4/16/18, documented she required a low bed with a mattress on floor next to bed related to falls, and a pressure alarm while in bed for safety.</p> <p>Resident #15's care plan, dated 4/10/18, directed staff to complete ongoing 15 minute checks as she experienced delusional thinking and sometimes thought she could ambulate without assistance. On 3/5/18, the care plan directed</p>	F 684	<p>F684 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Res. #15 Care plan updated to include neurological assessments (neuro checks) completed on all witnessed/unwitnessed falls.</p> <p>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? The care plans for all other residents have been updated to include neuro checks completed on all witnessed/unwitnessed falls.</p> <p>What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? The facility's "Fall and Accident Prevention" policy has been updated to direct staff to complete neuro checks on all witnessed/unwitnessed falls. In-services held 5/30/18; 6/5/18.</p> <p>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained? The Treatment Team meets on Mondays, Wednesdays and Thursdays. The Team will review the "Neurological Observation Flow Sheet" on any new witnessed/unwitnessed falls on an ongoing basis to ensure compliance. Audit results reported at Quarterly QA/PI</p>		

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F 684	<p>Continued From page 12</p> <p>staff to provide a low bed with a mattress on the floor next to the bed related to falls, and pressure alarm while in bed for safety. The care plan did not include the need to complete neurological assessments if Resident #15 experienced an unwitnessed fall.</p> <p>Resident #15's progress note, dated 2/12/18, documented she experienced an unwitnessed fall and was found face down on a mat on the floor by her bed. Resident #15's progress note, dated 3/7/18, documented she experienced an unwitnessed fall and was found sitting upright on the the fall mat next to her bed. During both incidents, Resident #15 was asked by staff if she had hit her head, and she stated no.</p> <p>As noted above, Resident #15 experienced delusions, was severely cognitively impaired, and had a diagnoses of vascular dementia. Resident #15's account of the fall could not be relied upon as accurate. Documentation of neurological assessments following the two falls were not found in Resident #15's record.</p> <p>On 5/2/18 at 1:59 PM, the DNS stated she would expect neurological assessments to be completed after Resident #15's 2/12/18 and 3/7/18 falls.</p> <p>The facility's Neurological Check Protocol, dated 8/10/17, documented neurological checks were for monitoring residents whose physical condition was such that they require increased staff assessment or monitoring to insure their wellbeing. The protocol documented that unless stated in an order, staff completing neurological checks were to follow the time frames noted on</p>	F 684	Meetings.		

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F 684	Continued From page 13 the Neurological Observation Flow Sheet. The Neurological Observation Flow Sheet documented neurological checks were to be completed every 15 minutes for one hour, every 30 minutes for one hour, every 1 hour for 4 hours, and then every 4 hours for 24 hours. Neurological checks were not completed for Resident #15 consistent with facility policy, following two unwitnessed falls.	F 684			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure physician orders were followed for	F 692	F692 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	6/7/18	

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F 692	<p>Continued From page 14</p> <p>residents who received nutritional interventions. This was true for 1 of 5 residents (#10) whose nutritional needs were reviewed. Resident #10 had the potential for harm when she was not provided with physician ordered nutritional supplements. Findings include:</p> <p>Resident #10 was admitted to the facility on 3/26/10 with diagnoses which included dementia and an eating disorder.</p> <p>A quarterly MDS assessment, dated 2/20/18, documented Resident #10 was severely cognitively impaired and required the assistance of one person for eating and drinking.</p> <p>The May 2018 Physician Orders documented Resident #10 was to receive Ensure (nutritional supplement) or Mighty Shake (nutritional supplement) three times a day between meals or as a meal replacement when meals were refused, ordered 7/6/15.</p> <p>The care plan addressing Resident #10's swallowing concerns, dated 6/4/15, documented Resident #10 had difficulty with thin liquids and solid foods. The care plan documented Resident #10 required pureed texture and pudding thick liquids. The care plan documented staff were to offer Ensure three times a day between meals and document when she accepted the Ensure.</p> <p>The 4/2/18 through 5/2/18 CNA documentation showed Resident #10 was provided Ensure on 4/30/18 only. Resident #10's clinical record did not include documentation that she was provided Ensure or a Mighty Shake 89 of 90 opportunities.</p>	F 692	<p>practice?</p> <p>Res. #10 Because resident's weight has remained stable, the previous order to "provide Ensure or Mighty Shakes TID between meals or as a meal replacement when meals are refused" was changed 5/24/18 to "provide Ensure when resident eats less than 25% of her meal." The system/process changes as described below apply to this resident.</p> <p>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? All other resident supplement orders were reviewed. A small "cheat sheet" listing each resident with his/her supplement orders was placed on the med. cart laptop on each floor to provide a "quick reference." The Registered Dietitian and MDS nurse will update the "cheat sheet" with any changes. The Alert Charting Note in CPRS, completed by licensed nursing, was revised to include a "Supplement Section." The note includes the type of supplement, amount consumed or refusal of supplement. Any supplements ordered but not given will be reported at the next shift report for follow-up with the oncoming shift.</p> <p>What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? A small "cheat sheet" listing each resident with his/her supplement orders was placed on the med. cart laptop on</p>		

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F 692	Continued From page 15 On 5/3/18 at 3:27 PM, the DNS stated she could not find documentation Resident #10 was provided the Ensure or Mighty Shake three times a day between meals.	F 692	each floor to provide a "quick reference." The Registered Dietitian and MDS nurse will update the "cheat sheet" with any changes. The Alert Charting Note in CPRS, completed by licensed nursing, was revised to include a "Supplement Section." Licensed nursing will document the type of supplement, amount consumed and any refusals. Any supplements ordered but not given will be reported at the next shift report for follow-up with the oncoming shift. In-services held 5/30/18 and 6/5/18. How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained? The Registered Dietitian/Designee will audit all resident charts with supplements 2 times weekly for 2 weeks and then 1 time weekly for 4 weeks and then 1 time monthly on an ongoing basis to ensure compliance. Audit results reported at Quarterly QA/PI Meetings.		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and review of in-service records, it was determined the facility failed to:	F 805	F805 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	6/7/18	

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F 805	<p>Continued From page 16</p> <p>a) Ensure physician ordered thickened liquids were the appropriate consistency when served to residents. This was true for 1 of 1 resident (#10) reviewed with orders for thickened liquids. Resident #10 was placed at risk of aspiration when she was provided nectar thick liquids rather than physician ordered pudding thick liquids.</p> <p>b) Ensure residents were provided proper positioning following food/fluid intake. This was true for 1 of 5 residents (#2) sampled for nutrition. The facility's failure placed Resident #2 at increased risk of aspirating or choking on food/fluids. Findings include:</p> <p>1. Resident #10 was admitted to the facility on 3/26/10 with diagnoses which included dementia and an eating disorder.</p> <p>A quarterly MDS assessment, dated 2/20/18, documented Resident #10 was severely cognitively impaired and was dependent on one staff member with eating.</p> <p>The May 2018 Physician Orders documented Resident #10's dietary orders were as follows:</p> <p>* Pureed diet texture with pudding thick liquids, ordered 7/3/14. * Resident #10 was to be upright 90 degrees with eating and drinking and staff were to encourage Resident #10 to hold her head in the central position, ordered 7/3/14.</p> <p>The care plan addressing Resident #10's swallowing difficulties, dated 6/4/15, documented Resident #10 had trouble with thin liquids and</p>	F 805	<p>practice? Res. #10 The facility now uses a better/simpler/less time-consuming thickener called, "Simply Thick" which consists of gel packets. This product is different than the thickener observed during the survey. Staff in-serviced on using the thickener to achieve the desired consistency as ordered for this resident. A P.T. evaluation was ordered to assess positioning. Staff also in-serviced on proper positioning with eating and drinking, using a teaspoon, and alternating between small bites of food and sips of fluids. The systems/process changes described below apply to this resident.</p> <p>Res. #2 Staff in-serviced on resident care regarding diet orders, proper positioning during intake, coughing when drinking, remaining upright for at least 30 minutes following intake before laying down, and proper bed elevation after eating. Additionally, the systems/process changes described below apply to this resident.</p> <p>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? All other resident orders were reviewed for therapeutic diets and thickened liquids. Diet order "Cheat Sheets" are posted in the SCNF kitchenettes, on clipboards in the nurse's stations and in the dining rooms on both floors for quick reference.</p>		

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F 805	<p>Continued From page 17</p> <p>solid foods. The care plan documented Resident #10 required pureed texture food and pudding thick liquids. The care plan documented staff were to alternate between small bites of food and sips of fluids. The care plan documented staff were to utilize a teaspoon for eating.</p> <p>a. On 5/1/18 at 12:15 PM, CNA #2 was assisting Resident #10 with her lunch meal and was not alternating between liquids and bites of foods. CNA #2 was providing Resident #10 her pureed food. CNA #2 was stirring Resident #10's cup of brown liquid which readily dripped off the spoon. CNA #2 stated the liquid was chocolate milk and stated CNAs prepared the liquids prior to the start of the meal.</p> <p>On 5/1/18 at 12:21 PM, CNA #2 was observed continuing to stir the chocolate milk, and the chocolate milk readily dripped off the spoon. CNA #2 provided Resident #10 a spoon full of the thin chocolate milk. The chocolate milk was removed and brought to the ADON.</p> <p>On 5/1/18 at 12:23 PM, the ADON stated the chocolate milk was not pudding thick and she would correct the issue. The ADON stated the food thickener was a new product and the facility had just completed a staff in-service on the new food thickener product on 4/24/18.</p> <p>A 4/24/18 In-service on Thickened Liquids new product, documented the following:</p> <ul style="list-style-type: none"> * The staff introduced the new product. * Staff discussed how to thicken the powder and to stir the new product. * Staff were to allow extra set time of 10 minutes 	F 805	<p>The Registered Dietitian or MDS nurse will update cheat sheets with changes. Instructions for using the thickener were posted in the snack room in the dining area on 1st street and the cup cupboard in the dining area on 2nd street where the thickener is kept. As an additional safety precaution, two staff will verify the consistency of thickened liquids per physician order.</p> <p>What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? Diet order "Cheat Sheets" are posted in the SCNF kitchenettes, on clipboards in the nurse's stations and in the dining rooms on both floors for quick reference. The Registered Dietitian or MDS nurse will update cheat sheets with changes. Instructions for using the thickener were posted in the snack room in the dining area on 1st street and the cupboard in the dining area on 2nd street where the thickener is kept. As an additional safety precaution, two staff will verify the consistency of thickened liquids per physician order. In-services held 6/30/18; 6/5/18.</p> <p>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained? Six meals will be monitored (2 Breakfast, 2 Lunch, 2 Dinner) weekly for 2 weeks, then 3 meals (1 Breakfast, 1 Lunch, 1 Dinner) for 4 weeks, then 1 rotating meal weekly on an ongoing basis</p>		

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

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F 805	<p>Continued From page 18 for milk and supplements.</p> <ul style="list-style-type: none"> * Staff were demonstrated how to thicken juice to pudding thick consistency. * Staff were shown where the directions were found in the food room for the new food thickener on the two floors. <p>A 4/24/18 sign-in sheet documented 21 of 35 staff members who worked during the week of 4/29/18, attended the in-service. CNA #2's name was not included as one of the employees who attended the in-service on 4/24/18.</p> <p>b. The facility's Instructions for Thickening Liquids included:</p> <ul style="list-style-type: none"> * Pudding-thick not pourable but holds its shape like a pudding and is usually ingested with a spoon. * Water, apple/orange/cranberry juice, and coffee/tea required 10 teaspoons of powdered thickener for 8 ounces of fluids and staff was to stir with a spoon until it was dissolved and let the product stand for 2 minutes. * Milk required 10 teaspoons of powdered thickener for 8 ounces of fluids and staff was to stir with a spoon until it was dissolved and let the product stand for 10 minutes. * Crystal light required 10-11 teaspoons of powdered thickener for 8 ounces of fluids and staff was to stir with a spoon until it was dissolved and let the product stand for 2 minutes. * Nutritional supplements required 11 teaspoons of powdered thickener for 8 ounces of fluids and staff was to stir with a spoon until it was dissolved and let the product stand for 10 minutes. <p>On 5/1/18 at 4:42 PM, CNA #1 stated the CNAs</p>	F 805	to ensure compliance with all issues identified in this FTag. Audit results reported at Quarterly QA/PI Meetings.		

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F 805	<p>Continued From page 19</p> <p>were responsible for thickening the liquids. CNA #1 was in the process of preparing Resident #10's dinner which included 8 ounces of crystal light pudding thickened liquid. CNA #1 had placed the thickener into the crystal light and set the cup down for the fluid to thicken.</p> <p>On 5/1/18 at 4:50 PM, the thickened liquid was observed to readily drip off the spoon as the ADON stirred the crystal light. The ADON asked CNA #1 how many teaspoons of thickener she placed in the crystal light. CNA #1 stated 9 teaspoons.</p> <p>On 5/1/18 at 4:51 PM, the ADON stated the directions for crystal light required 11 teaspoons of thickener. The ADON added an additional 2 teaspoons of powdered thickener to the drink.</p> <p>On 5/2/18 at 8:46 AM, the RD stated the food thickener the facility utilized was a new product and the facility completed an in-service on the new product on 4/24/18. The RD stated the food thickener was to be stirred and allowed to set for 2-10 minutes depending on the type of fluids used. The RD stated the kitchen staff did not prepare Resident #10's fluids ahead of time because the RD wanted Resident #2 to have the option of what beverage to consume with her meals. The RD stated she observed meals 1 time a week minimally to ensure the meal trays were correct. The RD stated the ADON and DNS were available and assisted during meal times as well. The RD stated there was not a formal checks and balance system in place for checking the consistency of thicken liquids.</p> <p>2. Resident #2 was readmitted to the facility on</p>	F 805			

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F 805	<p>Continued From page 20</p> <p>2/22/18, with multiple diagnoses, including dysphagia (difficulty speaking), Type II diabetes, schizoaffective disorder, major neurocognitive disorder due to traumatic brain injury, chronic kidney disease, edentulous (without teeth), and debility due to muscle weakness.</p> <p>Resident #2's physician order, dated 2/22/18, documented she was to receive a mechanical soft diet, no lettuce or rice.</p> <p>Resident #2's SLP consult, dated 11/13/17 and 11/22/17, documented recommendations for:</p> <ul style="list-style-type: none"> * Thin liquids via straw * Single sips and supervision * A mechanical soft diet with single textures and ground meats * Speech therapy <p>The treatment included training Resident #2 in safe swallow techniques, and strengthening of pharyngeal musculature to improve the safety of her swallow. Resident #2's Speech Therapy plan of care documented she would be seen at an off-site location 2 times a week for 5 weeks for swallow therapy. The Consultation Sheet in Resident #2's medical record documented on 11/27/17, 11/30/17 and 12/5/17, Resident #2 refused to go to the swallow therapy appointments. The 12/5/17 documentation also noted "...continues to refuse. Will DC (discontinue) consult."</p> <p>Resident #2's physician progress note, dated 12/4/17, documented the resident was being seen by speech therapy because she coughed after she ate and that she had refused treatment.</p>	F 805			

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F 805	<p>Continued From page 21</p> <p>The physician progress note stated nursing staff and Resident #2 reported that she continued to cough when she ate. The physician documented speech therapy treatment was discontinued but the other recommendations of the SLP would continue to be implemented. The physician progress note documented the physician discussed with Resident #2 that she was at risk of choking and aspirating that may lead to death.</p> <p>Resident #2's care plan, dated 3/8/18, directed staff to ensure she did not have a choking episode that required life saving measures, when receiving food/fluids that included a mechanical soft diet and supplements or other snack alternatives, and no lettuce or rice.</p> <p>Resident #2's MDS assessment, dated 3/1/18, documented the swallowing and nutritional status of the resident as coughing or choking during meals or when swallowing medications. Also, that she required a mechanically altered diet.</p> <p>Resident #2's dietitian progress note, dated 5/2/18 at 4:08 PM, documented the resident with a diagnosis of swallowing difficulty related to possible worsening of moderate oropharyngeal dysphagia as increased coughing during meal times, specifically with liquids.</p> <p>Resident #2's dietitian progress note, dated 4/12/18, documented her estimated nutritional needs were likely not being met due to poor appetite, more prompting required for foods, and the resident being a picky eater.</p> <p>Resident #2's nurse progress notes, dated 4/30/18 through 5/2/18, documented no issues</p>	F 805			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 805	<p>Continued From page 22 with coughing or choking during meals. Progress notes, dated 4/29/18, documented Resident #2 with a productive cough.</p> <p>Resident #2's CNA notes, dated 4/30/18 through 5/2/18, documented no issues with coughing or choking during meals.</p> <p>On 4/30/18 at 5:20 PM, Resident #2 was coughing after eating green beans, mashed potatoes and macaroni and cheese, and drinking thin milk. LPN #1 intervened and continued to give the resident milk three times. Each time the resident continued to cough. Resident #2 was then moved to the nurses' station and given a sip of water. At 5:30 PM, LPN #1 assessed Resident #2's oxygen level and wet vocal cough. At 5:33 PM, Resident #2 stated she was not hungry and wanted a milkshake. LPN #1 auscultated the resident's chest, and she continued to cough. At 5:37 PM, Resident #2 was given a chocolate Ensure supplement and continued to cough as she was drinking.</p> <p>On 5/1/18 at 9:13 AM, Resident #2 was lying in a low bed on an air mattress. The ADON assessed the resident, checked vital signs, checked her throat, and asked if she was hurting while swallowing. Resident #2 stated that it hurt to swallow. At 9:22 AM, after the ADON noted Resident #2's vital signs were stable, the resident, while sitting upright, was asked to take deep breaths and take her medicine, one pill at a time. After taking some of the medicine, Resident #2 stated that she was feeling dizzy and getting weaker. The resident completed taking her medicine and stated that her throat was not hurting while swallowing pills. At 9:28 AM, CNA</p>	F 805			

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F 805	<p>Continued From page 23</p> <p>#1 assisted Resident #2 into a wheelchair and helped her perform ADLs. The resident was asked about what she wanted for breakfast. Resident #2 stated she did not want any breakfast, except maybe oatmeal.</p> <p>On 5/1/18 at 9:52 AM, Resident #2 was in the dining room eating a hard crusty cinnamon roll, and was coughing. CNA #1 stated the cinnamon roll was dry and the resident had a banana, a cheese stick, and milk. The resident had a wet cough. Resident #2 was not having difficulty swallowing and was able to eat two cheese sticks and ½ of a banana, 25% percent of her meal. She was offered other food, but declined. After eating, Resident #2 began coughing three different times. CNA #1 stated she was going to lay the resident down in her bed. At 10:09 AM, Resident #2 was placed flat in her low bed. The bed was not elevated after eating. The resident continued to cough. The CNA #1 acknowledged the resident's coughing, then raised the bed approximately 15 degrees and offered her a drink of water. After sipping the water, Resident #2 again began to have a wet cough and continued to intermittently cough for 45 minutes. At 10:47 at AM, Resident #2 was sitting upright in bed and was given a glucerna supplement with a straw by LPN #2. After eating, Resident #2 was laid back down and continued to cough.</p> <p>On 5/1/18 at 11:02 AM, the ADON was asked about the positioning of the Resident #2 in bed and stated it was not appropriate for her to be in a flat position. She stated Resident #2 should not be laid down directly after meals or after consuming supplements. The ADON raised the head of the bed to 45 degrees. The ADON stated</p>	F 805			

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F 805	Continued From page 24 the hard crusty cinnamon roll was not appropriate and Resident #2 should have been provided with oatmeal. The ADON stated the physician was notified of Resident #2 coughing. On 5/1/18 at 2:28 PM, Resident #2 was lying in a low bed upright at 45 degrees and continued to cough three different times. On 5/2/18 at 8:46 AM, the RD stated Resident #2 had a history of coughing and had been seen by an SLP for speech therapy. The SLP recommended the resident be placed on pureed texture and nectar thick liquids, which the resident refused, and should not have lettuce or rice. The RD was unable to provide a physician's evaluation consenting for the non-use of thickened liquids. The RD stated that when residents have demonstrated swallowing difficulties, they are encouraged to sit upright and tuck their chins during intake, and remain upright for at least 30 minutes following the intake.	F 805			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		6/7/18	

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F 812	<p>Continued From page 25</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure cold food was stored at appropriate temperatures to prevent the growth of potential disease causing pathogen growth. This affected 20 of 20 sample residents (#1, #2, #5, #6, #8, #9, #10, #11, #12, #14, #15, #16, #17, #20, #22, #23, #24, #25, #26, and #27) and had the potential to affect the 9 additional residents who dined in the facility. Findings include:</p> <p>The 2017 FDA Food Code, Chapter 3, Part 3-5, Limitation of Growth of Organisms of Public Health Concern, subpart 3-501.12 Time/Temperature Control for Safety Food, Slacking, documented, "(A) Under refrigeration that maintains the food temperature at 5 C (41 F [Fahrenheit]) or less..."</p> <p>On 5/2/18 at 11:30 AM, Cook #1 was observed assessing the temperatures of the hot holding foods.</p> <p>On 5/2/18 at 11:43 AM, Cook #1 was observed removing the cold food items from a refrigerator and placed multiple small milk cartons, pears, cheese, pureed pear, Parmesan cheese, shredded lettuce, and sliced tomatoes into a transportation cart. Cook #1 was asked to assess</p>	F 812	<p>F812 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Res. #1, #2, #5, #6, #8, #9, #10, #11, #12, #14, #15, #16, #17, #20, #22, #23, #24, #25, #26, and #27. Nutrition Services in-service was completed on 5/23/18 on cold food temperatures. Laminated mini-posters on cold food temperatures and refrigeration were strategically placed in the PTF kitchen and SCNF kitchenettes to ensure compliance with regulations.</p> <p>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? All other residents have the potential to be affected by the deficient practice. Laminated mini-posters on cold food temperatures and refrigeration were strategically placed in the PTF kitchen and SCNF kitchenettes to ensure compliance with regulations. The system/process changes described below apply to all residents.</p> <p>What measures will be put in place and</p>		

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F 812	<p>Continued From page 26</p> <p>the cold food temperatures. The temperatures of the cold foods were as follows:</p> <ul style="list-style-type: none"> * Shredded Lettuce - 44 degrees F * Sliced Tomatoes - 44 degrees F * Pears - 52 degrees F * Parmesan cheese - 45 degrees F * Cheddar cheese - 45 degrees F * Pureed pear - 46 degrees F <p>Cook #1 utilized 3 different thermometers to verify the temperature of the food items.</p> <p>On 5/2/18 at 11:45 AM, Cook #1 stated she "normally" did not assess the temperature of the cold food items in the main kitchen. Cook #1 said she normally assessed the temperature of the food in the satellite kitchens. Cook #1 was unsure what to do with the food items that were out of temperature range and the surveyor suggested placing the food items in the freezer to assist with the cooling process and suggested asking for the assistance of a manager.</p> <p>On 5/02/18 at 11:50 AM, the Certified Dietary Manager (CDM) instructed Cook #1 to take the food items with her to the other building and placed the food items in the freezer. The CDM stated the staff would send over replacement items as needed. The CDM asked Cook #1 where the food was placed in the refrigerator and Cook #1 stated the items were flush against the inside of the door. The CDM said the refrigerator was due to be replaced and the facility was waiting for funding. The CDM began assessing the temperatures of the other food items remaining in the refrigerator. The CDM was unsure why these select few items were out of</p>	F 812	<p>what systemic changes will be made to ensure that the deficient practice does not recur? Cold food temperature procedures will include temperatures being taken before leaving the PTF kitchen and again at time of meal service. A cold food temperature log will be kept in the PTF kitchen and the SCNF kitchenettes. Cold foods for the SCNF will be kept in the walk-in refrigerator instead of the reach-in refrigerator in the PTF kitchen. Foods will then be refrigerated in the SCNF kitchenettes after transport. Ice wands also purchased to assist with cooling food faster.</p> <p>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained? Cold food temperatures are taken with every meal. The Nutrition Services Manager/Designee will monitor temperatures logs for cold foods being transported to SCNF 2 times weekly for 8 weeks, 1 time weekly for 4 weeks and then 1 time monthly on an ongoing basis . Audit results reported at Quarterly QA/PI Meeting.</p>		

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F 812	Continued From page 27 the acceptable temperature range.	F 812			
F 883 SS=F	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883		6/7/18	

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F 883	<p>Continued From page 28</p> <p>must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and record review, it was determined the facility failed to update and implement policies and processes to minimize the risk of residents acquiring, transmitting, or experiencing complications from pneumococcal pneumonia. Specifically,</p> <p>a) The facility failed to ensure residents who were offered the pneumococcal vaccine received the vaccine and information and education consistent with current CDC [Centers for Disease Control and Prevention] recommendations for</p>	F 883	<p>F883 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Res. #16 and #22 Consents signed and vaccinations administered on 5/24/2018. Next dose will be administered 5/2019.</p> <p>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? Since</p>		

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F 883	<p>Continued From page 29</p> <p>pneumococcal immunization for 2 of 5 residents (Residents #16 and #22) reviewed for the pneumococcal vaccination.</p> <p>b) The facility did not implement an immunization program to ensure residents' pneumococcal vaccines were being tracked with receiving or declining the pneumococcal vaccines PCV13 the first year, followed by the PPSV23 one year later. Findings include:</p> <p>The CDC website, updated 11/22/16, documented recommendations for pneumococcal vaccination (PCV13 or Prevnar13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older:</p> <p>* Adults 65 years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23.</p> <p>* If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most recent dose of PPSV23.</p> <p>The facility's policy for Pneumococcal Vaccinations, revised 9/15/17, documented, "Per CDC guidelines (published 10/6/09): Give 1 dose if unvaccinated or if previous vaccination history is unknown. 1. Give a 1-time revaccination 5 years or more after 1st dose to people: a. age 65 years and older if the 1st dose was given prior to age 65 years."</p> <p>The facility's policy stated administration of the pneumococcal vaccine would be made in</p>	F 883	<p>all other residents could be at risk, a report was generated from the Bar Code Medication Administration System (BCMA) showing the type (PCV13 or PPSV23) and the date(s) of previous vaccinations. This data was then entered into an Excel spreadsheet. All resident files were then reviewed for physician orders and consents. The spreadsheet was updated with this information. Consents and physician orders were obtained for residents needing vaccinations. All residents who didn't refuse were vaccinated on 5/24/18, 5/28/18, and 5/31/18.</p> <p>What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? An Excel spreadsheet was developed with all pertinent information. The MDS nurse will review the spreadsheet with each new MDS and update as needed to ensure all new admits and residents with pending vaccinations receive those as required. This requirement has been added to policy 320-24-400. The "SCNF Pneumovac" note has been revised to require the licensed nurse to document the vaccination type (PCV13 or PPSV23), previous vaccinations elsewhere, and if or when vaccinations were completed. The note requests the co-signature of MDS nurse and Infection Preventionist for tracking and monitoring purposes. Policy 320-214-400 "Pneumoccal Vaccinations" has been revised to include CDC</p>		

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F 883	<p>Continued From page 30</p> <p>accordance with current CDC recommendations, however the information and education provided to residents, as documented by the facility's pneumococcal vaccine policy, was not consistent with CDC recommendations. For adults older than 65 years old, CDC recommended vaccination of both PCV13 and PPSV23, at least a year apart. The facility's pneumococcal policy only referenced one (1) vaccine; Pneumovax.</p> <p>1. Resident #16 was readmitted to the facility on 1/7/16 with multiple diagnoses which included Alzheimer's.</p> <p>A quarterly MDS assessment, dated 1/30/18, documented Resident #16 was severely cognitively impaired and was not "up to date" and was "not offered" the Pneumococcal Vaccination.</p> <p>On 5/3/18 at 2:30 PM, the MDS Nurse provided Resident #16's Pneumococcal Vaccine Consent Form, dated 9/24/17, which documented Resident #16 gave the facility permission for the vaccine to be administered. The MDS Nurse was unable to provide documentation Resident #16 received the pneumococcal vaccine. The consent form did not document if the vaccine was the PCV13 vaccine, the PPSV23, or tracking documentation when Resident #16 was to receive the next vaccine.</p> <p>2. Resident #22 was admitted to the facility on 2/22/16 with multiple diagnoses which included dementia.</p> <p>A quarterly MDS assessment, dated 3/6/18, documented Resident #22 was not "up to date" and was "offered and declined" the</p>	F 883	<p>guidelines for pneumonia vaccinations. In-services held 5/30/18; 6/5/18.</p> <p>How the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained? The Infection Preventionist and MDS nurse will maintain compliance by keeping the tracking spreadsheet updated, reviewing vaccination data on new admissions and with each MDS. The Infection Preventionist, DNS, ADNS, and MDS nurse will be co-signed to every "SCNF Pneumovac" note. DNS/ADNS will audit Immunization Tracking Spreadsheet weekly on an ongoing basis. There will also be a yearly review of medication administration and chart reports. Compliance updates will be given at Quarterly QA/PI Meetings on an ongoing basis.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/03/2018
NAME OF PROVIDER OR SUPPLIER SYRINGA CHALET NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET BLACKFOOT, ID 83221		
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F 883	<p>Continued From page 31 Pneumococcal Vaccination.</p> <p>On 5/3/18 at 2:30 PM, MDS Nurse provided Resident #22's Pneumococcal Vaccine Consent Form, dated 9/19/17, which documented Resident #22 gave the facility permission for the vaccine to be administered. The MDS Nurse was unable to provide documentation Resident #22 received the pneumococcal vaccine or evidence of the refusal. The consent form did not document if the vaccine was the PCV13 vaccine, the PPSV23, or tracking documentation when Resident #22 was to receive the next vaccine.</p> <p>On 5/3/18 at 8:43 AM, the Infection Control Nurse was unable to provide current completed tracking of the Pneumococcal Vaccination PCV13 and PPSV23, which included tracking all residents receiving the pneumococcal vaccination PCV13 dose first, followed by the PPSV23 one year later. The Infection Control Nurse stated policies and procedures were reviewed annually with the CDC guidelines and then reviewed during the infection control committee meeting.</p>	F 883		