



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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May 18, 2018

Michael Crowley, Administrator
River's Edge Rehabilitation & Living Center
714 North Butte Avenue
Emmett, ID 83617-2725

Provider #: 135020

Dear Mr. Crowley:

On **May 4, 2018**, a survey was conducted at River's Edge Rehabilitation & Living Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 28, 2018**. Failure to submit an acceptable PoC by **May 28, 2018**, may result in the imposition of civil monetary penalties by **June 20, 2018**.

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

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

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

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

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

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

- **Civil Monetary Penalty**
- **Denial of payment for new admissions effective August 4, 2018**

In addition, we must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on November 4, 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.

Michael Crowley, Administrator
May 18, 2018
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If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

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

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

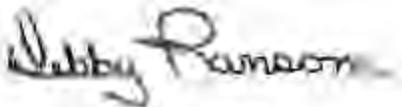
- BFS Letters (06/30/11)

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

This request must be received by May 28, 2018. If your request for informal dispute resolution is received after May 28, 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

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: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2018
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted April 30, 2018 to May 4, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN Team Coordinator Presie Billington, RN Cecilia Stockdill, RN</p> <p>Survey Acronyms:</p> <p>AFO = Ankle Foot Orthotic BLE = Bilateral Lower Extremities CM = Centimeter CNA = Certified Nursing Assistant CONT = Continue DON = Director of Nursing F/U = Follow Up HS = At Bedtime I & A = Incidents and Accidents IDT= Intedisciplinary Team Lt/L = Left LCSW = Licensed Clinical Social Worker LPN = Licesned Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set MS = Multiple Sclerosis NN = Nursing Notes mm/Hg = millimeter mercury MRR = Medication Regimen Review NPWT = Negative Pressure Wound Therapy PN = Progress Notes PRN = as needed PT = Patient RN = Registered Nurse</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

05/25/2018

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 000	Continued From page 1 SA = Skin Assessment SW- Skin/Wound TAR = Treatment Administration Record Vac = Vacuum W/ = With WCN = Wound CLinic Notes X = by	F 000			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i)	F 655		6/11/18	

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F 655	<p>Continued From page 2 of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <ul style="list-style-type: none"> (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff, resident, and family interviews, it was determined the facility failed to ensure baseline care plans were developed, implemented, and reviewed with residents and their representatives for 3 of 4 (#39, #47, and #201) residents whose baseline care plans were reviewed. This created the potential for harm should the care plans not reflect the actual needs of the resident. Findings include:</p> <p>1. Baseline care plans were not reviewed with residents or representatives as follows:</p> <p>a. Resident #39 was admitted on 12/28/17 with multiple diagnoses which included a right fibula (lower leg) fracture and Alzheimer's dementia.</p> <p>The most recent quarterly MDS assessment, dated 4/4/18, documented Resident #39 was severely cognitively impaired.</p>	F 655	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River's Edge Rehabilitation and Living Center does not admit that the deficiencies listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiencies.</p> <p>F655: Baseline Care Plans</p> <p>Corrective action for residents found to have been affected by this</p>		

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F 655	<p>Continued From page 3</p> <p>Resident #39's baseline care plan was initiated on 12/28/17. There was no documentation that the baseline care plan was reviewed with the resident and/or his representative.</p> <p>b. Resident #47 was admitted to the facility on 3/2/18 with multiple diagnoses which included diabetes mellitus and major depression.</p> <p>The most recent MDS assessment, dated 3/10/18, documented Resident #47 was cognitively intact.</p> <p>On 4/30/18 at 3:58 PM, Resident #47 stated she was not aware of a baseline care plan. Resident #47 stated the facility did not provide written documentation to her regarding her plan of care.</p> <p>On 5/3/18 at 10:06 AM, the Licensed Clinical Social Worker (LCSW) stated she was not aware the facility needed to provide a copy of the baseline care plan to residents or the resident representative. The DON, who was present during the interview, stated they did not review the care plan with the resident or the family.</p> <p>c. Resident #201 was readmitted to the facility on 4/23/18 with multiple diagnoses, including renal failure and hospice care.</p> <p>Resident #201's care plan documented it was initiated on 4/23/18. There was no documentation in his clinical record that a summary of the care plan was provided to the resident or his representative.</p> <p>On 5/01/18 at 9:15 AM, Resident #201 did not respond when asked if he and his family had a</p>	F 655	<p>deficiency:</p> <p>Resident #39 has had his care plan reviewed with him and his representative, and a copy of the care plan has been provided to them to ensure that the care plan reflects the actual needs of the Resident.</p> <p>Resident # 201 has discharged from the facility.</p> <p>Resident #47 has discharged from the facility.</p> <p>Corrective action for resident that may be affected by this deficiency:</p> <p>Newly admitted Residents will have their baseline care plans reviewed with them and/or their representatives within 48 hours of admission to the facility to ensure that the care plan reflects the actual needs of the Residents.</p> <p>Current Residents have had their care plans reviewed with them and/or their representative, and a copy of the care plan has been provided to them to ensure that the care plan reflects the actual needs of the Residents.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the LNs and LCSW on the requirement to develop and implement a baseline care</p>		

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F 655	Continued From page 4 meeting regarding his plan of care. On 5/03/18 at 11:25 AM, the DON said they discussed Resident #201's care plan with his family. The DON said there was no documentation that a copy or summary of the plan of care was provided to the resident's family.	F 655	plan for each resident that includes the instructions needed to provide effective person centered care of the resident that meet professional standards of quality care and that the baseline care plan must be reviewed with the resident and the resident's representative within 48 hours of admission. Education will be completed by 6/1/18. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The DON, SDC or designee will conduct audits to ensure that baseline care plans include the minimum healthcare information necessary to properly care for the resident and that they are reviewed with the resident and/or his or her representative within 48 hours of admission to the facility. Audits will begin the week of 6/4/18. Audits will be done weekly. The DON or ED will review and report The results of the audits monthly in QA committee meeting for 3 months, then further recommendations from the committee will be implemented as indicated. Corrective action completed by: 6/11/18		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		6/11/18	

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F 656	Continued From page 5 §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 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	F 656			

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F 656	<p>Continued From page 6</p> <p>plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>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 comprehensive resident centered care plans included the use of side rails. This was true for 2 of 7 residents reviewed for side rails (#30 and #34). This deficient practice placed the residents at risk of entrapment, falls, or other injuries related to the use of the side rails. Findings include:</p> <p>The facility's Policy/Procedure for assistive or positioning devices, dated 5/07, documented the following:</p> <ul style="list-style-type: none"> * Positioning devices would be used based on the resident's needs, used for treatment of medical symptoms or conditions, and used for mobility, positioning, and/or transferring. * The assist or positioning device would be evaluated by licensed or therapy staff for safety and appropriateness. * The resident would be assessed for the ability to safely use the device. * An order would be acquired, if appropriate. * The device would be implemented on the care plan. <p>This policy was not followed. Examples include:</p> <ol style="list-style-type: none"> 1. Resident #30 was readmitted to the facility on 4/14/18 with multiple diagnoses, including generalized muscle weakness. 	F 656	<p>F656: Develop/Implement Comprehensive Care Plans</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>The comprehensive resident centered care plan for Resident #30 has been updated to include the use of side rails in accordance with facility policies and procedures. The side rails for Resident #34 have been removed.</p> <p>Corrective action for resident that may be affected by this deficiency:</p> <p>An audit has been done to create a list of Current Residents that have side rails on their beds. The care plans were reviewed for those residents that have side rails to ensure that federal guidelines and the facility's policies and procedures are being followed.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the LNs, Therapy Staff and the IDT on the</p>		

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F 656	<p>Continued From page 7</p> <p>Resident #30's admission MDS assessment documented she was cognitively intact and did not use a side rails.</p> <p>Resident #30's March 2018 Physician Order did not include an order for side rails.</p> <p>On 5/2/18 at 4:25 PM, Resident #30 was observed in bed with bilateral side rails.</p> <p>On 5/04/18 LPN #4 said Resident #30 had bilateral side rails.</p> <p>On 5/04/18, the DON said Resident #30's side rails should have a physician's order and be included on her care plan.</p> <p>2. Resident #34 was admitted to the facility on 9/11/14 with multiple diagnoses, including Alzheimer's disease and age-related osteoporosis.</p> <p>Resident #34's care plan did not document the use of side rails.</p> <p>Resident #34 was in bed with bilateral positioning devices (side rails) in place on 4/30/18 at 11:57 AM, 4/30/18 at 12:40 PM, and 5/2/18 at 10:00 AM.</p> <p>On 5/02/18 at 4:05 PM, the DON said Resident #34's side rails should have a physician's order and be included on the resident's care plan.</p>	F 656	<p>requirement to develop and implement a comprehensive person-centered care plan for each Resident that is consistent with Resident rights and includes measurable objectives and timeframes to meet a Resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Comprehensive care plans include ensuring that side rails are used in accordance with the facility's policies and procedures where applicable. Education will be completed by 6/1/18.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The DON, SDC or designee will conduct audits to ensure that side rails are appropriately care planned and are used in accordance with the facility's policies and procedures. Audits will begin the week of 6/4/18. Audits will be done every other week. The DON or ED will review and report The results of the audits monthly in QA committee meeting for 3 months, then further recommendations from the committee will be implemented as indicated.</p>		

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

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F 656	Continued From page 8	F 656			
F 657 SS=D	<p>Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-</p> <p>(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 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, record review, policy review, and resident and staff interview, it was</p>	F 657	<p>Corrective action completed by: 6/11/18</p> <p>F657: Care Plan Timing and Revision</p>	6/11/18	

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F 657	<p>Continued From page 9</p> <p>determined the facility failed to ensure residents' care plans were revised and updated within seven days of her most recent quarterly MDS assessment. This was true for 1 of 12 sampled residents (#27) whose care plans were reviewed. This deficient practice placed Resident #2 at risk of harm due to inaccurate or incomplete information on her care plan. Findings include:</p> <p>The facility's Policy and Procedure regarding care planning, dated 5/07, documented the following:</p> <ul style="list-style-type: none"> * The resident and their family and/or responsible party should be participants in developing the care plan. * "Every effort will be made to schedule care plan meetings to accommodate the availability of the resident and family or responsible party." * The resident and their family and/or responsible party will be notified by the MDS coordinator and/or social services of the care plan meeting date and time two weeks before the meeting. <p>Resident #27 was readmitted to the facility on 7/14/17 with multiple diagnoses, including dissociative and conversion disorder (mental health disorders) and schizophrenia.</p> <p>Resident #27's quarterly MDS assessment, dated 3/10/18, documented she was cognitively intact.</p> <p>Resident #27's clinical record documented the last care plan conference was 1/17/18.</p> <p>On 4/30/18 at 10:17 AM, Resident #27 said her last care plan meeting was in December 2017.</p>	F 657	<p>Corrective action for residents found to have been affected by this deficiency:</p> <p>The Care Plan for Resident #27 has been reviewed and updated in accordance with the facility's policy and procedure. The Resident and her family and/or responsible party participated in developing the updated care plan.</p> <p>Corrective action for resident that may be affected by this deficiency:</p> <p>An audit will be done to ensure that current Residents' care plans are revised and updated within seven days of their most recent quarterly MDS assessment and that the Residents and their Family and/or responsible party will participate in developing the care plan.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the the IDT on the requirement to ensure Residents' care plans are revised and updated within seven days of the most recent quarterly MDS assessment in accordance with the facility's policy and procedure. Including, the Residents and their family and/or representative will participate in developing the care plan.</p>		

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F 657	Continued From page 10 On 5/03/18 at 10:52 AM, the LCSW said Resident #27's last care conference documented in January 2018 was probably correct, and there should have been another one since then. The LCSW said she would look to see if there was a more recent care plan meeting. A short time later, the LCSW provided a copy of the care plan conference on 1/17/18 and said that was the most recent care plan conference. Resident #27's care plan was not reviewed and updated within seven days of her 3/10/18 quarterly MDS assessment.	F 657	Education will be completed by 6/1/18. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The DON, SDC or designee will conduct audits to ensure that Residents' care plans are revised and updated within seven days of their most recent quarterly MDS assessments and that the Residents and their family and/or representative will participate in the developing of the care plan. Audits will begin the week of 6/4/18. Audits will be done weekly. The DON or ED will review and report The results of the audits monthly in QA committee meeting for 3 months, then further recommendations from the committee will be implemented as indicated.		
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	F 684	Corrective action completed by: 6/11/18	6/11/18	

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F 684	<p>Continued From page 11</p> <p>accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, policy review and review of fall scene investigations, it was determined the facility failed to check orthostatic blood pressures (blood pressure taken while lying, sitting, and standing) after resident falls. This was true for 2 of 5 sample residents (#27 and #34) reviewed for falls. This failed practice created the potential for harm should residents have undetected potentially significant changes in blood pressure. Findings include:</p> <p>The facility's Policy and Procedure for Falls, dated 5/07, documented it was the facility's policy to assess the extent of injury after falls and to prevent complications. The policy and procedure directed staff not to stand the resident upright, but to lift them to bed or a chair.</p> <p>1. Resident #27 was readmitted to the facility on 7/14/17 with multiple diagnoses, including presence of an artificial left knee joint and generalized osteoarthritis.</p> <p>Resident #27's care plan documented she was at risk for falls and directed staff to provide fall prevention interventions.</p> <p>A Fall Scene Investigation Report, dated 1/14/18 at 8:30 AM, documented Resident #27 was found on the floor and she stated she rolled out of bed. The Fall Scene Investigation Report directed staff to obtain orthostatic blood pressure readings if</p>	F 684	<p>F684: Quality of Care</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Residents #27 and #34 do not exhibit any complications related to the failure to check their orthostatic blood pressure after Resident falls.</p> <p>Corrective action for resident that may be affected by this deficiency:</p> <p>The facility will conducted an audit of current Residents that have had falls to ensure their orthostatic blood pressure was taken in accordance with the facility's policies and procedures.</p> <p>Residents that are identified as not having their orthostatic blood pressure taken in accordance with the facility's policy, will be assessed and appropriate interventions and treatments will be administered.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the</p>		

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F 684	<p>Continued From page 12</p> <p>the fall was within 5 feet of the transfer surface. The Fall Scene Investigation Report documented orthostatic blood pressure changes (a drop in blood pressure) did not contribute to the fall. There was no documentation orthostatic blood pressure readings were completed.</p> <p>A Progress Note, dated 1/14/18 at 6:41 PM, documented Resident #27 was found on her hands and knees on the floor. Resident #27 said she fell out of bed and hit her head and left arm. A bruise was noted on her left arm.</p> <p>There was no documentation found that orthostatic blood pressure readings were obtained after Resident #27's fall.</p> <p>On 5/3/18 at 10:10 AM, the DON said she would look to see if the orthostatic blood pressures were documented somewhere else. She said if the form said to check orthostatic blood pressures, they should have been checked.</p> <p>2. Resident #34 was admitted to the facility on 9/11/14 with multiple diagnoses, including Alzheimer's disease and age-related osteoporosis.</p> <p>Resident #34's care plan documented she was at risk for falls and directed staff to provide fall prevention interventions.</p> <p>A Fall Scene Investigation Report, dated 3/28/18 at 3:25 PM, documented Resident #34 fell on 3/28/18 and was found on the floor in her room. The Fall Scene Investigation Report directed staff to obtain orthostatic blood pressure readings if the fall was within 5 feet of the transfer surface,</p>	F 684	<p>the LNs on the requirement to check the orthostatic blood pressure after Resident falls in accordance with the facility's policies and procedures. Education will be completed by 6/1/18.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The DON, ED or designee will conduct post-fall audits to ensure that the orthostatic blood pressure was taken after a Resident falls in accordance with the facility's policies and procedures. Audits will begin the week of 6/4/18. Audits will be done weekly.</p> <p>The DON or ED will review and report The results of the audits monthly in QA committee meeting for 3 months, then further recommendations from the committee will be implemented as indicated.</p> <p>Corrective action completed by: 6/11/18</p>		

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F 684	Continued From page 13 and documented the fall was "6/5 ft [feet] from [the] transfer surface." The Fall Scene Investigation Report documented orthostatic blood pressure changes (a drop in blood pressure) did not contribute to the fall. There was no documentation orthostatic blood pressure readings were completed. There was no documentation found in Resident #34's clinical record regarding orthostatic blood pressures being taken after the fall on 3/28/18. On 5/4/18 at 9:22 AM, LPN #2 said if the resident was able (to tolerate it) the staff would do orthostatic blood pressure checks, but they would not do them if the resident was not able. LPN #2 said when Resident #34 fell she had significant back pain so orthostatic blood pressure readings could not be obtained. LPN #2 said she did not remember if that information was documented.	F 684			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		6/11/18	

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F 686	<p>Continued From page 14</p> <p>by:</p> <p>Based on observation, staff interview, resident interview, and review of facility policies, resident records, and Incident and Accident (I&A) Reports, it was determined the facility failed to prevent the development and worsening of a pressure ulcer. This was true for 1 of 3 sample residents (#32) reviewed for pressure ulcers. This deficient practice caused harm to Resident #32 when she developed a bruise on her left calf which deteriorated, became infected, and required surgical debridement. Findings include:</p> <p>Resident #32 was admitted to the facility on 5/3/17 with multiple diagnoses, including multiple sclerosis (disabling disease of the brain and spinal cord) and generalized muscle weakness.</p> <p>Resident #32's quarterly MDS assessment, dated 9/11/17, documented she was cognitively intact, required extensive assist of two staff for bed mobility, transfers, dressing and bathing, had impairments on both upper and lower extremities, used a wheelchair for locomotion, and was at risk for pressure ulcers.</p> <p>Resident #32's care plan, documented she had actual impairment to skin integrity related to edema and fragile skin with an abrasion. Interventions included Prevalon boots at all times to both lower extremities and staff were directed to keep the skin clean and dry, use lotion on dry skin, monitor/document location, size and treatment of skin injury, offer to help to lay her down in bed for offloading and elevation of legs and feet twice a day, reposition legs and feet frequently, check feet for new skin breakdown every HS (at bedtime), use caution during</p>	F 686	<p>F686: Treatment/Svcs to Prevent/Heal Pressure Ulcer</p> <p>Corrective action for resident found to have been affected by this deficiency:</p> <p>The pressure ulcer on Resident #32's left calf was assessed on 5/8/18 and her plan of care was updated. On 5/24/18 the Resident received an initial consultation from an external board certified wound care provider that the facility has contracted with to provide specialty wound care to Resident on a weekly basis at the facility. The IDT will review the progress of the pressure ulcer weekly and make recommendations as appropriate.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>On 5/17/18 An external board certified wound care provider performed Skin assessments on current Residents without known skin issues. Per Facility policy, facility planned to initiate an incident/accident form for any newly identified skin issues. However, no new skin issues were identified. Beginning on 5/24/18 an external board certified wound care provider that the facility has contracted with will be providing</p>		

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F 686	<p>Continued From page 15 transfers and bed mobility to prevent striking arms, legs and hands.</p> <p>Resident #32's September 2017 to November 2017 Treatment Administration Records (TAR) documented, "Monitor bilateral pitting edema to lower extremities, Keep feet elevated as patient will allow. Offer to lay down in bed for offloading of legs/feet twice daily during daytime. Prevalon boots at all times." The TARs did not include monitoring of Resident #32's feet for skin breakdown at bedtime.</p> <p>Resident #32's TAR dated December 2017 documented, Resident #32's feet and lower legs were checked for skin integrity for seven days related to new orthotic shoes. The TAR did not include monitoring of Resident #32's feet at bedtime.</p> <p>A Non Pressure Ulcer Skin Assessment, dated 10/30/17, documented Resident #32 pointed out a quarter sized bruise on her left calf and said it was present for about two weeks. The Skin Assessment did not document the actual measurement of Resident #32's bruise.</p> <p>The facility's October 2017 I&A Reports did not include report related to Resident #32's bruise when it was first discovered. There was no investigation documented regarding the origin of Resident #32's bruise.</p> <p>The facility's 5/2007 policy for Incident Accident Reporting documented a report will be completed for any incidents and accidents resulting in an injury or potential for injury involving residents, staff, or visitors. The charge nurse on the shift</p>	F 686	<p>weekly specialty wound care to facility Residents with skin issues and will coordinate care with the facilities nursing team.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the the LNs, CNAs, and IDT on the requirement to prevent the development and worsening of pressure ulcers and on following the facility's policy for incident and accident reporting. Including that a report will be completed for an incident and accident resulting in injury or potential for injury involving Residents, staff, or visitors and that the charge nurse on shift when the incident/accident was discovered is required to complete the report before the end of the shift and the Resident's physician and representative should be notified. Education will be completed by 6/1/18.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The DON, ED or designee will conduct audits to ensure the facility is meeting the requirement</p>		

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F 686	<p>Continued From page 16</p> <p>when the incident/accident was discovered is required to complete the report before the end of the shift, and the resident's physician and representative should be notified.</p> <p>Resident #32's Skin/Wound Progress Notes (SW), Interdisciplinary Team Progress Notes (IDT), Skin Assessments (SA), Nursing Notes (NN), Wound Clinic Notes (WCN), Geriatric Notes, Orthotic Clinic Note, and Physician Progress Notes (PN), documented bruise/ulceration to the left posterior calf as follows:</p> <p>*11/9/17 IDT - scabbed bruise being monitored for healing and was improving</p> <p>*11/13/17 SA - treated with ice therapy, edema noted to the BLE (bilateral lower extremities), elevation encouraged as tolerated</p> <p>*11/17/17 SW - decreased firmness to area and dry with scab in the middle, area remains open to air, ice treatment was discontinued, use skin prep to area until resolved</p> <p>*11/20/17 SA - small scabbed, no signs and symptoms of infection on the area noted</p> <p>*12/1/17 IDT - improving, Prevalon boot protects the area from contacting the wheelchair's leg rest</p> <p>*12/4/17 NN - left calf monitored by nursing, area is clean, dry and intact, 1+ to 3+ edema, tubi grips applied</p> <p>*12/8/17 NN - area improving with current therapy, Prevalon boots in placed for protection</p>	F 686	<p>to prevent the development and worsening of pressure ulcers and that the facility is following its policies and procedures regarding incident and accident reports. Audits will begin the week of 6/4/18. Audits will be done weekly.</p> <p>The DON or ED will review and report The results of the audits monthly in QA committee meeting for 3 months, then further recommendations from the committee will be implemented as indicated.</p> <p>Corrective action completed by: 6/11/18</p>		

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F 686	Continued From page 17 *12/11/17 SA - scab to the left calf being monitored by nursing, skin clean, dry and intact *12/11/17 IDT - skin was currently closed and scabbed, Prevalon boots in place at all times, off-loading continued as resident would allowed. Resident #32 wished to be up in power chair for most of the day. *12/15/17 IDT - 1.2 cm x 0.6 cm, improving with current treatment, Resident #32 was sometimes reluctant to get into bed and off-load feet from her power chair *12/18/17 SA - scab to the left calf was being monitored by nursing, skin was clean, dry and intact *12/22/17 SW - area of concern at left posterior calf, wound clinic classified the area as an ulceration. Treatment provided at time per wound clinic orders. Prevalon boots or orthotic in place at all times. Area is not receiving pressure from power chair or bed *12/25/17 SA - scab being monitored by nursing staff, dressing was clean, dry and intact. Skin was warm, dry and intact *1/5/18 at 11:54 AM IDT - additional intervention to include investigation of Resident #32 use of her power chair in her room. Prevalon boots to be worn immediately after showers prior to being transferred to bed for dressing *1/5/18 at 2:58 PM IDT - RN Resource investigated Resident #32's use of her power	F 686			

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F 686	<p>Continued From page 18</p> <p>chair and determined her left calf potentially came into contact with the metal portion of her power chair when her foot comes off the foot plate. A new strap was fabricated to keep Resident #32's feet on the foot plate. Prevalon boots were worn when up in power chair.</p> <p>*1/8/18 Orthotic Clinic Note - documented "Wound on L [left] posterior tibial shank/calf is concerning please have evaluated by wound care prior to resuming AFO [ankle foot orthosis] use on L side. Recommend stretching ankle/foot prior to donning AFOs in AM: abduct forefoot while dorsiflexing ankle (2-5 minutes) on ea[ch] side..."</p> <p>*1/8/18 Geriatric Note - documented "L calf wound, DTI [deep tissue injury] now surfaced w/ [with] ulceration w/ large eschar [dead tissue], pt [patient] to f/u [follow-up] w/ wound care next week, dressing applied."</p> <p>*1/10/18 Physician's PN - documented "...The patient has a new ulcer and it is in her right [left] posterior calf. It started as a deep bruise and then eventually erupted itself. This was treated with some offloading and she has been going to the wound clinic...The left sore seems to be a deeper pressure sore that is now sloughing off. She has a wound care appointment in two days..."</p> <p>*1/10/18 NN - assessed by the physician, continue current treatment, referred to wound clinic for possible debridement</p> <p>*1/12/18 SW - 2.0 cm x 1.6 cm with no depth, pressure relieving measures in place</p>	F 686			

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F 686	Continued From page 19 *1/12/18 WCN - eschar 2.8 cm x 1.9 cm x 0.1 cm post debridement measurement, Interventions included a Medihoney and directed staff to change dressings 2-3 times per week *1/26/18 WCN - left posterior calf biopsied, continue with Medihoney *1/26/18 IDT - wound continues to be painful and not improving *1/31/18 SW - 4.2 cm x 2.5 cm x 0.8 cm after recent debridement *2/2/18 Biopsy result - Fragments of fibroconnective tissue with ulceration, granulation tissue, mixed inflammation and fat necrosis, no fungal organism seen on stain, negative for malignancy *2/2/18 Wound Culture result - multiple organisms found with predominance of Proteus mirabilis (type of infection) *2/9/18 IDT - ulceration at the posterior calf slow to heal and infected, treated with antibiotics *2/12/18 WCN - Medihoney had been used for quite some time now and the ulceration continues to deepen, deep enough for a snap VAC[uum]. "Ideally, we would use a snap VAC but given that she is in a facility, the wound VAC would be more appropriate." New order obtained to change dressings with wet to dry micro-cleanse and staff were directed to apply a wound vacuum	F 686			

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F 686	<p>Continued From page 20</p> <p>*2/16/18 SW - 4.0 cm x 2.5 cm by 0.8 cm after recent debridement. Wound clinic had recommended wound VAC (vacuum) therapy which was scheduled to arrive 2/19/18</p> <p>*2/23/18 IDT - wound vacuum in place, wound clinic involved with care</p> <p>*2/24/18 NN - wound vacuum in place, patent with no foul odor</p> <p>*2/26/18 WCN - 4.8 cm x 2 cm x 0.6 cm with a tendon exposure, antibiotic completed, and with wound vacuum on her left posterior calf. Interventions were to hold the wound vacuum therapy and staff were directed to keep the ulcer dry with all personal cares, change dressing and apply Iodoflex 3 times per week</p> <p>*3/7/18 Physician's PN - documented "...She had developed some sores on her legs. They are working on them. They did appear to be infected. She has been treated with antibiotics and that has improved. Their healing has somewhat stagnated secondary to her vasculature [vein structure] as well as comorbid states [multiple diagnoses]..."</p> <p>*3/9/18 IDT - wound is stagnant in healing with recent debridement</p> <p>*3/15/18 WCN - documented "...Multiple different wound care modalities have been used on the left proximal lower leg ulcer without much success. These include Medihoney as well as MicroKlenz wet-to-dry's, VAC therapy and most recently Iodosorb...I do feel she has persistent rubbing from the left leg wheelchair support</p>	F 686			

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F 686	<p>Continued From page 21</p> <p>directly causing trauma to the calf. This ongoing trauma has resulted in progressive deterioration now down to necrotic muscle and tendon. She is in a Prevalon boots at all times as well but the wound is at the superior edge of the Prevalon boot which may be causing further trauma."</p> <p>*3/20/18 SW - 5.5 cm x 2.6 cm x 0.7 cm, followed by wound clinic</p> <p>*3/28/18 SW - 5.0 cm x 2.25 cm x 1.0 cm, treatment with Iodoflex and ABD (Absorbent Dressing) pad changed daily</p> <p>*3/29/18 WCN - ulceration had significant odor and necrosis of subcutaneous, muscle and tendon, debridement done</p> <p>*3/31/18 NN - wound bed is beefy red, free of odor and dark areas after recent debridement done at the wound clinic</p> <p>*4/4/18 Physician's PN - documented "...She is seeing a chronic wound doctor. Her wound is slowly healing and she currently has a wound VAC..."</p> <p>*4/9/18 SW - continue with NPWT (negative pressure wound treatment) at 125 mm/hg (millimeter mercury) being change 2 times weekly. Ulcer is 40% filled this week with healthy beefy granulation tissue, tendon is covered with healthy granulation tissue, no odor noted, skin is pink, and blanchable</p> <p>*4/11/18 WCN - left posterior calf ulceration is a healthy granulating muscle level. There is some scattered areas of fibrin and necrosis both</p>	F 686			

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F 686	<p>Continued From page 22</p> <p>superiorly and inferiorly that debrides to a healthy muscle base. Continue with VAC therapy</p> <p>*4/24/18 SW - continue with NPWT at 125 mg hg, ulcer is 50% filled in this week with healthy beefy granulation, with little pain with dressing, no odor noted, peri[pheral]skin is pink and blanchable, no redness or bogginess noted</p> <p>*4/30/18 SW - ulcer is 80% filled this week with healthy beefy granulation tissue noted, Resident #32 with little to no pain with dressing changes, no redness or bogginess noted</p> <p>*5/3/18 WCN - 4.1 cm x 2.1 cm x 0.3 cm. Left posterior calf ulceration into muscle and tendon improved</p> <p>On 5/1/18 at 9:21 AM, Resident #32 was in her power wheelchair inside her room. She had a wound vacuum on her left leg under her pants. Resident #32 said she had a wound on her left leg which was probably due to her left leg rubbing on the leg support of her power wheel chair. Resident #32 said "I have MS (multiple sclerosis) and I can't move my legs." Resident #32 said her wound vac had been changed a day before by the wound nurse, and she was very happy with the progress of her wound healing.</p> <p>On 5/2/18 at 10:50 AM, LN #5 said Resident #32 had a non-pressure wound on her left calf which started as an abrasion which could be due to the resident's leg resting on the leg support of her wheelchair or secondary to the orthotic shoes she was wearing. LN #5 said Resident #32 had MS, was unable to move her legs, and needed a belt to keep her legs together whenever she was</p>	F 686			

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F 686	<p>Continued From page 23 using her power wheelchair.</p> <p>On 5/4/18 at 1:07 PM, RN #1 said Resident #32 wore different types of orthotic shoes, and they had found a discolored area on her left calf, that was possibly due to trauma. RN #1 described the area as a bruise, and said it was closed. RN #1 said they were unable to determine the source of the bruise.</p> <p>On 5/4/18 at 10:25 AM, the DON said the facility's process for skin checks is that CNAs complete a skin sheet form if they find something on the resident and report it to the nurse. The nurse on duty then informs the physician, wound nurse and the resident's family. The DON said she could not locate the I&A Report for Resident #32's bruise on her left calf after it was discovered, and one should have been completed. The DON said Resident #32 wore orthotic shoes, and the best practice was for the staff to check the resident's skin whenever the orthotic shoes or Prevalon boots were removed. The DON said she did not find the documentation that Resident #32's skin was being checked for new skin breakdown in the Resident #32's September, October and November 2017 TARs.</p> <p>Resident #32 was harmed when the bruise on her left posterior calf deteriorated, became infected, required surgical debridement, and placement of a wound vacuum. There was no documented investigation regarding the origin of Resident #32's bruise, at the time she reported it on 10/30/17. The wound clinic classified the area as an ulceration according to Resident #32's 12/22/17 Skin/Wound Progress Notes. The IDT initiated an investigation on 1/5/18 regarding</p>	F 686			

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F 686	Continued From page 24 Resident #32's bruise.	F 686			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident family and staff interviews, and review of facility policies, resident records, and Fall Scene Investigation Reports, the facility failed to ensure sufficient supervision of residents to prevent falls. This was true for 1 of 5 sampled residents (#34) reviewed for falls. Resident #34 was harmed when she fell in her room multiple times and sustained vertebral fractures (fractures in the spine), increased pain, decreased appetite, and a hematoma (a collection of blood under the skin) to her forehead. Findings include: The facility's Fall Prevention policy, dated 5/2007, documented the facility would investigate circumstances around resident falls, implement action to decrease additional falls, and minimize the potential for injuries. Resident #34 was admitted to the facility on 9/11/14 with multiple diagnoses, including Alzheimer's disease and age-related osteoporosis.	F 689	F689: Free of Accident/ Hazards/Supervision/Devices Corrective action for resident found to have been affected by this deficiency: On 3/29/18 Resident #34 was moved to a room closer to the nurse's station to provide increased supervision. On 3/29/18 Resident began Physical Therapy to increase lower extremity strength and improve her balance. Physical Therapy was discontinued on 5/1/18 after Resident met her goals. Resident continues to have a lipped mattress as an intervention to assist with defining the edge of her bed. On 3/30/18 a new pressure alarm was tested to ensure proper function and placed as an intervention to help alert staff of the	6/11/18	

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F 689	<p>Continued From page 25</p> <p>Resident #34's admission MDS assessment, dated 9/18/14, documented the following:</p> <ul style="list-style-type: none"> * Severe cognitive impairment. * Required extensive assistance of two persons with bed mobility, transfers, and toileting. * Required limited assistance of one person with ambulation. * Required use of a wheelchair and walker. * No restraints or alarms were in place. * The resident experienced falls prior to admission. <p>Resident #34's Fall Risk Evaluation, dated 3/2/18, documented she was at high risk for falls.</p> <p>Resident #34's significant change MDS assessment, dated 3/24/18, documented the following:</p> <ul style="list-style-type: none"> * Severe cognitive impairment. * The resident exhibited inattention, disorganized thinking, and altered level of consciousness. * Required extensive assistance from two people for bed mobility, transfers, and toileting. * Two falls since admission, including one with major injury. * A bed alarm was in place. <p>Resident #34's care plan documented the following interventions related to falls:</p> <ul style="list-style-type: none"> * Interventions initiated on 9/11/14 included ensuring the resident wore appropriate footwear, keeping needed items within reach, and maintaining a clear pathway. * A bed pressure alarm was initiated on 3/7/18. * A lipped mattress was initiated on 3/19/18. 	F 689	<p>need for assistance. Resident has not had a fall since 3/28/18.</p> <p>Resident is assessed daily for pain. Resident has only had 2 episodes of breakthrough Pain with routine pain management since 4/25/18.</p> <p>Resident has gained weight appropriately and her average meal intake has increased over the last 30 days.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>Current Residents <input type="checkbox"/> Fall Risk Assessments will be reviewed for accuracy. The Plans of Care will be updated for all Residents that are identified as having a high risk for falls to ensure that they are receiving adequate supervision and assistance devices to prevent falls and accidents.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the LNs, CNAs, and IDT on the requirement to ensure the Residents <input type="checkbox"/> environment is as free of accident hazards as is possible and</p>		

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F 689	<p>Continued From page 26</p> <ul style="list-style-type: none"> * Interventions initiated on 3/29/18 included a physical therapy evaluation, placing the bed in the lowest position, and moving her to a room closer to the nurse's station. <p>A Fall Scene Investigation Report, dated 3/6/18 at 12:00 AM, documented the following:</p> <ul style="list-style-type: none"> * Resident #34 was confused at times. * Resident #34 was found on the floor in her room. * Resident #34 was coming back from the bathroom, she was unassisted, and she fell. * The root cause of the fall was the resident lost her balance when she was walking back to her bed from the bathroom. * The follow-up investigation recommended a pressure alarm, try to move closer to the nurse's station, and check with the physician regarding a back brace. <p>Resident #34's Fall Prevention Devices flowsheet documented the following:</p> <ul style="list-style-type: none"> * Checks were made for non-skid slippers and a visual check of the resident at 12:16 AM on 3/6/18. * A check was made for the bed in low position at 1:59 PM on 3/6/18. * A visual check of the resident was made at 3:21 PM on 3/6/18. <p>A Progress Note, dated 3/6/18 at 12:10 AM, documented the nurse was called into the resident's room by a CNA, and the resident was lying on the floor on her right side. Resident #34 said she was going back to bed after using the bathroom, she lost her balance and fell. No</p>	F 689	<p>that they are receiving adequate supervision and assistance devices to prevent accidents.</p> <p>Education will be completed by 6/1/18.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The DON, ED or designee will conduct audits to ensure the facility is meeting the requirement to ensure the Residents are receiving adequate supervision and assistance devices to prevent falls and accidents. Audits will include: Reviewing incident reports to ensure they are complete and accurate for new incidents. Reviewing the protective device monitoring log. Reviewing the fall risk assessments for new admissions to ensure accuracy and that protective devices are in place if appropriate.</p> <p>Audits will begin the week of 6/4/18. Audits will be done every other week.</p> <p>The DON or ED will review and report The results of the audits monthly in QA committee meeting for 3 months, then further recommendations from the committee will be implemented as indicated.</p>		

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F 689	<p>Continued From page 27</p> <p>injuries were noted by the nurse, and the resident was assisted back to bed by two staff members.</p> <p>A physician's order, dated 3/6/18 at 8:28 AM, documented spinal X-rays to rule out fractures.</p> <p>A report from a CT scan (a radiology imaging study) of the lumbar spine (low back), dated 3/6/18 at 9:01 AM, documented the following:</p> <ul style="list-style-type: none"> * A fracture at L1 (the first lumbar vertebra), similar to a previous study from 9/5/14. * A fracture at L3 (the third lumbar vertebra) which could have been acute (of recent onset). <p>A report from a CT scan of the abdomen and pelvis, dated 3/6/18 at 9:06 AM, documented the following:</p> <ul style="list-style-type: none"> * Severe compression fracture of T8 (the eighth thoracic vertebra, near the mid-back), age undetermined but it was new since a previous study in 2014. * Stable severe compression fracture of T12 (the twelfth thoracic vertebra, near the upper portion of the low back). <p>A Progress Note, dated 3/7/18 at 9:39 AM, documented Resident #34 fell and sustained a fracture that occurred on 3/6/18. She was evaluated in the emergency room related to back pain, and X-rays showed fractures of lumbar and thoracic vertebrae.</p> <p>A physician's note, dated 3/7/18, documented Resident #34 fell and was transported to the hospital for a CT scan. The CT scan showed a stable fracture of T12 and a probable new</p>	F 689	<p>Corrective action completed by: 6/11/18</p>		

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F 689	<p>Continued From page 28</p> <p>fracture in the lumbar spine. Resident #34 complained of pain, and the hydrocodone (narcotic pain medication) was not effective in controlling her pain. The Fentanyl patch (narcotic pain medication) dosage was increased from 37 to 50 micrograms, anti-inflammatory medication was added, the dosing of narcotic medication was increased to every four hours as needed, and Tylenol was added four times a day for two weeks.</p> <p>A physician's order, dated 3/9/18 at 11:57 AM, directed staff to monitor the bed alarm every shift for placement and function.</p> <p>A Progress Note, dated 3/10/18, documented Resident #34 complained of pain in her back "continuously." She received a Fentanyl patch, Norco, and Tylenol, and she "whimpered" when she was up in the chair for a meal.</p> <p>A Fall Scene Investigation Report, dated 3/17/18 at 12:00 PM, documented the following:</p> <ul style="list-style-type: none"> * Resident #34 was found on the floor in her room. * She attempted to self-transfer and fell. * The bed alarm was not turned on. * The root cause of the fall was the resident being hungry and an unsafe self-transfer. * The follow-up investigation recommendations included staff education on alarms and using a lipped mattress (a mattress with raised edges that help define the perimeter of the mattress). <p>Resident #34's Fall Prevention Devices flowsheet documented the following:</p>	F 689			

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

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F 689	<p>Continued From page 29</p> <ul style="list-style-type: none"> * The mobility monitor (alarm) was checked at 9:19 AM, 3:23 PM, and 11:57 PM on 3/17/18. * Non-skid slippers were checked at 9:19 AM on 3/17/18. * Visual checks were made of the resident at 9:19 AM, 3:23 PM, and 11:58 PM on 3/17/18. <p>A Progress Note, dated 3/17/18 at 10:37 PM, documented Resident #34 was found sitting on the floor and she was crying, whimpering, and complaining of pain. There were no visible injuries. She was assisted back to bed and medicated with Norco for pain.</p> <p>A Progress Note, dated 3/18/18 at 2:57 PM, documented Resident #34 was whimpering and complaining of pain when assisted getting up into a chair. She received Norco every 4 hours and she would say "please don't make me move."</p> <p>A Progress Note, dated 3/19/18 at 9:57 AM, documented that at the time of the 3/17/18 fall Resident #34 was found lying on the floor after a self-transfer. The note stated Resident #34 was alone in her room and was wearing one sock. It further documented Resident #34 complained of increased pain since the fall, pain medication was given, and a lipped mattress was going to be placed on her bed.</p> <p>A Progress Note, dated 3/21/18 at 3:40 PM documented the LCSW and the MDS nurse spoke to Resident #34's family member about the recent falls and possibly moving her to a room closer to the nurse's station. The resident's family member did not want to move the resident to a different room due to the resident's familiarity with her room.</p>	F 689			

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F 689	<p>Continued From page 30</p> <p>A Fall Scene Investigation Report, dated 3/28/18 at 3:25 PM, documented the following:</p> <ul style="list-style-type: none"> * Resident #34 was found on the floor in her room. * The bed alarm did not sound to alert staff the resident got up from bed * Prior to the fall, Resident #34 was confused and "picking at things that aren't there." * Resident #34 got out of bed and walked across the room. She removed pieces of the cotton-like material from her incontinence brief, which was clean and dry. * She fell and hit her head, and the result was a large lump above her right eye. * The root cause of the fall was increased confusion and an alarm that was not functioning properly. * The follow-up investigation recommendations included moving to a room closer to the nurse's station, physical therapy evaluation, and changing out the alarm. <p>Resident #34's Fall Prevention Devices flowsheet documented the following:</p> <ul style="list-style-type: none"> * A check was made for the bed in low position at 11:06 AM and 9:32 PM on 3/28/18. * The mobility monitor was checked at 11:06 AM and 9:31 PM on 3/28/18. * The mobility monitor for the chair was checked at 9:31 PM on 3/28/18. * A visual check of the resident was made at 9:32 PM on 3/28/18. <p>A Progress Note, dated 3/28/18 at 4:33 PM, documented Resident #34 was not aware of her</p>	F 689			

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F 689	<p>Continued From page 31</p> <p>safety needs and frequently attempted to self-transfer.</p> <p>A Progress Note, dated 3/28/18 at 7:06 PM, documented the fall earlier in the day where Resident #34 was found on the floor in her room and she was calling for help. The bed alarm was not sounding when the resident was found on the floor. Resident #34 had a "large lump" on her forehead above her right eye. Resident #34 was moved to a room closer to the nurse's station, her family member was notified and agreed to the room change.</p> <p>A physician's order, dated 3/29/18 at 11:45 AM, documented a physical therapy evaluation and treatment was ordered for Resident #34.</p> <p>A physician's note, dated 4/4/18, documented Resident #34 had a vertebral compression fracture, had recently fallen again and had a contusion (bruise) to her head. Resident #34 had occasional hallucinations and was "writhing in pain at times." The physician's note documented "While it is possible that she has another compression fracture causing the pain since she is complaining about pain all over and palpating her back does not elicit any discomfort, we will just go with the generalized osteoarthritis causing the pain."</p> <p>A Progress Note, dated 4/5/18 at 1:44 PM, documented Resident #34 had a new order to increased the dosage of her Fentanyl patch to 50 micrograms per hour.</p> <p>A Progress Note, dated 4/5/18 at 7:23 PM,</p>	F 689			

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

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FORM APPROVED
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F 689	<p>Continued From page 32</p> <p>documented Resident #34 had a change of condition related to falls and fractures in her back, increased pain medication, and decrease in appetite.</p> <p>A Progress Note, dated 4/19/18 at 12:51 PM, documented Resident #34's weight had decreased by 8.6 pounds since 2/19/18. She had 3 recent falls, her oral intake decreased after the falls but was improving.</p> <p>Resident #34 was in bed with a bed alarm in place on 4/30/18 at 11:57 AM, 4/30/18 at 12:40 PM, and 5/2/18 at 10:00 AM.</p> <p>On 5/1/18 at 2:09 PM, Resident #34's family member said she was aware of 3 or 4 falls in the past month, and there were previous falls at home and in the previous assisted living facility. Resident #34's family member said the resident would have periods where she didn't sleep and would get "wound up," possibly looking for her husband, and she would get weaker the longer she was up. Resident #34's family member said the resident did not remember to ask for help to get up and had turned her bed alarm off at times.</p> <p>On 5/2/18 at 10:21 AM, LPN #1 said Resident #34 would try to get up by herself, would not use the call light and was at high risk for falls. LPN #1 said Resident #34 had a couple of falls in the past one to three months, and she used to have an alarm prior to her fall but it was discontinued for a time due to the new state regulations and the facility was trying to slowly decrease the use of alarms. The alarm was re-instated after the resident fell. LPN #1 said she routinely made sure the alarm was on when she administered</p>	F 689			

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F 689	<p>Continued From page 33</p> <p>medications and when the resident was in her chair, and the CNAs could refer to the care plan Kardex for guidance regarding monitoring Resident #34's alarm and the level of assistance she required.</p> <p>On 5/2/18 at 11:10 AM, the MDS nurse said Resident #34 had an alarm before the first fall, but it was discontinued because she didn't have any falls and was getting herself up to the bathroom without calling for assistance. The MDS nurse said the alarm was re-instated after the first fall, a lipped mattress was put in place after the second fall, and physical therapy was implemented after the third fall.</p> <p>On 5/2/18 at 2:07 PM, CNA #1 said she would ask Resident #34 what level of assistance she needed. CNA #1 said Resident #34 fell a couple of months ago and sustained a bruise to her head. CNA #1 said she should ensure the bed alarm is on when Resident #34 lays down, and there were times she found the alarm not working or not turned on and she fixed it.</p> <p>On 5/2/18 at 2:13 PM, CNA #2 said the CNAs should read the care plan Kardex every day for instructions on assisting and monitoring residents. CNA #2 said she was involved in Resident #34's care the day she fell and hit her head. CNA #2 said Resident #34 had been up late and was tired, so she took her to the restroom and then assisted her to lie down. The alarm was on and they were supposed to check her often. CNA #2 said she went on a break after Resident #34 was assisted to lie down, and found out she had fallen during the time she was on break. CNA #2 said the alarm would act</p>	F 689			

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F 689	Continued From page 34 "weird" if the battery was low, but it was working when she last checked the resident. CNA #2 said Resident #34 was not getting up on her own very much after she hurt her back, and sometimes she would use the call light but needed frequent reminding. After Resident #34 fell, CNA #2 said they were to watch her closer by looking in the room when passing by to make sure she was safe, but they did not document it. On 5/2/18 at 2:44 PM, the LCSW said the facility was reducing the use of alarms prior to Resident #34's first fall and had just removed her alarm prior to the fall. The LCSW said after the third fall Resident #34's family member agreed to moving her to a different room. The LCSW said Resident #34 was walking pretty well when she was first admitted to the facility, and she was previously a lot more social and interactive and used to go out for dinner with her family before her falls. On 5/2/18 at 3:06 PM, the DON said if a resident was admitted to the facility with a history of falls, she would want an alarm placed and it was not appropriate for Resident #34's alarm to be removed. The DON said she expected staff to make sure the alarm was turned on and was functioning, and she did not know how often staff checked the alarm.	F 689			
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following	F 700			6/11/18

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F 700	<p>Continued From page 35 elements.</p> <p>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and record review, it was determined the facility failed to ensure that prior to the placement of bed rails, residents were thoroughly assessed for the risk of entrapment and a consent was in place. This was true for 2 of 7 residents (#30 and #34) sampled for bed rail use and created the potential for harm from entrapment or injury related to the use of bed rails. Findings include:</p> <p>1. Resident #34 was admitted to the facility on 9/11/14 with multiple diagnoses, including Alzheimer's disease and age-related osteoporosis.</p> <p>The facility's Policy/Procedure for assist or positioning devices, dated 5/07, documented the following:</p> <p>* Positioning devices would be used based on</p>	F 700	<p>F700: Bed Rails</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>The bed rails for Resident #34 have been removed. Residents #30 has been assessed for risk of entrapment from bed rails. The risks and benefits of using bed rails have been reviewed with the Resident and/or her Representative and a consent has been obtained, and a' physicians order is in place for the use of bed rails.</p> <p>Corrective action for resident that may be affected by this deficiency:</p>		

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F 700	<p>Continued From page 36</p> <p>the resident's needs, used for treatment of medical symptoms or conditions, and used for mobility, positioning, and/or transferring.</p> <p>* The assist or positioning device would be evaluated by licensed or therapy staff for safety and appropriateness.</p> <p>* The resident would be assessed for the ability to safely use the device.</p> <p>* An order would be acquired, if appropriate.</p> <p>* The device would be implemented on the care plan.</p> <p>Resident #34's care plan did not document the use of side rails.</p> <p>Resident #34's Restraint/Enabling Device/Safety Device Evaluations, dated 12/12/17 and 3/9/18, documented the only safety device was a pressure alarm while the resident was in bed.</p> <p>There was no documentation found in Resident #34's clinical record that the side rails were assessed for safety, a consent was signed for side rails, or an order was obtained for use of side rails.</p> <p>Resident #34 was in bed with bilateral side rails in place on 4/30/18 at 11:57 AM, 4/30/18 at 12:40 PM, and 5/2/18 at 10:00 AM.</p> <p>On 5/2/18 at 3:49 PM, the DON said Resident #34's side rails should have been included on the Restraint/Enabling Device/Safety Device Evaluation and they were not.</p> <p>On 5/02/18 at 4:05 PM, the DON said Resident #34's side rails should have an order and should be on the care plan.</p>	F 700	<p>An audit will be done to ensure that current Residents that have bed rails have been assessed for the risk of entrapment from bed rails. The risks and benefits of using bed rails have been reviewed with the Residents and/or their Representative and consents have been obtained, and physicians orders are in place for the use of bed rails.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the the LNs, IDT, and therapy staff on the requirements to perform assessments for risk of entrapment from bed rails, to review the risks and benefits of using bed rails with the Residents and/or their Representative and obtain consents, and A physicians orders prior to the use of bed rails.</p> <p>Education will be completed by 6/1/18.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The DON, ED or designee will conduct audits to ensure that the assessment for risk of entrapment from bed rails,</p>		

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F 700	Continued From page 37 2. Resident #30 was readmitted to the facility on 4/14/18 with multiple diagnoses which included generalized muscle weakness. Resident #30's admission MDS assessment documented she was cognitively intact and did not use side rails. Resident #30's March 2018 Physician Orders did not include an order for side rails. On 5/2/18 at 4:25 PM, Resident #30 was observed in bed with two side rails. On 5/04/18 at 12:46 PM, LPN #4 said Resident #30 had bilateral side rails. There was no documentation on Resident #30's clinical record that she was assessed for safety with side rails use. On 5/4/18, the DON said Resident #30 should have an order for side rails and should have been assessed for safety with use of the side rails.	F 700	the risks and benefits of using bed rails have been reviewed with the Residents and/or their Representative, consents have been obtained, and physicians orders are in place for the use of bed rails. Audits will begin the week of 6/4/18. Audits will be done weekly. The DON or ED will review and report The results of the audits monthly in QA committee meeting for 3 months, then further recommendations from the committee will be implemented as indicated. Corrective action completed by: 6/11/18		
F 758 SS=E	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	F 758		6/11/18	

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F 758	<p>Continued From page 38</p> <p>(iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§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;</p> <p>§483.45(e)(2) Residents who use psychotropic 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</p>	F 758			

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F 758	<p>Continued From page 39</p> <p>by: Based on record review and staff interview, it was determined the facility failed to ensure there was a clinical rationale to continue PRN psychotropic medications and behaviors were monitored for a resident receiving an antidepressant medication. This was true for 2 of 6 residents (#4 and #39) reviewed for psychotropic medications. This failed practice created the potential for harm should residents experience adverse reactions from unnecessary psychotropic medications. Findings include:</p> <p>1. Resident #4 was readmitted to the facility on 3/23/18 with multiple diagnoses, including anxiety disorder and major depressive disorder.</p> <p>Resident #4's significant change MDS assessment, dated 3/23/18, documented she had active diagnoses of anxiety and depression and had received antidepressant medication in the past 7 days.</p> <p>Resident #4's physician's orders documented Lexapro (antidepressant medication) 10 mg tablet once a day was ordered on 3/23/18.</p> <p>Resident #4's care plan documented antidepressant medication use and directed staff to monitor, document, and report to the physician any ongoing signs or symptoms of depression that were unchanged by antidepressant medication.</p> <p>Resident #4's March 2018 MAR documented the Lexapro was administered each day from 3/1/18-3/17/18. There was no documentation of behaviors being monitored related to signs and</p>	F 758	<p>F758: Free from Unnec Psychotropic Meds/PRN Use</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Resident #4 has discharged from the facility. Clinical rationale to continue The PRN psychotropic medication for Resident #39 will be provided and behaviors are being monitored the rationale will include a duration.</p> <p>Corrective action for resident that may be affected by this deficiency:</p> <p>Current Residents that have PRN psychotropic medications will be reviewed and the facility will ensure that the requirement to ensure there is clinical rational for continuing their use is in place along with monitoring behaviors for any PRN orders extended beyond 14 days. A Duration will be included with the clinical rationale for PRN psychotropic medications.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the the Social Worker and LNs on the requirement to provide clinical rationale to continue PRN psychotropic</p>		

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F 758	<p>Continued From page 40 symptoms of depression.</p> <p>Resident #4's April 2018 MAR documented the Lexapro was administered each day from 4/1/18-4/30/18, except for 4/12/18 when the resident refused it. There was no documentation of behaviors being monitored related to signs and symptoms of depression.</p> <p>Resident #4's May 2018 MAR documented the Lexapro was administered each day from 5/1/18-5/3/18. There was no documentation of behaviors being monitored related to signs and symptoms of depression.</p> <p>On 5/3/18 at 3:40 PM, the DON said staff should be monitoring behaviors for residents receiving antidepressants and anti-anxiety medications. The DON said it was not reflected on the MAR that behaviors were being monitored for Resident #4.</p> <p>2. Resident #39 was admitted on 12/28/17 with multiple diagnoses which included dementia with behavioral disturbances, anxiety disorder, restlessness, and agitation.</p> <p>The most recent quarterly MDS assessment, dated 4/4/18, documented Resident #39 had severe cognitive impairment and received psychotropic medications.</p> <p>A Care Plan dated 1/9/18, documented Resident #39 had potential for behaviors including anxiety, hallucinations, and delusions.</p> <p>A physician's order for Resident #39, dated 12/28/17, directed staff to provide:</p>	F 758	<p>medications beyond 14 days and that behaviors must be monitored for a Resident receiving a psychotropic medication.</p> <p>Education will be completed by 6/1/18.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The DON, SDC or designee will conduct weekly audits to ensure that the requirement to provide clinical rationale to continue PRN psychotropic medications beyond 14 days and that behaviors must be monitored for a Resident receiving a psychotropic medication is being met and that a duration is included.</p> <p>Audits will begin the week of 6/4/18 Audits will be done weekly.</p> <p>The DON or ED will review and report The results of the audits monthly in QA committee meeting for 3 months, then further recommendations from the committee will be implemented as indicated.</p> <p>Corrective action completed by: 6/11/18</p>		

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F 758	Continued From page 41 a. Lorazepam 0.5 mg by mouth every 8 hours as needed (PRN) for anxiety. b. Lorazepam 0.5 mg intramuscular (IM) every 2 hours PRN for anxiety. A pharmacy Medication Regimen Review, (MRR) dated 2/14/18, documented Resident #39 had an order for PRN Lorazepam tabs and PRN injectable for anxiety. The Pharmacist in the MMR review asked the prescribing physician to provide a specific length of time and medical support for the PRN medication. Resident #39's physician discontinued the lorazepam IM PRN order. There was no documentation in Resident #39's medical record to support the continuation of Lorazepam tabs beyond 14 days. A pharmacy MRR dated 3/23/18, documented Resident #39 had an order for PRN Lorazepam. The MRR documented the need for medical justification for continued use and length of therapy. A handwritten note documented [Resident #39] "continues to use [PRN Lorazepam] frequently with effectiveness. Recommend to review every 90 days" signed by the DON. The physician signed the MRR on 4/3/18. There was no documentation in Resident #39's medical record to support the continuation of Lorazepam beyond 14 days. On 5/2/18 at 2:30 PM, the DON stated she was not aware of the need to document medical justification for the use of PRN psychotropic medications or the need to reassess every 14 days.	F 758			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		6/11/18	

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F 761	<p>Continued From page 43</p> <p>On 5/3/18 at 9:00 AM, during the inspection of the Medication Cart on 200 Hall with LPN #3 present, the following were found:</p> <p>*one tablet of Tramadol 50 mg which had expired 4/20/18. *24 tablets of hydrocodone acetaminophen 10/325 mgs which had 2/20/18.</p> <p>At the time of the inspection LPN #3 verified the expiration dates and said she would dispose the controlled medications with another nurse.</p> <p>On 5/3/18 at 9:20 AM, during the inspection of the laboratory supplies with RN #1 present, four Green top test tube were found which expired 12/13/17. RN #1 confirmed the expiration date of the test tubes.</p>	F 761	<p>Corrective action for resident that may be affected by this deficiency:</p> <p>Current Residents will be audited to ensure that all expired medications are properly disposed of and not available to be administered. Additionally, laboratory test tubes will be appropriately disposed of if expired.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the the LNs on the requirements to ensure that all expired medications are properly disposed of and are not available for administration to Residents and that laboratory test tubes are to be properly disposed of if expired.</p> <p>Education will be completed by 6/1/18.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The DON, SDC or designee will conduct weekly audits to ensure that the requirements to ensure that all expired medications are not available for administration to Residents and expired laboratory test tubes are disposed of, are being met.</p>		

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: 135020	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2018
NAME OF PROVIDER OR SUPPLIER RIVER'S EDGE REHABILITATION & LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 714 NORTH BUTTE AVENUE EMMETT, ID 83617		
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F 761	Continued From page 44	F 761	<p>Audits will begin the week of 6/4/18 Audits will be done weekly.</p> <p>The DON or ED will review and report The results of the audits monthly in QA committee meeting for 3 months, then further recommendations from the committee will be implemented as indicated.</p> <p>Corrective action completed by: 6/11/18</p>		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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February 20, 2019

Michael Crowley, Administrator
River's Edge Rehabilitation & Living Center
714 North Butte Avenue,
Emmett, ID 83617-2725

Provider #: 135020

Dear Mr. Crowley:

On **May 4, 2018**, an unannounced on-site complaint survey was conducted at River's Edge Rehabilitation & Living Center. The complaint was investigated during an on-site recertification and complaint survey conducted April 30, 2018 through May 4, 2018.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007553

ALLEGATION #1:

Residents were not being showered frequently enough.

FINDINGS #1:

The clinical records were reviewed for two residents regarding activities of daily living. Observations were made of 8 residents. Four residents and three residents' family members were interviewed. One staff member was interviewed. General observations were made of residents and staff providing care throughout the facility during the survey.

All observed residents appeared appropriately clean and groomed. During resident and family interviews, there were no concerns regarding showers not being done often enough. The shower schedule for one resident documented a shower was given twice a week per the facility's policy with the exception of one week where there was one shower documented.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

Residents were not receiving physical therapy according to the ordered frequency.

FINDINGS #2:

The clinical records of 4 residents were reviewed for rehabilitation services. Four residents and three residents' family members were interviewed. One therapy staff member was interviewed. General observations were made of residents participating in therapy during the survey.

During resident and family interviews, there were no identified concerns regarding physical therapy sessions. The clinical record of one resident documented physical therapy was ordered three times per week. It was documented the resident received physical therapy 3 times per week during the specified times, with the exception of one week prior to being discharged from physical therapy. During an interview, a physical therapist said the resident participated well in therapy and he did not hear of any concerns regarding the physical therapy that was provided.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents were not receiving appropriate care related to Foley catheters.

FINDINGS #3:

The clinical records of two residents with Foley catheters were reviewed. Two residents with Foley catheters were interviewed. One staff member was interviewed.

One resident's clinical record documented catheter care was provided each shift. During interviews, two residents with Foley catheters did not express any concerns regarding care of their Foley catheter. One interviewed staff member said the CNA's routinely provided catheter care each shift, usually when emptying the catheter bag and measuring the urine output on their shift.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents' pain was not managed adequately related to pain medications not being administered appropriately.

FINDINGS #4:

Observations were made of 8 residents. Four residents and three residents' family members were interviewed. Two nursing staff members were interviewed. General observations were made of residents and staff providing care throughout the facility during the survey. The clinical record of four residents were reviewed related to pain management.

There were no residents observed who exhibited signs and symptoms of unmanaged pain. During interviews, there were no concerns regarding unmanaged pain. Staff verbalized appropriate measures for pain management. The clinical records of residents documented PRN pain medications were administered per physician's orders, pain medication efficacy was monitored, and resident pain levels were monitored appropriately.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Residents' incontinence briefs were not changed in a timely manner.

FINDINGS #5:

The clinical records of seven residents were reviewed. Observations were made of 6 residents who had issues with incontinence. Four residents and three residents' family members were interviewed. One nursing staff member was interviewed. General observations were made of residents and staff providing care throughout the facility during the survey.

One resident's clinical record documented personal hygiene and catheter care were provided appropriately. Staff were observed providing incontinence care to residents and changing incontinence briefs appropriately. There were no concerns expressed regarding incontinence care or having incontinence briefs changed. Residents were found without foul odors or signs of deteriorating incontinent briefs.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Residents were not receiving necessary assistance with meals.

FINDINGS #6:

Three observations were made in a dining room during meal times. The clinical record was reviewed for one resident. Four residents and three residents' family members were interviewed. Two CNAs and one nurse were interviewed. General observations were made of residents and staff providing care throughout the facility during the survey.

All observed residents were appropriately assisted by facility staff members during meals. One resident's clinical record documented one-person physical assistance was provided with eating until the resident was able to eat independently.

There were no verbalized concerns regarding residents not receiving necessary assistance during meals. Facility staff members identified those residents who required assistance with dining and how to determine the level of assistance required for a resident.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Residents' privacy was not respected during physician appointments.

FINDINGS #7:

Facility grievance files were reviewed for the past six months. The clinical record was reviewed for one resident. Four residents and three residents' family members were interviewed. Two facility staff members were interviewed. General observations were made of residents and staff interactions throughout the facility during the survey.

There were no documented grievances pertaining to privacy at physician appointments. There were no concerns verbalized regarding privacy or physician appointments. Facility staff interacted appropriately and respected residents' privacy when observed throughout the survey.

Michael Crowley, Administrator
February 20, 2019
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One resident's clinical record did not document any concerns regarding privacy, although it did document the resident had anxiety about being transported to a doctor's appointment. During an interview, one facility staff member stated there was no policy or direction regarding non-medical staff accompanying a resident into a physician's appointment. The facility staff member said there was an instance where an office nurse was speaking to her in the presence of a resident and his family member regarding getting the resident to the hospital for diagnostic testing procedures. The facility staff member said she was unaware of any issues with the resident or his family member at that time; however, after the appointment she was informed the resident and his family member did not want her to accompany them into the room in future appointments. The facility staff member said she did not accompany the resident into any other physician appointments and there were no further issues.

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

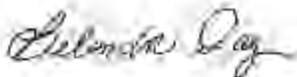
CONCLUSIONS:

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