



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
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June 15, 2018

CORRECTED LETTER

Emily Engberson, Administrator
Advanced Health Care Of Coeur D'Alene Llc
1578 W Riverstone Drive,
Coeur D'Alene, ID 83814

Provider #: 135142

Dear Ms . Engberson:

On **June 1, 2018**, a survey was conducted at Advanced Health Care Of Coeur D'Alene Llc by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Emily Engberson, Administrator
June 15, 2018
Page 2

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 **June 25, 2018**. Failure to submit an acceptable PoC by **June 25, 2018**, may result in the imposition of additional civil monetary penalties by **July 18, 2018**.

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

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

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

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

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

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

Denial of Payment for new admission September 1, 2018

Emily Engberson, Administrator
June 15, 2018
Page 3

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 1, 2018**, if substantial compliance is not achieved by that time.

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

Your facility's noncompliance with the following:

F0883 -- S/S: F -- 483.80(d)(1)(2) -- Influenza And Pneumococcal Immunizations

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **#134, #179, #180 #182, #184** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required

Emily Engberson, Administrator
June 15, 2018
Page 4

information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

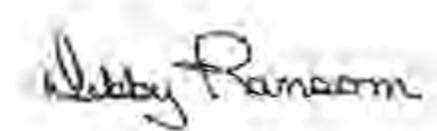
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **June 25, 2018** . If your request for informal dispute resolution is received after **June 25, 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/
Enclosures

cc: Chairman, Board of Examiners - Nursing Home Administrators

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

PRINTED: 07/06/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/01/2018
NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF COEUR D'ALENE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1578 W RIVERSTONE DRIVE COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted May 30, 2018 to June 1, 2018. The surveyors conducting the survey were: Teresa Kobza, RDN/LD, Team Coordinator Cecilia Stockdill, RN Teri Hobson, RN Abbreviations: CDC = Center for Disease Control and Prevention CDM - Certified Dietary Manager CNA = Certified Nursing Assistant DON = Director of Nursing FDA = Food and Drug Administration IM = Intramuscular (injection) I&O = Input and Output LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams mmhg = millimeters of mercury PICC = Peripherally Inserted Central Catheter RD = Registered Dietician RN = Registered Nurse TAR = Treatment Administration Record	F 000			
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any	F 604		7/13/18	

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

TITLE

(X6) DATE

Electronically Signed

06/22/2018

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 604	<p>Continued From page 1</p> <p>physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident and family interview, record review, and policy review it was determined the facility failed to ensure residents were assessed, and consents obtained, prior to the initiation of bed and chair alarms. This was true for 3 of 4 (#24, #132, and #184) residents sampled for restraint. This had the potential for harm if position change devices were improperly used and if the resident experienced a psychological decline due to feelings of being restricted in movement.</p>	F 604	<p>F604 Patient Specific: Resident 24: Body alarms have been discontinued as of 6/2/18. Resident 132: discharged Resident 184: discharged</p> <p>Systemic Changes: Assessments, consents and care plans will be completed prior to the implementation of body alarms.</p>		

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F 604	<p>Continued From page 2</p> <p>Findings include:</p> <p>The facility's policy and procedure for Physical Restraints and Adaptive Equipment, dated 2/27/18, documented the following:</p> <ul style="list-style-type: none"> * The licensed nurse would evaluate the necessity of the restraint/assistive device. * The resident, resident's family, physician, and interdisciplinary team would be consulted. * Evaluation would include "exhaustion of less restrictive measures, contributing environmental factors and adaptation, appropriateness of use, potential benefits and adverse effects, behavioral modification or management alternatives and their effectiveness, as well as the purpose and nature of the intervention and procedures for proper use." * Informed consent would be obtained from the resident, family, or legal representative, and the consent would include the rationale for use, conditions where the intervention could be discontinued, and potential hazards or adverse effects of the intervention. <p>The facility's policy and procedure for Fall Prevention, dated 2/27/18, documented the following:</p> <ul style="list-style-type: none"> * The licensed nurse could initiate safety alarms at any time if the device could reduce the risk of falls. * Safety alarms would be added to the TAR, indicating the type of alarm, site of the alarm use, and frequency/duration of use. * The licensed nurse would be responsible to make certain the alarm was used as care planned and sign the TAR to indicate the alarm 	F 604	<p>Reviewed all current patients and corrected as appropriate. Staff in-servicing will be provided</p> <p>Surveillance: DON or designee will audit to ensure assessment, consent and care plan was completed prior to initiating alarms weekly for 3 weeks and monthly x 4. Results and recommendations will be reported to the quarterly QA committee.</p>		

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F 604	<p>Continued From page 3 placement and functioning have been verified. * The CNA would be responsible for placement and maintenance of the alarm.</p> <p>The above policies were not followed. Examples include:</p> <p>1. Resident #24 was admitted to the facility on 4/12/18 with multiple diagnoses, including cerebral infarction (stroke) and Parkinson's disease.</p> <p>Resident #24's Event Report documented he had an unwitnessed fall on 5/14/18 at 6:57 PM when he attempted to self-transfer in his room. New interventions were initiated after the fall, including chair and bed pressure alarms.</p> <p>Resident #24's Physician Order Report, documented a 5/15/18 order for a pressure alarm to his bed and wheelchair and instructed staff to check placement of the alarms every shift.</p> <p>Resident #24's TAR documented a pressure alarm to his bed and wheelchair and to verify placement every shift, and it was signed as completed each day from 5/15/18 through 5/27/18.</p> <p>On 5/31/18 at 3:36 PM, Resident #24 was lying in bed and the pressure alarm was not present.</p> <p>On 5/31/18 at 3:54 PM, LPN #2 said Resident #24's pressure alarm was used at night because he was up in his chair during the day. LPN #2 said Resident #24 was doing better and had not had any recent issues. LPN #2 said there was an order for a pressure alarm for Resident #24. LPN</p>	F 604			

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F 604	<p>Continued From page 4</p> <p>#2 said she did not know why the alarm was not there, and the more appropriate thing to do was to write a note to the doctor to discontinue the alarm. LPN #2 said the CNAs should put the alarm in place, and it was her responsibility to make sure the alarm was there.</p> <p>On 5/31/18 at 4:00 PM, the DON said if a pressure alarm was ordered, it was her expectation that staff make sure the alarm was in place and working.</p> <p>On 5/31/18 at 4:46 PM, Resident #24's clinical record did not document consent for use of a pressure alarm or assessment for safety of the alarm being used.</p> <p>On 6/1/18 at 8:19 AM, the pressure alarm was in place on Resident #24's bed, and Resident #24's family member said the resident did not like the alarm and she was not aware of the bed alarm being used before the facility called her 5/31/18 and asked her to sign a consent for the alarm. A Safety Alarm Utilization Assessment and Consent form documented Resident #24 was assessed and his family member signed a consent for use of the pressure alarm on 5/31/18. Resident #24's family member said she signed the consent when she came in the evening of 5/31/18, after the alarm was in place.</p> <p>The facility failed to ensure Resident #24 was assessed and consent was garnered prior to initiation of the bed and wheelchair alarms.</p> <p>2. Resident #132 was admitted to the facility on 5/8/18 with multiple diagnoses, including epilepsy and hypotension (low blood pressure).</p>	F 604			

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

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F 604	Continued From page 5 Resident #132's care plan documented "Equip resident with device that monitors rising" was started on 5/8/18. A Fall Risk Protocol and Care Plan documented safety alarms were applied to Resident #132's bed and wheelchair per the request of Resident #132's family member, and was signed by a nurse on 5/8/18. Resident #132's Event Report documented he fell on 5/20/18 at 11:05 AM when he attempted to self-transfer. A pressure alarm was placed on Resident #132's wheelchair, bed, and recliner after the fall. Resident #132's Physician Order Report included an order dated 5/20/18, for a pressure alarm to his bed, recliner, and wheelchair and directed staff to verify placement of the alarms every shift. Resident #132's TAR documented the pressure alarm to his bed, recliner, and wheelchair, and for staff to verify placement every shift. It was signed as completed each day from 5/20/18 through 5/30/18. On 5/30/18 at 9:12 AM and at 11:02 AM, Resident #132 was in bed and an alarm was in place on his bed and recliner. On 5/31/18 at 8:25 AM, Resident #132 was in bed with a pressure alarm in place. At that time, DON said there was not a policy in place for use of alarms, and they were not using a signed consent for residents to have an alarm. The DON said the facility did not view alarms as a restraint.	F 604			

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F 604	<p>Continued From page 6</p> <p>The DON said the facility used an alarm if the resident was a high fall risk or if the resident's family requested it.</p> <p>Resident #132's clinical record did not include an assessment for the use of safety alarms or documentation that the resident or his family member signed consent for use of the alarms.</p> <p>3. Resident #184 was readmitted to the facility on 5/12/18, for aftercare following a hip fracture sustained during a fall at home. The resident's diagnoses included heart disease, dementia, and seizures.</p> <p>An admission MDS assessment dated 5/12/18, documented Resident #184 was confused and had a moderate cognitive deficit.</p> <p>Resident #184's care plan documented alarms on his bed and wheelchair were initiated on admission, 5/12/18.</p> <p>On 5/29/18 at 10:27 AM, Resident #184 was observed to have a chair alarm on his wheelchair.</p> <p>Resident #184's Event Report dated 5/28/18, documented an unwitnessed fall while trying to reach his phone at bedside. A nursing progress note dated 5/28/18, documented Resident #184 fell out of bed and landed on his knees.</p> <p>On 5/30/18 at 11:23 AM, the DON stated the alternative measures she would try prior to initiation of alarms, were to change the time of therapy, provide a toileting schedule, or provide every two hour checks at night to prevent falls.</p>	F 604			

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F 604	Continued From page 7 A progress note dated 5/31/18, documented Resident #184 was confused, unable to make needs known, was very impulsive, unable to use his call light, and had poor safety awareness. The note documented a pressure alarm was on his bed and chair. The facility provided a Safety Alarm Utilization Assessment and consent signed by Resident #184 on 5/31/18. The assessment and consent documented under "Additional Comments", that Resident #184's wife was "involved in the pressure alarm implementation." The facility documented decreased safety awareness and multiple falls at home as a reason for the use of the alarms. Alternatives were listed as toilet every two hours, bed in lowest position, fall mats, turn every two hours, PT evaluation, and physician evaluation. The assessment documented the reason alternatives were not effective, was Resident #184 continued to attempt to self-transfer regardless of interventions.	F 604			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		7/13/18	

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F 656	<p>Continued From page 8</p> <p>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 -</p> <p>(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</p> <p>(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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care 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: Based on record review, policy review, and staff interview, it was determined the facility failed to</p>	F 656	F656 Patient Specific:		

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F 656	<p>Continued From page 9</p> <p>ensure comprehensive resident-centered care plans included CPR choice, use of a nebulizer and pressure alarm. This was true for 3 of 12 sampled residents (#24, #132 and #184) whose care plans were reviewed. This failure created the potential for harm should residents receive inappropriate or inadequate care. Findings include:</p> <p>The facility's Comprehensive Care Plan Policy Statement, dated 2/27/18, documented "All items of services ordered to be provided or withheld shall be included in each resident's plan of care."</p> <p>Resident #24 was admitted to the facility on 4/12/18 with multiple diagnoses, including cerebral infarction (stroke), Parkinson's disease, and shortness of breath.</p> <p>Resident #24's Physician Order Report, dated 4/12/18-5/31/18, documented the following:</p> <ul style="list-style-type: none"> * 5/15/18 - Pressure alarm to his bed and wheelchair and to check placement of the alarms every shift * 4/12/18 - Ipratropium-albuterol solution for nebulization (a breathing treatment) 0.5 mg/3 ml (milliliters) four times a day as needed. <p>Resident #24's current care plan did not document the pressure alarm or need for a breathing treatment.</p> <p>On 5/31/18 at 10:54 AM, the DON said the pressure alarm and breathing treatment should be on the care plan and she did not see them documented on the care plan.</p>	F 656	<p>Resident 24: Care plan updated to reflect discontinuation of body alarms and use of nebulizer.</p> <p>Resident 184: Discharged</p> <p>Resident 132: Discharged</p> <p>Systemic Changes: Nursing staff will be in-serviced regarding updating patient care plans as new orders are received. Advanced directives will be care planned; all current patients have been reviewed and corrected as appropriate. Admission nurse has been educated regarding care plan for advanced directive</p> <p>Surveillance: DON or designee will audit new patients admitting to the facility to ensure the advanced directives are care planned weekly for 4 weeks and monthly x 4. Results and recommendations will be reported to the quarterly QA committee.</p>		

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F 656	<p>Continued From page 10</p> <p>On 5/31/18 at 11:07 AM, the MDS Nurse said if a new order was written, a paper form came to her and that indicated the care plan should be updated. She said she did not see the orders for Resident #24's pressure alarm or breathing treatment. The MDS Nurse said she only had to update the care plan every 90 days, and she did not always put a breathing treatment on the care plan unless the resident was unable to hold on to the breathing treatment independently.</p> <p>Resident #24's care plan did not comprehensively address items ordered by the physician, and it did not direct staff in providing appropriate care in the areas of pressure alarms and breathing treatments.</p> <p>2. Resident #184 was readmitted to the facility on 5/12/18, with multiple diagnoses which included heart disease, dementia, and seizures.</p> <p>A baseline care plan dated 5/12/18, documented Resident #184 as a Full Code.</p> <p>Resident #184's comprehensive care plan dated 5/12/18, did not include documentation of his advance directives.</p> <p>The facility's Advance Directives Policy dated 2/27/18, documented the facility would notify the physician of advance directives so the appropriate orders may be documented in the resident's medical record and care plan.</p> <p>On 6/1/18 at 11:15 AM, the Regional Director of Nursing stated that the comprehensive care plan did not include Resident #184's advanced directives.</p>	F 656			

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F 656	Continued From page 11 3. Resident #132 was admitted to the facility on 5/8/18 with multiple diagnoses, including epilepsy and hypotension (low blood pressure). Resident #132's Physician Order Report, dated 4/30/18-5/30/18, documented a code status of Full Code. Resident #132's Idaho Physician Orders for Scope of Treatment (POST) documented a Full Code status with aggressive interventions, and was signed by the resident's family member on 5/8/18. Resident #132's comprehensive care plan, last revised 5/18/18, did not document his code status. On 5/31/18 at 9:48 AM, the DON said when residents were admitted they were given a POST form and their code status was on the interim care plan. The DON said the MDS nurse did the comprehensive care plan and would be the one to ask about incorporating the resident's code status on the comprehensive care plan. On 5/31/18 at 9:50 AM, the MDS Nurse said as long as she had been there (approximately one year) she had not put advanced directive information on the comprehensive care plan. The MDS Nurse said she had not been directed to do so, and did not know where to find the advance directives information in the electronic record system.	F 656			
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		7/13/18	

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F 684	<p>Continued From page 12</p> <p>§ 483.25 Quality of care</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and clinical record review, it was determined the facility failed to ensure professional standard of practice related to hypertension monitoring, diabetic management, and PICC line maintenance and site monitoring. This was true for 3 of 4 (#22, #29, #184) residents reviewed for professional standards of practice. These failed practices had the potential to result in adverse resident outcomes and uncertainty of the events leading up to a residents death. Findings include:</p> <p>1. Resident #22 was admitted to the facility 4/23/18, with multiple diagnoses including diabetes, endocarditis (inflammation around the heart), and bacteremia (bacteria in the blood), and congestive heart failure.</p> <p>An admission MDS assessment dated 4/30/18, documented Resident #22 was cognitively intact.</p> <p>a. Resident #22's care plan documented a goal for his blood glucose levels to range between 60-100 and be absent signs and symptoms of hypoglycemia. The care plan documented to see the physician's orders for administration of medications related to diabetes.</p>	F 684	<p>F684</p> <p>Patient Specific: Resident 22: Discharged Resident 184: Discharged Resident 29: Discharged</p> <p>Systemic Changes: 1. A task for PICC Line Site Assessment will be added to the TAR to ensure proper assessment. 2. Hypoglycemia/Hyperglycemia protocols will be added to the patient general orders. a. Received telephone order to follow hypoglycemia/hyperglycemia protocols for current patients</p> <p>Staff In-Serviced regarding: 1. Initiating Neurological Assessment for all un-witnessed falls 2. Hypoglycemia/hyperglycemia policy 3. PICC line assessments and documentation 4. Documentation and notification of changes in condition; in the event a patient has a baseline of abnormal vitals,</p>		

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F 684	<p>Continued From page 13</p> <p>The facility's Hypoglycemia/Hyperglycemia Policy dated 3/12/18, documented the following:</p> <ul style="list-style-type: none"> * If an alert resident's blood glucose level was less than 80, the resident should be given 1 serving of glucose gel or a half cup of juice or soft drink (not diet). * Recheck the resident's blood glucose every 15 minutes, (up to four times) prior to calling the physician. * If the resident was unconscious the resident was to be given 1 mg Glucagon IM if blood glucose is less than 80. * If the resident does not awaken in 15 minutes, give another dose of Glucagon (1 mg IM) and notify emergency services immediately. * As soon as the resident awakens give a protein snack when able to safely swallow. * Notify the physician of the event, interventions, and outcome. <p>Resident #22's active physician orders for administration of a glucose sliding scale, included an order with a start date 4/32/18, which documented if his pre-meal blood glucose level was less than 120, insulin was not to be administered. The orders did not include further instructions related to hypoglycemic events. Resident #22's care plan stated to maintain a blood glucose range of 60-100. The facility policy documented interventions were to be initiated if a resident experienced a blood glucose level of less than 80. Resident #22's physician orders did not clarify when, or if, the interventions in the facility's Hypoglycemia/Hyperglycemia Policy, were to be initiated if Resident #22's blood glucose levels ranged between 60 and 79.</p>	F 684	<p>the physician will be contacted and parameters for notification will be established.</p> <p>Surveillance: DON or designee will audit compliance weekly for 4 weeks and monthly x 4. Audit will include PICC Line observation in addition to documentation reviews. Results and recommendations will be reported to the quarterly QA committee.</p>		

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F 684	<p>Continued From page 14</p> <p>The physician orders, additionally, did not address actions staff were to take if Resident #22's blood glucose level fell below 60.</p> <p>On 5/30/18 at 2:40 PM, the DON stated nurses had access to standing diabetic orders to call the physician if a residents' glucose level is less than 60.</p> <p>b. The facility's Intravenous Access Device Maintenance Protocol, dated 12/15/17, documented PICC lines were to be flushed with saline before and after each use.</p> <p>Resident #22's May 2018 Physician orders documented he was to receive IV antibiotics twice a day.</p> <p>Resident #22's care plan dated 4/23/18, did not address the PICC line, flushes of the two lumens, or assessment of the PICC site.</p> <p>Flushes (prior to and after antibiotic administration) of the double lumen PICC line site were not documented 27 of 60 shifts in May 2018.</p> <p>The facility did not document assessments of the PICC line site 32 of 60 shifts in the month of May 2018.</p> <p>On 5/31/18 at 2:40 PM, the DON stated she would expect nurses to follow the protocol regarding flushing a PICC line before and after use, and monitor a PICC line site for infection.</p> <p>c. Resident #22's care plan dated 4/23/18, documented Resident #22's intake and output was to be monitored every shift.</p>	F 684			

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F 684	<p>Continued From page 15</p> <p>Resident #22's physician order, dated 4/23/18, documented he was on Lasix (diuretic) 40 mg by mouth twice a day.</p> <p>A Vitals Report for May 2018 documented Resident #22 had multiple intakes daily. The report did not include documentation of Resident #22's urinary output.</p> <p>On 6/1/18 at 10:48 AM, the DON stated documentation of Resident #22's urinary output was not documented in May 2018 as directed in his care plan.</p> <p>2. Resident #184 was admitted to the facility on 5/12/18, with multiple diagnoses that included repeated falls, seizures, dementia, and atherosclerotic (plaque build up in arteries) heart disease.</p> <p>The facility's Accident and Incident Policy, dated 1/1/16, documented a resident who experienced an unwitnessed fall or a fall in which the resident head was bumped, hit or otherwise injured, would have a neurological assessment completed for a total of 72 hours.</p> <p>An Event Report dated 4/12/18, documented Resident #184 experienced an unwitnessed fall in the hallway. The Event Report documented neurological checks were started. Documentation of the neurological checks was not found in Resident #184's clinical record.</p> <p>On 6/1/18 at 11:21 AM, the DON stated she was unable to locate documentation of the neurological assessments related to Resident</p>	F 684		

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F 684	<p>Continued From page 16 #184's 4/12/18 fall.</p> <p>3. Resident #29 was admitted to the facility on 4/2/18 with multiple diagnoses which included severe aortic stenosis (narrowing of the aortic value which reduces blood flow). Resident #29 passed away on 4/8/18.</p> <p>A Nurse's Progress Note, dated 4/6/18 at 11:34 PM, documented Resident #29 was alert and oriented and had no complaints of discomfort or pain.</p> <p>A Nurse's Progress Note, dated 4/8/18 at 11:18 PM, documented, "Resident is declining and family request Hospice. Hospice was contacted by [the] dayshift LPN and will evaluate tomorrow. Family at bedside until 1700 (5:00 PM). Resident expired at 1900 (7:00 PM)...."</p> <p>Resident #29's Vital Signs documented her blood pressure as follows:</p> <ul style="list-style-type: none"> * 4/6/18 at 9:03 AM- 107/62 mmHg * 4/7/18 at 7:53 AM- 76/49 mmHg * 4/7/18 at 7:11 PM- 102/60 mmHg * 4/8/18 at 8:28 AM- 100/66 mmHg * 4/8/18 at 1:34 PM- 103/67 mmHg * 4/8/18 at 3:24 PM- 82/56 mmHg <p>Further documentation of Resident #29's change in condition and related events was not found in her clinical record.</p> <p>On 6/1/18 at 7:39 AM, the DON stated she was unaware facility nurses did not document Resident #29's change of condition assessments, family involvement, or coordination</p>	F 684			

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F 684	Continued From page 17 of care with the physician in the nurses' progress notes during the last 48 hours of Resident #29's life. The DON stated the facility nurses should have documented Resident #29's condition throughout the rest of 4/6/18 to 4/8/18 when Resident #29 passed away. The DON stated the nurses' notes should have included physician notifications of low blood pressures and her change of condition from 4/6/18 to 4/8/18.	F 684			
F 686 SS=D	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 by: Based on observation, staff interview, policy review and record review, it was determined the facility failed to consistently implement the plan of care for pressure ulcer prevention for 1 of 3 residents (#132) reviewed for pressure ulcers. This failure created the potential for harm should Resident #132 develop pressure ulcers to the heels. Findings include: The facility's policy and procedure for pressure	F 686	F686 Patient Specific: Resident 132: Discharged Systemic Changes: Nursing spreadsheets will be updated to include skin breakdown prevention interventions and serve as a quick reference for interventions on each patient. Nursing staff will be in-serviced	7/13/18	

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F 686	<p>Continued From page 18</p> <p>ulcer prevention, dated 2/27/18, documented "Patients will receive care consistent with professional standards of practice to prevent pressure ulcers and/or ensure patients do not develop pressure ulcers unless the individual's clinical condition demonstrates they are unavoidable." The policy also documented "Residents having pressure ulcers receive necessary treatment and services to promote healing, prevent infection and [prevent] new pressure ulcers from developing."</p> <p>Resident #132 was admitted to the facility on 5/8/18 with multiple diagnoses, including weakness, atrial fibrillation (irregular heartbeat), and hypotension (low blood pressure).</p> <p>Resident #132's care plan directed staff to use a heel riser as needed to relieve pressure on the heels.</p> <p>A physician order, dated 5/8/18, documented Resident #132 was to have a heel riser when in bed and staff were to verify placement of the heel riser every shift.</p> <p>Resident #132's Progress Notes documented wound care was provided to his left great toe on 5/25/18 at 4:48 PM for a non-healed stage 3 pressure ulcer (full thickness skin loss).</p> <p>On 5/30/18 at 11:02 AM, Resident #132 was asleep on his bed and the heel riser was not in place.</p> <p>On 5/30/18 at 2:08 PM, Resident #132 was sleeping on his bed and the heel riser was not in place.</p>	F 686	<p>regarding the responsibility to ensure interventions are in place. Current patients have been reviewed and corrected as necessary.</p> <p>Surveillance: DON or designee will audit compliance weekly for 6 weeks and monthly x 4. Audit will include observation of patients and equipment to ensure interventions are being implemented and used appropriately. Results and recommendations will be reported to the quarterly QA committee.</p>		

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F 686	Continued From page 19	F 686			
F 689 SS=D	<p>On 5/30/18 at 2:23 PM, Resident #132 was asleep on his bed and the heel riser was not in place. At that time, RN #1 said Resident #132 had a pressure ulcer on his toe and staff should make sure he is not on pressure areas. LPN #3, also present, said Resident #132's heel riser should be in place anytime he was in bed.</p> <p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§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</p> <p>§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, staff interview, and record review, it was determined the facility failed to ensure residents received sufficient supervision to prevent falls and were provided safety equipment necessary to reduce potential injuries from falls. This was true for 1 of 3 residents (#24) reviewed for supervision and accidents. These failed practices placed residents at risk of bone fractures and other injuries related to fall. Findings include: 1. The facility's policy and procedure for Fall Prevention, dated 2/27/18, documented the following:</p> <p>* The licensed nurse would be responsible to make certain the alarm was used as care planned and sign the TAR to indicate the alarm</p>	F 689	<p>F689 Patient Specific: Resident 24: Patient has refused fall mats and alarms, use of both interventions have been discontinued and care plan updated.</p> <p>Systemic Changes: Nursing spreadsheets will be updated to include fall prevention interventions and serve as a quick reference for interventions on each patient. Nursing staff will be in-serviced regarding the responsibility to ensure interventions are in place. Current patients have been reviewed and corrected as necessary.</p>	7/13/18	

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F 689	<p>Continued From page 20</p> <p>placement and functioning have been verified. * The CNA would be responsible for placement and maintenance of the alarm.</p> <p>Resident #24 was admitted to the facility on 4/12/18 with multiple diagnoses, including cerebral infarction (stroke) and Parkinson's disease.</p> <p>Resident #24's Event Report documented he had an unwitnessed fall on 5/14/18 at 6:57 PM when he attempted to self-transfer in his room. New interventions were initiated after the fall, including chair and bed pressure alarms.</p> <p>Resident #24's Physician Order Report, documented a 5/15/18 order for a pressure alarm to his bed and wheelchair and instructed staff to check placement of the alarms every shift.</p> <p>Resident #24's care plan directed staff to place fall mats beside the bed when the resident was in bed.</p> <p>On 5/31/18 at 3:36 PM, Resident #24 was lying in bed, and the pressure alarm and fall mats were not present.</p> <p>On 5/31/18 at 3:54 PM, LPN #2 said Resident #24's pressure alarm was used at night because he was up in his chair during the day. LPN #2 said Resident #24 was doing better and had not had any recent issues. LPN #2 said there was an order for a pressure alarm for Resident #24. LPN #2 said she did not know why the alarm was not there, and the more appropriate thing to do was to write a note to the doctor to discontinue the alarm. LPN #2 said the CNAs should put the</p>	F 689	<p>Surveillance: DON or designee will audit compliance weekly for 6 weeks and monthly x 4. Audits will include observation of patient and room to ensure interventions are being utilized as ordered. Results and recommendations will be reported to the quarterly QA committee.</p>		

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NAME OF PROVIDER OR SUPPLIER ADVANCED HEALTH CARE OF COEUR D'ALENE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1578 W RIVERSTONE DRIVE COEUR D'ALENE, ID 83814		
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F 689	Continued From page 21 alarm in place, and it was her responsibility to make sure the alarm was there. On 5/31/18 at 4:00 PM, the DON said if a pressure alarm was ordered, it was her expectation that staff make sure the alarm was in place and working.	F 689			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of a resident's meal ticket, it was determined the facility failed to document a resident's meal intake, food allergies on meal tickets, and offer alternative meals to meet	F 692	F692 Patient Specific: Resident 181: Discharged Systemic Changes:	7/13/18	

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F 692	<p>Continued From page 22</p> <p>resident's nutritional needs. This was true for 1 of 4 residents reviewed for nutrition. Resident #181 was at risk for harm due to malnutrition related to poor dietary intake. Findings include:</p> <p>1. Resident #181 was admitted to the facility on 5/22/18, with multiple diagnoses including compression fracture of the a lumbar vertebrae, acute pain due to trauma, and GERD.</p> <p>An MDS assessment dated 5/23/18, documented Resident #181 was cognitively intact and being provided choices was very important to her.</p> <p>An admission nutrition services review dated 5/23/18, documented Resident #181 had an admission weight of 93 pound. The review also listed Resident #181's allergies as gluten, lactose, soy, night shade vegetables (such as potatoes, tomatoes, peppers, eggplant, tomatillo, goji berries, pimentos), fresh fruits, and pork.</p> <p>A Vitals Results document showed Resident #181 missed 11 of 21 meals between 5/23/18 and 5/30/18. The document also noted Resident #181 missed lunch and dinner on 5/24/18 and on 5/25/18 ate only 26% - 50% of her lunch and missed the dinner meal.</p> <p>On 5/30/18 at 1:43 PM, the RD stated Resident #181 needed a supplement, but the facility did not provide them. She said if Resident #181 needed a special dietary supplement, the family would be asked to purchase it and bring it in.</p> <p>An Event Report dated 5/30/18, documented Resident #181 needed a supplement because she was not getting the nutrition she needed, due</p>	F 692	<p>1. Meal tickets will include allergies</p> <p>2. Dietary Manager will document alternates offered for patients with poor intake.</p> <p>3. C.N.A charting will require meal intake recording</p> <p>Education provided to appropriate staff regarding charting of meal intake and documentation of alternates offered.</p> <p>Surveillance: Administrator or designee will audit compliance weekly for 6 weeks and monthly x 4. Results and recommendations will be reported to the quarterly QA committee</p>		

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F 692	Continued From page 23 to her poor dietary intake. It also stated that she refused the first type of supplement offered. On 5/30/18 at 3:10 PM, the RD stated she realized that after reviewing Resident #181's record, Resident #181's dietary needs should be re-evaluated. She stated she understood that the resident had the right to have supplements without being charged extra or have her family bring them in for her. On 5/30/18 at 4:01 PM, the CDM provided Resident #181's dinner meal ticket for 5/30/18. The dinner meal ticket did not include Resident #181's allergies to soy, night shade vegetables, or fresh fruits. On 5/30/18 at 4:10 PM, the RD stated she knew what night shade vegetables were and it was Resident #181's preference not to eat them and that Resident #181 was not allergic to them. The RD stated Resident #181's record did not include documentation that alternative meal options were offered or that the resident had refused missed meals.	F 692			
F 695 SS=B	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		7/13/18	

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F 695	<p>Continued From page 24</p> <p>by: Based on staff interview, and record and policy review, it was determined the facility failed to ensure oxygen saturation levels (the percentage of oxygen measured in the body) were sufficiently monitored. This was true for 1 of 1 resident (#132) reviewed for use of oxygen, when no oxygen saturation values were documented and the use of oxygen was based on the oxygen saturation result. This failed practice created the potential for harm should the resident not receive oxygen when required. Findings include:</p> <p>The facility's policy and procedure for oxygen administration, dated 3/12/18, documented the following:</p> <ul style="list-style-type: none"> * Confirm there is a physician order to administer oxygen. * The order must include liter flow of oxygen with "parameters, frequency, and duration of oxygen." * Review the physician's order/facility protocol regarding oxygen administration. * Review the care plan regarding any special needs the resident has. * Prior to administering oxygen and while oxygen is being administered, assess signs and symptoms of low oxygen or oxygen toxicity, vital signs, lung sounds, oxygen saturation, and other laboratory results. <p>Resident #132 was admitted to the facility on 5/8/18 with multiple diagnoses, including chronic obstructive pulmonary disease (a lung disease) and atrial fibrillation (irregular heart rhythm).</p> <p>Resident #132's Physician Order Report, dated 4/30/18- 5/30/18, documented oxygen at 2 liters</p>	F 695	<p>F695 Patient Specific: Resident 132: Discharged</p> <p>Systemic Changes: When oxygen saturations are being monitored, results will be documented in the medical record. Current patients have been reviewed and corrected as necessary. Nursing staff have been in-serviced regarding documentation of oxygen saturation.</p> <p>Surveillance: DON or designee will audit compliance weekly for 3 weeks and monthly x 4. Audit will include a record review to ensure proper documentation. Results and recommendations will be reported to the quarterly QA committee.</p>		

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F 695	<p>Continued From page 25</p> <p>per minute to maintain oxygen saturation above 90 percent and instructed staff to document the liters per minute every shift.</p> <p>Resident #132's care plan directed staff to administer oxygen per the physician's orders and monitor oxygen saturation as ordered.</p> <p>Resident #132 was observed to not have oxygen in place on 5/29/18 at 1:13 PM, 5/30/18 at 9:12 AM, and 5/31/18 at 9:05 AM.</p> <p>Resident #132's TAR, dated 5/1/18-5/30/18, documented oxygen saturation levels were checked every shift from 5/8/18 through 5/30/18. There were no values documented to indicate what the oxygen saturation levels were for Resident #132.</p> <p>On 5/30/18 at 4:13 PM, LPN #3 said staff should check Resident #132's oxygen saturation every shift.</p> <p>On 5/30/18 at 4:33 PM, the DON said the order was to check Resident #132's oxygen saturation every shift, and it was signed as being done but she would have to look for the results of the oxygen saturation being documented. The DON said the nurse was checking the oxygen saturation every shift, and if the oxygen saturation was below 90 it would be documented under the PRN (as needed) section on the TAR. The DON said there was nothing documented under the PRN section because Resident #132's oxygen saturation levels had not dropped below 90. The DON said the order should have been set up to force staff to enter a value for the oxygen saturation and it was not. The DON said</p>	F 695			

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F 695	Continued From page 26 there was no documentation of the oxygen saturation values but she knew staff were completing the assessments.	F 695			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it is determined the facility failed to ensure adequate communication was provided to a dialysis center. This was true for 1of 1 resident (#180 reviewed for dialysis. The failure created the potential for harm when the facility failed to provide communication of a resident's current care, medications, access site, and orders were provided to the dialysis center. Findings include: Resident #180 was admitted to the facility 5/21/18 with diagnoses which included dependence on dialysis. On 6/1/18 at 11:30 PM the DON provided an active continuously changing report that she said was provided to the dialysis center for Resident #180 every visit. The document provided the current medication, assessments, and intake and output for the resident. All computerized information was updated daily and automatically populated into the report. On 6/1/18 at 11:30 AM, the DON stated she did	F 698	F698 Patient Specific: Resident 180: Discharged Systemic Changes: Order will be added to the TAR to ensure proper records are sent to dialysis with the patient. Current patients receiving dialysis care have been reviewed and corrected as necessary. Surveillance: DON or designee will audit compliance weekly for 3 weeks and monthly x 4. Audit will include observation of patient leaving for dialysis to ensure proper documents accompany them to appointment. Results and recommendations will be reported to the quarterly QA committee.	7/13/18	

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F 761	<p>Continued From page 28</p> <p>for administration to residents and expired biological supplies (lab specimen tubes) were not available for resident use. This was true for one of one medication storage rooms when seven vials of influenza vaccine were expired and multiple lab specimen tubes were expired. This failed practice had the potential to affect 12 of 12 sampled residents who received medications (#12, #22, #24, #131, #132, #133, #136, #140, #180, #181, #184, and #185) and 20 other residents who resided in the facility. This failed practice created the potential for harm should residents receive expired medications with decreased efficacy and inaccurate laboratory results if a lab samples were collected in expired laboratory tubes. Findings include:</p> <p>The facility's policy and procedure for Medication Storage, dated 2/27/18, documented "outdated, contaminated, or deteriorated medications... are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy..."</p> <p>On 6/01/18 at 10:06 AM, the medication storage room was inspected. The medication refrigerator contained seven vials of Flulaval Quadrivalent Influenza Vaccine that expired April 2018. One of the Influenza Vaccine vials was previously opened and the remaining six vials were intact. Multiple lab specimen tubes were found expired, including the following:</p> <p>* Universal Viral Transport for Viruses, Chlamydiae, Mycoplasmas and Ureaplasmas expired on 10/2017. * Media for blood cultures expired on 10/31/17 and 12/31/17.</p>	F 761	<p>12,22,131,132,133,140,180,181,184,185: Discharged Residents: 24, 136: outdated vaccines and lab tubes were disposed of.</p> <p>Systemic Changes: Education was provided to the appropriate nursing staff to ensure disposal of outdated medications and lab tubes.</p> <p>Surveillance: DON or designee will audit compliance weekly for 3 weeks and monthly x 4. Results and recommendations will be reported to the quarterly QA committee.</p>		

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F 761	Continued From page 29 * BBL CultureSwab Collection and Transport System expired on 09/2017. * Multiple blood specimen tubes, including yellow, green, and purple top tubes that expired on 10/31/17 and 1/31/18. On 6/1/18 at 10:20 AM, LPN #2 said the expired influenza vaccines and expired lab tubes should not be in the medication room. LPN #2 said she did not know if any doses of expired influenza were given, and the staff did not use lab tubes very often because the lab routinely did lab draws.	F 761			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		7/13/18	

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F 812	<p>Continued From page 30</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure food was handled properly and maintained according to safe practices. This was true when the facility failed to ensure refrigerated foods were dated and covered, and Potentially Hazardous Food (PHF) cold food temperatures were assessed prior to service, and/or were stored at appropriate temperatures to prevent the growth of potential disease causing pathogens. These failed practices placed 12 of 12 sample residents (#12, #22, #24, #131, #132, #133, #136, #140, #180, #181, #184, and #185) and the other 20 residents who resided in, and dined in the facility, at risk of adverse health outcomes. Findings include:</p> <p>a. On 5/29/18 at 8:58 AM, during a brief kitchen tour, the following was observed:</p> <p>In the walk-in refrigerator:</p> <p>-Four 25 fluid ounce containers of juice concentrate (cranberry, orange, apple, and grape) uncovered and open to air. The top portion of each container had approximately a 2 inch by 3 inch opening at the top.</p> <p>On 5/29/18 at 9:08 AM, the CDM stated the juice containers should be covered and dated.</p> <p>b. The 2017 FDA Food Code, Chapter 3, Part 3-5, Limitation of Growth of Organisms of Public Health Concern, subpart 3-501.12 Time/Temperature Control for Safety Food, Slacking, documented, "(A) Under refrigeration that maintains the food temperature at 5 C (41 F [Fahrenheit]) or less..."</p>	F 812	<p>F812 Patient Specific: Residents 12,22,131,132,133,140,180,181,184,185: Discharged Residents: 24, 136: Cold temperature foods that are potentially hazardous are monitored</p> <p>Systemic Changes: Education was provided to the dietary staff on 6/8/18 regarding obtaining temperatures of potentially hazardous foods prior to service and the proper covering and labeling of food in the refrigerator.</p> <p>Surveillance: CDM or designee will audit compliance weekly for 6 weeks and monthly x 4; audit will include visual inspection of refrigerators to ensure proper covering and labeling, and observation of tray line to ensure proper food temperatures are recorded. Results and recommendations will be reported to the quarterly QA committee.</p>		

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F 812	<p>Continued From page 31</p> <p>On 5/31/18 at 11:45 AM, the lunch meal consisted of tri-tip roast, baked potatoes, broccoli florets, watermelon, a cottage cheese plate, a side chopped salad, and a roast beef salad sandwich. Cook #2 assessed the temperatures of the hot foods for the lunch meal and the food items were at appropriate temperatures. Cook #2 stated she was finished assessing the temperatures of the food items for lunch and proceeded to work on other tasks.</p> <p>On 5/31/18 at 11:53 AM, Cook #1 was asked to assess the temperatures of the cold food items. The cold food items were within acceptable temperatures, except for the roast beef salad sandwich. The roast beef salad was assessed to be 53.3 degrees F. Cook #1 placed the sandwiches in the refrigerator to chill until service.</p> <p>On 5/31/18 at 12:02 PM, Cook #2 stated she normally did not assess cold food temperatures prior to services. Cook #2 states she normally assessed the hot food only. Cook #2 stated it was facility practice to obtain the cold food items from the refrigerator and place them directly on ice to keep them cold. Cook #2 stated the cottage cheese, chopped salad, and the roast beef salad sandwiches from the 5/31/18 lunch meal were considered PHF and should be assessed for temperature.</p> <p>On 5/31/18 at 12:02 PM, Cook #1 removed the roast beef salad sandwiches from the refrigerator and plated a sandwich to be served to a resident. Cook #1 did not reassess the sandwich temperature and was attempting to pass the</p>	F 812			

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F 812	Continued From page 32 plate to be served to the nursing staff. Cook #1 was asked to assess the temperature of the sandwich and the sandwich temperature was 48.1 degrees F. Cook #1 stated the temperature was "okay" to be served and, "It was just on the border of the danger zone." Cook #2 overheard the conversation and stated the danger zone was less than 41 degrees F and the sandwiches should not have been served. On 5/31/18 at 12:19 PM, the CDM stated it was not facility practice to assess the temperature of all PHF unless the food items were apart of the menu. The CDM stated the sandwiches should not be served within the danger zone if there were directly out of the refrigerator. The CDM stated the staff should know what the danger zone of PHF foods.	F 812			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable	F 880		7/13/18	

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F 880	<p>Continued From page 33</p> <p>diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the</p>	F 880			

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F 880	<p>Continued From page 34 corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 of 2 sampled residents (#132) reviewed for dressing changes, when staff failed to perform effective hand hygiene during a dressing change. This failed practice created the potential for harm should residents experience infection from cross contamination. Findings include:</p> <p>The facility's policy and procedure for Application of Clean Dressings, dated 3/25/10, directed staff to do the following:</p> <p>* Wash hands thoroughly with soap and water before the procedure, before resuming the task after being interrupted, anytime they become soiled with blood or body fluids, when changing or removing gloves or personal protective equipment, whenever in doubt, and upon finishing the task. * "Maintain clean technique and isolation precautions as indicated."</p> <p>Resident #132 was admitted to the facility on</p>	F 880	<p>Patient Specific: Resident 132: Discharged</p> <p>Systemic Changes: Education was provided to the nurse immediately following the issues with hand hygiene. In-service for all licensed staff on proper hand hygiene while applying dressing. Audits were initiated to ensure compliance with all other nurses regarding the policy and procedure for Application of Clean Dressing. Audits include observation of wound care to ensure proper hand hygiene.</p> <p>Surveillance: DON or designee will audit compliance weekly for 6 weeks and monthly x 4. Results and recommendations will be reported to the quarterly QA committee.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 35</p> <p>5/8/18 with multiple diagnoses, including weakness, epilepsy and hypotension (low blood pressure).</p> <p>A Wound Healing Progress Note, dated 5/11/18, documented Resident #132 had a stage 3 pressure ulcer on his left great toe.</p> <p>Resident #132's Physician Order Report, dated 4/30/18-5/30/18, documented a wound to the left great toe, clean with normal saline, skin prep around the wound, apply Bacitracin ointment (antibiotic) and cover with a bordered gauze dressing once a day.</p> <p>Resident #132's care plan directed staff to "assess the pressure ulcer for location, stage, size (length, width, and depth), presence/absence of granulation tissue and epithelization (healing with new tissue). The care plan directed staff to look for and report signs of cellulitis (skin infection) such as pain, redness, swelling, drainage, fever, chills, discomfort, rapid heart rate, and low blood pressure.</p> <p>On 5/31/18 at 9:05 AM, LPN #1 prepared to change the dressing on Resident #132's left great toe. LPN #1 washed her hands, obtained a pair of gloves and walked toward the resident's bed. LPN #1 held the gloves in one hand, bent down and touched the fall mat on the floor next to the bed as she picked up an item with her bare hand. LPN #1 did not perform hand hygiene. She then applied the gloves on both hands. LPN #1 walked across the room and picked up a small trash can with her thumb inside the trash can and placed the trash can next to the resident's bed. LPN #1 moved the tray table closer to the bed,</p>	F 880			

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F 880	Continued From page 36 placed a blue pad under Resident #132's feet, removed the resident's sock and proceeded as if to remove the old dressing. The surveyor asked LPN #1 to pause and asked her if she was aware she had contaminated her hands then applied gloves over her contaminated hands. LPN #1 said she did not realize she touched the mat on the floor and after a brief time of consideration LPN #1 removed her gloves, cleansed hands and applied new gloves. On 6/1/18 at 9:25 AM, the DON said it was not acceptable for a nurse to touch the mat on the floor with her bare hand then apply gloves and proceed with changing a dressing. The DON said the nurse should have washed her hands then applied new gloves.	F 880			
F 883 SS=F	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883		7/13/18	

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F 883	<p>Continued From page 37</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and policy review, it was determined the facility failed</p>	F 883	<p>F883 Patient Specific:</p>		

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F 883	<p>Continued From page 38</p> <p>to develop and implement a process to minimize the risk of residents acquiring, transmitting, or experiencing complications from pneumococcal (bacterial) pneumonia. The facility failed to implement an immunization program that tracked resident's type of pneumococcal vaccine, so immunizations could be offered or provided as indicated. This was true for 5 of 5 (#134, #179, #180, #182, and #184) residents sampled for the pneumococcal immunizations and had the potential to affect all residents residing in the facility. This deficient practice placed residents at risk of developing pneumococcal pneumonia and developing subsequent serious, potentially life threatening, complications. Findings include:</p> <p>The Center for Disease Control and prevention (CDC) website, updated 11/22/16 recommendation for pneumococcal vaccination (PCV13 or Prevnar13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older that documented:</p> <p>* Adults 65 years who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23</p> <p>* If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most recent dose of PPSV23.</p> <p>The facility Immunization policy dated 4/27/15, documented if a resident had not received a pneumococcal vaccination per current CDC guidelines, the facility will offer the vaccination to the resident in accordance with the facility's</p>	F 883	<p>Residents 134,179,180,184: Discharged</p> <p>Systemic Changes: New consent for pneumococcal vaccinations was obtained to differentiate between PCV13 and PPSV23. Tracking system has been updated to include documenting the patient's immunization history in the eMar system under Preventative Healthcare. This allows fast tracking and reporting of the patient's history and when or if future vaccines are necessary. The monthly tracking record has also been updated to include the date the consent was signed as well as to distinguish which pneumococcal vaccine was administered. All current patients were reviewed and corrected as necessary.</p> <p>Education provided to nursing staff regarding pneumococcal policy and procedure.</p> <p>Surveillance: DON or designee will audit consents and tracking to ensure compliance weekly for 4 weeks and monthly x 4. Results and recommendations will be reported to the quarterly QA committee.</p>		

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F 883	<p>Continued From page 39</p> <p>Standing orders for pneumococcal vaccination unless otherwise contraindicated by the CDC. The policy did not reference the current CDC recommendations noted above.</p> <p>The facility's Pneumococcal Immunization Informed Consent form documented:</p> <p>* I hereby give Advanced Health Care permission to administer a pneumococcal vaccine (PPV) during my stay if:</p> <ul style="list-style-type: none"> - I am aged 65 or over and have not recently received a PPV. - I received the PPV prior to age 65 and 5 or more years have passed since the initial vaccination. - I received a PPV on or after 65, have an increased risk, and 5 or more years have passed since the initial vaccine. - Benefits and risks have been reviewed with patient and/or responsible party. <p>The current CDC recommendations regarding administration of the PCV13 and PPSV23 vaccines were not included in the facility's Pneumococcal Immunization Informed Consent.</p> <p>Pneumococcal Immunization Informed Consents were reviewed as follows:</p> <p>* Resident #134's Pneumococcal Immunization Informed Consent, signed by the resident/resident representative on 5/16/18, documented she had already received the vaccine in 2017.</p> <p>* Resident #179's Pneumococcal Immunization</p>	F 883			

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F 883	<p>Continued From page 40</p> <p>Informed Consent, signed by the resident/resident representative on 5/10/18, documented she had already received the vaccine 2 years ago.</p> <p>* Resident #180's Pneumococcal Immunization Informed Consent, signed by the resident/resident representative on 5/21/18, documented he had already received the vaccine and was "Current within 5 years."</p> <p>* Resident #182's Pneumococcal Immunization Informed Consent, signed by the resident/resident representative on 5/16/18, documented he had already received the vaccine and was "Current within 5 years."</p> <p>* Resident #184's Pneumococcal Immunization Informed Consent, signed by the resident/resident representative on 5/14/18, documented the resident/resident representative refused the administration of the vaccine.</p> <p>The above consents did not include documentation of what type of pneumococcal vaccine(s) the residents previously received.</p> <p>The facility provided Immunization Tracking forms for March and April 2018. The form for March included the names of 2 residents and the form for April included the names of 3 residents. The forms documented the date each resident received a pneumococcal vaccine. The type of vaccine each resident received was not documented on the forms.</p> <p>On 6/1/18 at 8:16 AM, the Regional Director of Nursing stated the facility did not have a tracking</p>	F 883			

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F 883	Continued From page 41 system in place for immunizations consistent with current CDC recommendations. The Regional Director of Nursing also said she understood the consents were incomplete because they did not differentiate between PCV13 and PPSV23.	F 883			