



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

June 17, 2018

Joseph Frasure, Administrator
Aspen Transitional Rehabilitation
2867 East Copper Point Drive,
Meridian, ID 83642-1716

Provider #: 135130

Dear Mr. Frasure:

On **June 1, 2018**, a survey was conducted at Aspen Transitional Rehabilitation 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.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 27, 2018**. Failure to submit an acceptable PoC by **June 27, 2018**, may result in the imposition of additional civil monetary penalties by **July 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.
- 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 effective September 1, 2018

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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 # **#14, #72, #73, #74, #75, #78, #125, #128 and #132** 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

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given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

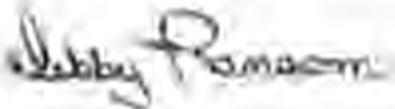
- BFS Letters (06/30/11)

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

This request must be received by **June 27, 2018** . If your request for informal dispute resolution is received after **June 27, 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: 07/19/2018
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135130 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/01/2018 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 000 | INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted May 29, 2018 to June 1, 2018. The surveyors conducting the survey were: Edith Cecil, RN Team Coordinator Presie Billington, RN ADM = Administrator CDC = Centers for Disease Control and Prevention DON = Director of Nursing ICN = Infection Control Nurse MDS = Minimum Data Set | F 000 | | | |
| F 571 SS=D | Limitations on Charges to Personal Funds CFR(s): 483.10(f)(11)(i)-(iii) §483.10(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.) (i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not | F 571 | | 7/13/18 | |

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

TITLE

(X6) DATE

Electronically Signed

06/27/2018

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 571 | Continued From page 1 charge a resident for the following categories of items and services: (A) Nursing services as required at §483.35. (B) Food and Nutrition services as required at §483.60. (C) An activities program as required at §483.24(c). (D) Room/bed maintenance services. (E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry. (F) Medically-related social services as required at §483.40(d). (G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan. (ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: | F 571 | | | |

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| F 571 | Continued From page 2 (A) Telephone, including a cellular phone. (B) Television/radio, personal computer or other electronic device for personal use. (C) Personal comfort items, including smoking materials, notions and novelties, and confections. (D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. (E) Personal clothing. (F) Personal reading matter. (F) Gifts purchased on behalf of a resident. (H) Flowers and plants. (I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c). (J) Non-covered special care services such as privately hired nurses or aides. (K) Private room, except when therapeutically required (for example, isolation for infection control). (L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60. (1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60. (2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population. (iii) Requests for items and services. (A) The facility can only charge a resident for any | F 571 | | | |

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| F 571 | <p>Continued From page 3</p> <p>non-covered item or service if such item or service is specifically requested by the resident.</p> <p>(B) The facility must not require a resident to request any item or service as a condition of admission or continued stay.</p> <p>(C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure residents were not charged for services required to meet the needs for residents. This was true for 1 of 2 resident (#121) who required increased supervision due to behavior symptoms. The deficient practice created the potential for financial harm when the facility required the family to provide additional staffing to meet resident needs. Findings include:</p> <p>Resident #121 was admitted to the facility on 11/2/17 with multiple diagnoses, including pneumonia and weakness.</p> <p>Resident #121's Prospective Payment System (PPS) MDS assessment, dated 11/18/17, documented she was severely cognitively impaired, required extensive assistance of one staff member for bed mobility, transfers, and dressing.</p> <p>Resident #121's Fall Risk Assessment dated 11/02/17, documented she was at moderate risk for falls. Interventions included fall mats and bed and chair safety alarms.</p> | F 571 | <p>F571</p> <p>"This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p> <p>1. Resident #121 was discharged. The facility did not impose a charge against the personal funds of resident #121. For this reason the facility objects to this citation and has submitted a request for an Informal Dispute Resolution.</p> | | |

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| F 571 | <p>Continued From page 4</p> <p>Resident #121's Nursing Notes documented the following:</p> <p>*11/03/18 - Resident #121 set off her alarms about 15 times at the beginning of the shift. Staff gave Resident #121 tour of the facility, offered her snacks, toileted, and reminded to use her call light for help.</p> <p>*11/04/17 - Resident #121 was yelling out for help and kept on pushing her call light.</p> <p>*11/06/17 - Resident #121 was confused and had to be redirected at all times. She continued to call out for help repeatedly through the night.</p> <p>*11/9/17 at 11:19 PM - "Patient had required a 1:1 staff assist which entails nursing staff keeping patient with them at all times this evening to provide patient with emotional support r/t [related to] patient continuously calling out "Help me" and multiple attempts to self-transfer from bed and/or w/c [wheelchair] and attempts to ambulate independently in-patient room."</p> <p>*11/10/17 at 3:53 PM - Resident #121 continued to yell out for help in the hallway.</p> <p>*11/13/17 at 5:49 PM - Resident #121 was confused and needed frequent redirection.</p> <p>*11/14/17 at 6:08 PM - Resident #121 was confused, forgetful and frequently yelling out for help, and needed frequent redirection.</p> <p>*11/15/17 at 5:54 PM - Resident #121 was confused, forgetful, yelling out for help at all</p> | F 571 | <p>2. All resident billing statements from the most recent billing cycle, June 2018, were reviewed to ensure residents were not charged for anything except for applicable deductible and coinsurance amounts. No resident was found to have been charged for anything except for applicable deductible and coinsurance amounts.</p> <p>3. Resident billing statements are sent once monthly between the 10th and 15th. All resident billing statements will be reviewed by the Business Office Manager before being sent to ensure residents are not charged for anything except for applicable deductible and coinsurance amounts. Any items other than applicable deductible and coinsurance amounts will be removed from the billing statements before being mailed. The Financial Agreement was reviewed to ensure the phrase "Routine nursing services and supplies do NOT include the following: Special duty nursing care of 1:1 direct care." Does not appear under the heading: "Medicare Beneficiary" and only appears under the heading "Private Pay Patient". All Nurse Managers and Administration staff have been in-serviced to ensure they will not require residents of families to pay for additional staffing to meet resident needs.</p> <p>4. The Business Office Manager will report any items on billing statements other than applicable deductible and coinsurance amounts to the Quality Assurance and Performance Improvement committee each quarter.</p> | | |

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| F 571 | <p>Continued From page 5 times.</p> <p>*11/16/17 at 4:03 PM - Resident #121 continue to yell out for help, usually wanted the staff to put her to bed when she was already in bed.</p> <p>*11/22/17 at 6:04 PM - Resident #121 was confused, and needed frequent redirection. She continued to yell "help" out of her room.</p> <p>*11/25/17 at 6:15 PM - Call light within reach at all times, Resident #121 continued to yell "help me," "somebody please help me." When staff responded to her calling, Resident #121 would ask the staff to bring her to the restroom and as soon as she sat down on the toilet, she would stand up and said, "I don't need or want anything." Resident #121 was also impulsive as evidenced by her attempting to self-transfer from bed and/or wheelchair, and threatened the staff that she would keep on getting out of bed or wheelchair and walk down the hall without assistance if the staff would not come immediately after she called out for help.</p> <p>The 11/25/17 nursing note also documented, the nurse contacted Resident #121's family member on 11/24/17 at 6:30 PM related to the resident's increased behaviors and requested for a sitter. A family member came in and sat with the resident until the scheduled sitter arrived at 10:00 PM.</p> <p>*11/26/17 at 6:10 PM - Call light within reach at all times, Resident #121 continues to call out "help me," "somebody help me" instead of using the call light.</p> <p>On 5/31/18 at 10:01 AM, the DON said Resident</p> | F 571 | <p>The Business Office Manager will also show how the affected resident billing statements were corrected before mailing. The QAPI Committee will review Nurse Managers and Administration staff in-service prohibiting the requirement of residents or families to pay for additional staffing to meet resident needs.</p> <p>5. Completion Date: July 13, 2018</p> | | |

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| F 571 | <p>Continued From page 6</p> <p>#121 became disruptive especially at night and required one to one staff supervision. The DON said if they determined a resident needed one to one supervision, they would ask the family if they could stay with the resident to provide one to one supervision. If no one in the family could stay with the resident they asked the family to hire a private sitter. The DON said if the family cannot afford to pay for the private sitter the facility would bring in additional staff to provide one to one supervision to the resident.</p> <p>On 6/1/18 at 2:28 PM, the ADM said Resident #121's family paid a private duty personnel to provide one to one supervision to Resident #121 from 10:00 PM to 6:00 AM, and the facility paid the private duty personnel from 6:00 AM to 9:00 AM. The ADM provided a copy of the facility's Financial Agreement which was included in their admission packet. The following was documented:</p> <p>*If the patient is covered by a health insurance plan, managed care organization, Veteran's Administration contract, Medicare, Medicaid, or other third-party payor, the patient agrees to pay for any costs not covered by such third-party payor.</p> <p>*Routine nursing services and supplies do NOT include the following: Special duty nursing care of 1:1 direct care.</p> <p>*The Patient/Legal Representative may request, and the Facility may provide, non-routine services and/or supplies. However, the Patient/Legal Representative Party is financially responsible for any charges not covered by a</p> | F 571 | | | |

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| F 571 | Continued From page 7 third-party payor (e.g., Medicare, Medicaid, Insurance etc.) *The Patient/Legal Representative may hire the services of private duty personnel (i.e. nurses, aids, sitters, etc.) while in the Facility, but only with advance approval from the Facility's Administrator or Director of Nursing. The Patient/Legal Representative Party agrees to be financially responsible for any charges from private duty personnel. *The Patient/Legal Representative, as applicable acknowledges that under no circumstances can employees or agents of the Facility serve as private duty personnel. | F 571 | | | |
| F 604 SS=E | 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 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). §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. | F 604 | | 7/13/18 | |

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| F 604 | <p>Continued From page 8</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, family interview, record review, and policy review, it was determined the facility failed to ensure residents were free from restraints, including bed and chair alarms. This was true for 4 of 8 (#4, #72, #75 and #77) residents sampled for restraints, when the facility failed to adequately assess the resident for use of the alarm and to obtain consent from the resident and/or resident's representative. In addition, 3 of 8 (#14, #125, and #128) residents sampled for restraints had the potential to experience the use of restraints due to an order for use of safety alarms as needed. This had the potential for harm if restraints were improperly used and if the resident experienced a psychological decline due to feelings of being restricted in movement. Findings include:</p> <p>The facility's policy and procedure for Fall Prevention, dated 1/21/16, documented "to ensure optimal resident safety while promoting resident independence and maximizing psychosocial well-being. Safety alarms will be placed and monitored with appropriate documentation as indicated," as well as the</p> | F 604 | <p>F604</p> <p>"This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p> <ol style="list-style-type: none"> Residents #4, #72, #75, #77, #14, #125, #128 were discharged. All residents had their records reviewed to ensure no alarms of any type were found to be in use. Alarms of any | | |

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| NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642 | | |
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| F 604 | <p>Continued From page 9 following:</p> <ul style="list-style-type: none"> * Upon admission, each resident will be evaluated for risk of falls utilizing the Fall Risk Assessment. * Based upon the calculated score of the Fall Risk Assessment; the Fall Risk Protocol and Care Plan will be completed and the appropriate interventions initiated. * The Admitting Nurse/Nurse Manager will be responsible for ensuring the interventions are initiated and communicated to appropriate staff for follow through. * At any time, the assigned Licensed Nurse may initiate the use of safety alarms, if based on resident assessment, the device may serve to reduce the risk of unassisted transfers or falls. * If indicated, safety alarms will be added to the Resident's Treatment Administration Record identifying the type of alarm (i.e. pressure or tab,) the location it is to be used (i.e. bed, recliner, wheelchair,) and frequency/duration of use (i.e. at all times, night only.) <p>The facility's Patient General Orders, dated 12/20/17, documented a list of medication related general orders and treatment related general orders that can be initiated without physician contact. The list of general treatments stated staff "may apply safety alarms as needed to maintain safety. The General Orders documented, "These orders shall be noted in the interdisciplinary notes and placed on the medication or treatment record as appropriate. No other medication or</p> | F 604 | <p>type have been removed from all residents' general orders.</p> <p>3. The Policy & Procedure was changed to indicate alarms may be initiated "after the completion of the Safety Alarm Utilization, Assessment and Consent form" and after receiving "an order from the patient's physician or physician extender based upon the identified medical symptom(s) noted in the patient assessment." The Safety Alarm Utilization, Assessment and Consent form identifies the medical symptoms, time, and duration of the need for the alarms. Alarms of any type have been removed from all residents' general orders.</p> <p>4. DON will audit charts of any residents with alarm(s) in place to ensure Safety Alarm Utilization, Assessment and Consent forms are completed and that an order from the patient's physician or physician extender based upon the identified medical symptom(s) noted in the patient assessment. DON will audit 10% of all remaining charts to ensure general orders do not include alarms of any type. DON will complete audits weekly x 4 weeks, then monthly x 2 months, and quarterly x 2 quarters. Results of the audits will be reported to the Quality Assurance and Performance Improvement committee each quarter.</p> <p>5. Completion Date: July 13, 2018</p> | | |

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| F 604 | <p>Continued From page 10 treatments should be given without specific authorization from a physician. The form is signed by a physician upon the admission date."</p> <p>1. Resident #4 was admitted to the facility on 4/23/18 with multiple diagnoses, including hypertension and weakness.</p> <p>Resident #4's admission MDS assessment, dated 4/30/18, documented he was cognitively intact and dependent on staff for all cares except for eating and drinking. He needed "set-up" only for eating and drinking, and did not use a safety alarm.</p> <p>Resident #4's Fall Risk Assessment dated 4/23/18, documented he was moderate risk for falls. Intervention included OT (Occupational Therapy)/PT (Physical Therapy).</p> <p>Resident #4's Nursing Notes dated 5/9/18, documented he was found on the floor in his bathroom and 15 minute checks were started. The Nursing Notes also documented "Pt [patient] will have pressure alarms."</p> <p>Resident #4's Fall Risk Assessment was updated on 5/8/18 to include pressure alarms in his bed and wheelchair.</p> <p>On 5/31/18 at 8:35 AM, Resident #4 was in his wheelchair in his room with an alarm attached to the back of his wheelchair. At that time, Resident #4 said the alarm would sound if he tried to get up from his wheelchair.</p> <p>Resident #4's care plan did not include the use of a wheelchair alarm.</p> | F 604 | | | |

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| F 604 | <p>Continued From page 11</p> <p>Resident #4's clinical record did not include an assessment of his use of bed and chair alarms as possible restraints.</p> <p>On 5/30/18 at 2:40 PM, the DON said she would look for the safety alarm assessment.</p> <p>On 5/31/18 at 12:14 PM, the DON provided a copy of Resident #4's Safety Alarm Utilization Assessment & [and] Consent, dated and signed by Resident #4's family member on 5/31/18. The assessment and consent were garnered after the initiation of the safety alarms.</p> <p>2. Resident #72 was admitted to the facility on 5/22/18 with multiple diagnoses, including post-operative care following a surgical correction of a femur (thigh bone) fracture.</p> <p>Resident #72's admission MDS assessment, dated 5/29/18, documented Resident #72 had moderate cognitive impairment, required extensive assistance of two staff members for bed mobility, transfers and toilet use. The MDS assessment also documented he had history of falls and did not utilize a safety alarm.</p> <p>Resident #72's Fall Risk Assessment, dated 5/22/18, documented he was at moderate risk for falls. Intervention included fall mats, OT/PT consult, alarms secondary to episodic STML (short term memory loss), and a history of falls with injury.</p> <p>Resident #72's baseline care plan, dated 5/22/18 documented a problem due to alteration in mobility and safety. The goal was that Resident</p> | F 604 | | | |

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| F 604 | <p>Continued From page 12</p> <p>#72 would not have an injury related to falls. Intervention included placement of safety devices such as fall mats and bed and wheelchair alarms.</p> <p>On 5/29/18 at 9:09 AM, Resident #72 was in his room sitting in his wheelchair with an alarm attached on the back of his wheelchair. An alarm was also noted attached to Resident 72's bed. Resident #72's family member, present at the time, said she believed the alarm would sound if Resident #72 tried to stand up.</p> <p>On 5/30/18 at 7:50 AM, Resident #72 was in his wheelchair being assisted by a staff member to the dining room. An alarm was observed attached on the back of his wheel chair.</p> <p>Resident #72's clinical record did not include an assessment of his use of bed and chair alarm as possible restraints.</p> <p>On 5/30/18 at 2:40 PM, the DON said she would look for the safety alarm assessment.</p> <p>On 5/31/18 at 12:14 PM, the DON provided a copy of Resident #72's Safety Alarm Utilization Assessment & [and] Consent, dated 5/31/18 and signed by Resident #72's family member. The assessment and consent were completed after the initiation of the safety alarms.</p> <p>3. Resident #75 was admitted to the facility on 5/21/18 with multiple diagnoses, including difficulty walking and a hip fracture.</p> <p>Resident #75's admission MDS assessment dated 5/28/18, documented she was severely cognitively impaired, required the assistance of</p> | F 604 | | | |

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| F 604 | <p>Continued From page 13</p> <p>two staff members for bed mobility, transfers and toilet use, and that she used bed and chair alarms daily. The MDS assessment also documented Resident #75 had a history of falls in the last month prior to admission to the facility.</p> <p>Resident #75's care plan dated 5/28/18, documented she was at risk for falls related to mobility and functional deficits, poor safety awareness, history of isolated falls incident and pelvic (hip) fracture. Intervention included a safety alarm to bed and wheelchair, bed in the low position, fall mats at bedside. The care plan stated staff were to assist Resident #75 with transfers and ambulation as needed, educate her and her family regarding fall risks and safety needs, and encourage her to keep room door open when not engaged in personal cares.</p> <p>On 5/29/18 at 9:20 AM, Resident #75 was in bed with an alarm attached to her bed. An alarm was also observed attached on the back of her wheelchair.</p> <p>Resident #75's clinical record did not include an assessment of her use of bed and chair alarm as a possible restraint.</p> <p>On 5/30/18 at 2:40 PM, the DON said she would look for the safety alarm assessment.</p> <p>On 5/31/18 at 12:14 PM, the DON provided a copy of Resident #75's Safety Alarm Utilization Assessment & [and] Consent, dated 5/31/18 and signed by Resident #75. The assessment and consent were completed after the initiation of the safety alarms.</p> | F 604 | | | |

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| F 604 | <p>Continued From page 14</p> <p>4. Resident #77 was admitted to the facility on 5/23/18 with multiple diagnoses, including left ankle fracture and dementia.</p> <p>Resident #77's admission MDS assessment dated 5/30/18, documented he was severely cognitively impaired, required the assistance of two staff members for bed mobility, transfers and toilet use, and that he used bed and chair alarms daily. The MDS assessment also documented Resident #77 had a history of falls in the last month prior to admission to the facility.</p> <p>Resident #77 Fall Risk Assessment dated 5/23/18, documented he was at moderate risk for falls. Intervention included a fall mats, OT and PT consult, and alarms placed due to dementia and history of falls with injury.</p> <p>Resident #77's baseline care plan documented a problem of alteration in mobility and safety. Intervention included placement of safety devices: bed and chair alarm, and fall mats.</p> <p>On 5/29/18 at 9:21 AM, Resident was observed in his wheelchair in his room and the back of his wheelchair had an alarm attached.</p> <p>On 5/31/18 at 8:56 AM, Resident #77 was in his wheelchair outside his room. An alarm was observed attached on the back of his wheelchair.</p> <p>Resident #77's clinical record did not include an assessment of his use of bed and chair alarm as a possible restraint.</p> <p>On 5/30/18 at 2:40 PM, the DON said she would look for the safety alarm assessment.</p> | F 604 | | | |

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| F 604 | Continued From page 15 On 5/31/18 at 12:14 PM, the DON provided a copy of Resident #77's Safety Alarm Utilization Assessment & [and] Consent, dated 5/31/18 and signed by Resident #77. The assessment and consent were completed after the initiation of the safety alarms. 5. The medical records for Resident #14, Resident #125, and Resident #128 included the physician order "may apply safety alarms as needed to maintain safety." The residents were observed throughout the survey without the use of safety alarms in their beds or wheelchairs. On 6/1/18 at 2:00 PM, the DON indicated the order "may apply safety alarms as needed to maintain safety." was a standing order. The facility failed to ensure safety alarms were not used "as needed" as restraints for Resident #14, Resident #125, and Resident #128. | F 604 | | | |
| F 636 SS=E | Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least | F 636 | | 7/13/18 | |

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| F 636 | <p>Continued From page 16</p> <p>the following:</p> <ul style="list-style-type: none"> (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.</p> <ul style="list-style-type: none"> (i) Within 14 calendar days after admission, excluding readmissions in which there is no | F 636 | | | |

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| F 636 | <p>Continued From page 17</p> <p>significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p> <p>(iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure residents' chair and bed safety alarm were assessed prior to implementation. This was true for 4 of 8 (#4, #72, #75 and #77) residents sampled for potential restraints. This deficient practice had the potential for harm if safety alarm were improperly used and if the resident experienced a psychological decline due to feelings of being restricted in their movement. Findings include:</p> <p>1. Resident #4 was admitted to the facility on 4/23/18 with multiple diagnoses, including hypertension and weakness.</p> <p>Resident #4's admission MDS assessment, dated 4/30/18, documented he was cognitively intact and dependent on staff for all cares except for eating and drinking. He needed "set-up" only for eating and drinking, and did not use a safety alarm.</p> <p>Resident #4's Fall Risk Assessment dated 4/23/18, documented he was moderate risk for falls. Intervention included OT (Occupational Therapy)/PT (Physical Therapy).</p> <p>Resident #4's Nursing Notes dated 5/9/18, documented he was found on the floor in his</p> | F 636 | <p>F636</p> <p>"This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p> <p>1. Residents #4, #72, #75, and #77 were discharged.</p> <p>2. All residents had their records reviewed to ensure no alarms of any type were found to be in use. Alarms of any type have been removed from all residents' general orders.</p> <p>3. The Policy & Procedure was changed to indicate alarms may be initiated "after the completion of the Safety Alarm</p> | | |

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| F 636 | <p>Continued From page 18 bathroom and 15 minute checks were started. The Nursing Notes also documented "Pt [patient] will have pressure alarms."</p> <p>Resident #4's Fall Risk Assessment was updated on 5/8/18 to include pressure alarms in his bed and wheelchair.</p> <p>On 5/31/18 at 8:35 AM, Resident #4 was in his wheelchair in his room with an alarm attached to the back of his wheelchair. At that time, Resident #4 said the alarm would sound if he tried to get up from his wheelchair.</p> <p>Resident #4's clinical record did not include an assessment which identified the medical symptoms, time and duration of the need for the alarms.</p> <p>On 5/30/18 at 2:40 PM, the DON said she would look for the safety alarm assessment.</p> <p>On 5/31/18 at 12:14 PM, the DON provided a copy of Resident #4's Safety Alarm Utilization Assessment & [and] Consent, dated and signed by Resident #4's family member on 5/31/18. The assessment was completed after the initiation of the safety alarms.</p> <p>2. Resident #72 was admitted to the facility on 5/22/18 with multiple diagnoses, including post-operative care following a surgical correction of a femur (thigh bone) fracture.</p> <p>Resident #72's admission MDS assessment, dated 5/29/18, documented Resident #72 had moderate cognitive impairment, required extensive assistance of two staff members for</p> | F 636 | <p>Utilization, Assessment and Consent form" and after receiving "an order from the patient's physician or physician extender based upon the identified medical symptom(s) noted in the patient assessment." The Safety Alarm Utilization, Assessment and Consent form identifies the medical symptoms, time, and duration of the need for the alarms. Alarms of any type have been removed from all residents' general orders.</p> <p>4. DON will audit charts of any residents with alarm(s) in place to ensure Safety Alarm Utilization, Assessment and Consent forms are completed and that an order from the patient's physician or physician extender based upon the identified medical symptom(s) noted in the patient assessment. DON will audit 10% of all remaining charts to ensure general orders do not include alarms of any type. DON will complete audits weekly x 4 weeks, then monthly x 2 months, and quarterly x 2 quarters. Results of the audits will be reported to the Quality Assurance and Performance Improvement committee each quarter.</p> <p>5. Completion Date: July 13, 2018</p> | | |

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| F 636 | <p>Continued From page 19</p> <p>bed mobility, transfers and toilet use. The MDS assessment also documented he had history of falls and did not utilize a safety alarm.</p> <p>Resident #72's Fall Risk Assessment, dated 5/22/18, documented he was at moderate risk for falls. Intervention included fall mats, OT/PT consult, alarms secondary to episodic STML (short term memory loss), and a history of falls with injury.</p> <p>Resident #72's baseline care plan, dated 5/22/18 documented a problem due to alteration in mobility and safety. The goal was that Resident #72 would not have an injury related to falls. Intervention included placement of safety devices such as fall mats and bed and wheelchair alarms.</p> <p>On 5/29/18 at 9:09 AM, Resident #72 was in his room sitting in his wheelchair with an alarm attached on the back of his wheelchair. An alarm was also noted attached to Resident 72's bed. Resident #72's family member, present at the time, said she believed the alarm would sound if Resident #72 tried to stand up.</p> <p>On 5/30/18 at 7:50 AM, Resident #72 was in his wheelchair being assisted by a staff member to the dining room. An alarm was observed attached on the back of his wheel chair.</p> <p>Resident #72's clinical record did not include an assessment which identified the medical symptoms, time and duration of the need for the alarms.</p> <p>On 5/30/18 at 2:40 PM, the DON said she would look for the safety alarm assessment.</p> | F 636 | | | |

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| F 636 | <p>Continued From page 20</p> <p>On 5/31/18 at 12:14 PM, the DON provided a copy of Resident #72's Safety Alarm Utilization Assessment & [and] Consent, dated 5/31/18 and signed by Resident #72's family member. The assessment was completed after the initiation of the safety alarms.</p> <p>3. Resident #75 was admitted to the facility on 5/21/18 with multiple diagnoses, including difficulty walking and a hip fracture.</p> <p>Resident #75's admission MDS assessment dated 5/28/18, documented she was severely cognitively impaired, required the assistance of two staff members for bed mobility, transfers and toilet use, and that she used bed and chair alarms daily. The MDS assessment also documented Resident #75 had a history of falls in the last month prior to admission to the facility.</p> <p>Resident #75's care plan dated 5/28/18, documented she was at risk for falls related to mobility and functional deficits, poor safety awareness, history of isolated falls incident and pelvic (hip) fracture. Intervention included a safety alarm to bed and wheelchair, bed in the low position, fall mats at bedside.</p> <p>On 5/29/18 at 9:20 AM, Resident #75 was in bed with an alarm attached to her bed. An alarm was also observed attached on the back of her wheelchair.</p> <p>Resident #75's clinical record did not include an assessment which identified the medical symptoms, time and duration of the need for the alarms.</p> | F 636 | | | |

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| F 636 | <p>Continued From page 21</p> <p>On 5/30/18 at 2:40 PM, the DON said she would look for the safety alarm assessment.</p> <p>On 5/31/18 at 12:14 PM, the DON provided a copy of Resident #75's Safety Alarm Utilization Assessment & [and] Consent, dated 5/31/18 and signed by Resident #75. The assessment was completed after the initiation of the safety alarms.</p> <p>4. Resident #77 was admitted to the facility on 5/23/18 with multiple diagnoses, including left ankle fracture and dementia.</p> <p>Resident #77's admission MDS assessment dated 5/30/18, documented he was severely cognitively impaired, required the assistance of two staff members for bed mobility, transfers and toilet use, and that he used bed and chair alarms daily. The MDS assessment also documented Resident #77 had a history of falls in the last month prior to admission to the facility.</p> <p>Resident #77 Fall Risk Assessment dated 5/23/18, documented he was at moderate risk for falls. Intervention included a fall mats, OT and PT consult, and alarms placed due to dementia and history of falls with injury.</p> <p>On 5/29/18 at 9:21 AM, Resident was observed in his wheelchair in his room and the back of his wheelchair had an alarm attached.</p> <p>On 5/31/18 at 8:56 AM, Resident #77 was in his wheelchair outside his room. An alarm was observed attached on the back of his wheelchair.</p> <p>Resident #77's clinical record did not include an</p> | F 636 | | | |

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| F 636 | Continued From page 22 assessment which identified the medical symptoms, time and duration of the need for the alarms. On 5/30/18 at 2:40 PM, the DON said she would look for the safety alarm assessment. On 5/31/18 at 12:14 PM, the DON provided a copy of Resident #77's Safety Alarm Utilization Assessment & [and] Consent, dated 5/31/18 and signed by Resident #77. The assessment was completed after the initiation of the safety alarms. | F 636 | | | |
| F 883 SS=F | Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza | F 883 | | 7/2/18 | |

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| F 883 | Continued From page 23 immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (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; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and record review, it was determined the facility failed to develop, update, and implement policies and processes to minimize the risk of residents acquiring, transmitting, or experiencing complications from Pneumococcal (bacterial) pneumonia. This was true for 9 of 9 sample | F 883 | F883 This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is | | |

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| F 883 | <p>Continued From page 24</p> <p>residents (#14, #72, #73, #74, #75, #78, #125, #128, and #132) residing in the facility and reviewed for Pneumococcal vaccination, and had the potential to impact the other 9 residents residing in the facility. Specifically,</p> <p>a) The facility failed to ensure residents who were offered the Pneumococcal vaccine received information and education consistent with current CDC recommendations for Pneumococcal immunization.</p> <p>b) The facility's Pneumococcal immunization process and Pneumococcal immunization consent form did not reflect current CDC recommendations.</p> <p>c) The facility did not implement an immunization program to ensure residents' Pneumococcal vaccine status were being tracked with receiving or declining the Pneumococcal vaccines PCV 13 the first year, followed by the PPSV 23 one year later.</p> <p>Findings include:</p> <p>The Centers for Disease Control and Prevention (CDC) website, updated 11/22/16, documented recommendations for Pneumococcal vaccination (PCV 13 or Pevnar13®, and PPSV 23 or Pneumovax23®) for all adults 65 years or older:</p> <p>* "Adults 65 years or older who have not previously received PCV 13, should receive a dose of PCV 13 first, followed 1 year later by a dose of PPSV 23."</p> <p>*If the patient already received one or more</p> | F 883 | <p>hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p> <ol style="list-style-type: none"> Residents #14, #73, #74, #75, #78, #125, #128, and #132 were discharged. Resident #72 or her/his representative have been given pneumococcal education that reflects the latest CDC guidelines concerning PCV 13 or Pevnar13 and PPSV 23 or Pneumovax23. She/he or her/his representative signed a consent form that also reflects the latest CDC guidelines concerning PCV 13 or Pevnar13 and PPSV 23 or Pneumovax23. All resident charts have been reviewed to ensure all residents or their representatives were provided education that reflects the latest CDC guidelines concerning PCV 13 or Pevnar13 and PPSV 23 or Pneumovax23. Also that all residents or their representatives signed consent forms that reflect the latest CDC guidelines concerning PCV 13 or Pevnar13 and PPSV 23 or Pneumovax23. Admission information given to every new resident at time of admit has been | | |

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| F 883 | <p>Continued From page 25</p> <p>doses of PPSV 23, the dose of PCV 13 should be given at least 1 year after they received the most recent dose of PPSV 23."</p> <p>The facility's policy and procedure "Patient Immunization Program," dated 4/27/15, documented, "will ensure all patients are offered appropriate Pneumococcal vaccinations in accordance with recommendations set forth by the Centers for Disease Control (CDC)."</p> <p>The policy documented "If the patient declines receipt of, or is unable to receive, a Pneumococcal vaccination, the facility will document the refusal, reason for refusal or medical contraindication in the patient's clinical record and the patient or responsible party will sign the Immunization Consent indicating that he/she has declined to receive a Pneumococcal vaccination and have been educated regarding the risk and benefits of vaccination." The Patient Education provided direction of:</p> <p>*All patients will be educated regarding the benefits, risks, and recommendations per the CDC.</p> <p>*Education will be discussed verbally and patient or responsible party will be given the Vaccine Information Statement for each recommended/administered immunization as published by the CDC.</p> <p>The facility's Policy and Procedure Manual was signed by the Medical Director, Administrator, and Director of Nursing on 12/14/17 affirming the policies reflected current standards of practice for resident care. The Patient Immunization Program policy and procedure did not reflect current CDC</p> | F 883 | <p>updated to reflect the latest CDC guidelines concerning PCV 13 or Pevnar13 and PPSV 23 or Pneumovax23. This includes benefits, risks, and recommendations per the CDC. Pneumococcal Immunization Informed Consent forms completed with every resident at time of admission were updated to reflect the latest CDC guidelines concerning PCV 13 or Pevnar13 and PPSV 23 or Pneumovax23. This includes if past vaccines received were PCV 13 or PPSV 23, when they were received, and the next scheduled vaccine.</p> <p>4. DON will audit 10% of all resident charts to ensure residents have been provided education that reflects the latest CDC guidelines concerning PCV 13 or Pevnar13 and PPSV 23 or Pneumovax23. Also that the residents or their representatives signed consent forms that reflect the latest CDC guidelines concerning PCV 13 or Pevnar13 and PPSV 23 or Pneumovax23. DON will complete audits weekly x 4 weeks, then monthly x 2 months, and quarterly x 2 quarters. Results of the audits will be reported to the Quality Assurance and Performance Improvement committee each quarter.</p> <p>5. Completion Date: July 2, 2018</p> | | |

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| F 883 | <p>Continued From page 26 guidelines.</p> <p>The facility's Pneumococcal Immunization Informed Consent form gave the facility permission to administer a Pneumococcal vaccination (PPV) (PPSV 23 or Pneumovax23®) during the the patient stay if:</p> <ul style="list-style-type: none"> *they were aged 65 and over and had not previously received a PPV *they received a PPV prior to age 65 and 5 or more years had passed since the initial immunization *they had received a PPV on or after age 65, have an increased risk, and 5 or more years have passed since the initial vaccination. *benefits and risks were reviewed with patient and/or responsible party. <p>The facility's consent form only provided consent for the PPSV 23. The consent form did not provide the opportunity for the resident to obtain the PCV 13.</p> <p>On 5/31/18 at 10:38 AM, the Infection Control Nurse (ICN) stated the Pneumococcal vaccine Polyvalent Pneumovax 23 was the only Pneumococcal immunization the facility provided. The ICN stated she was not aware of the new CDC guidelines for immunizations.</p> <p>1. Resident #14 was admitted to the facility on 4/27/18 with multiple diagnoses including weakness and atrial fibrillation.</p> | F 883 | | | |

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| F 883 | <p>Continued From page 27</p> <p>Resident #14's admission MDS assessment, dated 5/4/18, documented Resident #14 was "up to date" with the Pneumococcal vaccination.</p> <p>On 6/1/18 at 1:30 PM, the DNS provided Resident #14's Pneumococcal Immunization Informed Consent form, dated 4/27/18. The informed consent documented declination as Resident #14 (over the age of 65) "already received" the Pneumococcal vaccine in "17." The informed consent did not document if the vaccine received was the PCV 13 vaccine or the PPSV 23 vaccine, the month it was given, or the tracking documentation of when Resident #14 was to receive the next vaccine. Resident #14's medical record did not provide documentation of education regarding the benefits, risks, and recommendations per the CDC, or the provision of the Vaccine Information Statement for each recommended/administered immunization as published by the CDC.</p> <p>On 6/1/18 at 1:30 PM, the DON stated she could not determine when Resident #14 received the immunization other than it was in 2017.</p> <p>2. Resident #125 was admitted to the facility on 5/17/18 with multiple diagnoses including diabetes mellitus type 2 and gout.</p> <p>Resident #125's admission MDS assessment, dated 5/24/18, documented Resident #125 was "up to date" with the Pneumococcal vaccination.</p> <p>On 6/1/18 at 1:30 PM, the DNS provided Resident #125's Pneumococcal Immunization Informed Consent form, dated 4/27/18. The informed consent documented declination as</p> | F 883 | | | |

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| F 883 | <p>Continued From page 28</p> <p>Resident #125 (over the age of 65) "already received." The date was not documented. The informed consent did not document if the vaccine received was the PCV 13 vaccine or the PPSV 23 vaccine, the month it was given, or the tracking documentation of when Resident #125 was to receive the next vaccine. Resident #125's medical record did not provide documentation of education regarding the benefits, risks, and recommendations per the CDC, or the provision of the Vaccine Information Statement for each recommended/administered immunization as published by the CDC.</p> <p>On 6/1/18 at 1:30 PM, the DON stated she could not determine when Resident #125 received the immunization.</p> <p>3. Resident #128 was admitted to the facility on 5/22/18 with multiple diagnoses including left knee replacement and chronic obstructive pulmonary disease.</p> <p>Resident #128's admission MDS assessment, dated 5/29/18, documented Resident #128 was "up to date" with the Pneumococcal vaccination.</p> <p>On 6/1/18 at 1:30 PM, the DNS provided Resident #128's Pneumococcal Immunization Informed Consent form, dated 4/27/18. The informed consent documented declination as Resident #128 (over the age of 65) "already received" and dated "171." The informed consent did not document if the vaccine received was the PCV 13 vaccine or the PPSV 23 vaccine, the month it was given, or the tracking documentation of when Resident #128 was to receive the next vaccine. Resident #128's</p> | F 883 | | | |

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| F 883 | <p>Continued From page 29</p> <p>medical record did not provide documentation of education regarding the benefits, risks, and recommendations per the CDC, or the provision of the Vaccine Information Statement for each recommended/administered immunization as published by the CDC.</p> <p>On 6/1/18 at 1:30 PM, the DON stated she could not determine when Resident #128 received the immunization but thought the date written was 2017.</p> <p>4. Resident #132 was admitted to the facility on 5/25/18 with multiple diagnoses including heart failure and end-stage renal disease.</p> <p>Resident #132's admission MDS assessment, dated 6/1/18, documented Resident #132 was "up to date" with the Pneumococcal vaccination.</p> <p>On 6/1/18 at 1:30 PM, the DNS provided Resident #132's Pneumococcal Immunization Informed Consent form, dated 4/27/18. The informed consent documented declination as Resident #132 (over the age of 65) "already received." The date was not documented. The informed consent did not document if the vaccine received was the PCV 13 vaccine or the PPSV 23 vaccine, the month it was given, or the tracking documentation of when Resident #132 was to receive the next vaccine. Resident #132's medical record did not provide documentation of education regarding the benefits, risks, and recommendations per the CDC, or the provision of the Vaccine Information Statement for each recommended/administered immunization as published by the CDC.</p> | F 883 | | | |

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| F 883 | <p>Continued From page 30</p> <p>On 6/1/18 at 1:30 PM, the DON stated she could not determine when Resident #132 received the immunization.</p> <p>5. Resident #72 was admitted to the facility on 5/22/18 with multiple diagnoses, including post-operative care following a surgical correction of a femur (thigh bone) fracture.</p> <p>Resident #72's admission MDS assessment, dated 5/29/18, documented Resident #72 had moderate cognitive impairment and was "up to date" with his Pneumococcal vaccination.</p> <p>Resident #72's Pneumococcal Immunization Informed Consent form, dated 5/22/18, documented he had received the vaccine in "17." The consent form did not document if the vaccine was the PCV 13 vaccine or PPSV 23 or tracking documentation when Resident #72 was to receive the next vaccine.</p> <p>On 5/31/18 at 10:38 AM, the ICN said she did not know what type of Pneumococcal vaccine did the resident received.</p> <p>6. Resident #73 was admitted to the facility on 5/17/18 with multiple diagnoses, including dementia.</p> <p>Resident #73's admission MDS assessment dated 5/24/18, documented he had moderate cognitive impairment and was up to date with his Pneumococcal vaccination.</p> <p>Resident #73's Pneumococcal Immunization Informed Consent form, dated 5/17/18, documented he had received the vaccine in "17".</p> | F 883 | | | |

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| NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642 | | |
| (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 883 | <p>Continued From page 31</p> <p>The consent form did not document if the vaccine was PCV 13 or the PPSV 23 or tracking documentation when Resident #73 was to receive the next vaccine.</p> <p>On 5/31/18 at 10:38 AM, the ICN said she did not know what type of Pneumococcal vaccine did the resident received.</p> <p>7. Resident #74 was admitted to the facility on 5/17/18 with multiple diagnoses, including weakness and hypertension.</p> <p>Resident #74's 14 day MDS assessment dated 5/31/18, documented she was cognitively intact and was up to date with her Pneumococcal vaccination.</p> <p>Resident #74's Pneumococcal Immunization Informed Consent form, dated 5/17/18, documented she had received the vaccine in [date written on the consent was hard to read]. The consent form did not document if the vaccine was PCV 13 or the PPSV 23 or tracking documentation when Resident #74 was to receive the next vaccine.</p> <p>On 5/31/18 at 10:38 AM, the ICN looked at Resident #74's consent form and said she was not sure what date did the resident received the Pneumococcal vaccine. The ICN also said she did not know what type of Pneumococcal vaccine did the resident received.</p> <p>8. Resident #75 was admitted to the facility on 5/21/18 with multiple diagnoses, including difficulty in walking and hip fracture.</p> | F 883 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135130 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/01/2018 |
| NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642 | | |
| (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 883 | <p>Continued From page 32</p> <p>Resident #75's admission MDS assessment dated 5/28/18, documented she was severely cognitively impaired and was up to date with her Pneumococcal vaccination.</p> <p>Resident #75's Pneumococcal Immunization Informed Consent form dated 5/21/18, documented she had received the vaccine in "17." The consent form did not document if the vaccine was PCV 13 or the PPSV 23 or tracking documentation when Resident #75 was to receive the next vaccine.</p> <p>On 5/31/18 at 10:38 AM, the ICN said she did not know what type of Pneumococcal vaccine did the resident received.</p> <p>9. Resident #78 was admitted to the facility on 5/18/18 with multiple diagnoses, including hip fracture.</p> <p>Resident #78's entry MDS assessment dated 5/18/18, documented he was cognitively intact. The MDS did not indicate if he was up to date with his Pneumococcal vaccination.</p> <p>Resident #78 Pneumococcal Immunization Informed consent form dated 5/13/18, documented he had received the vaccine last year. The consent form did not document if the vaccine was PCV 13 or the PPSV 23 or tracking documentation when Resident #78 was to receive the next vaccine.</p> <p>On 5/31/18 at 10:38 AM, the ICN said she did not know what type of Pneumococcal vaccine did the resident received.</p> | F 883 | | | |

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

PRINTED: 07/19/2018
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135130 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/01/2018 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642 | | |
| (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 883 | Continued From page 33 These failed practices represented a systemic failure which increased residents' risk for contracting pneumonia with its associated complications of infection of the blood and covering of the brain and spinal cord which could cause death or brain damage. | F 883 | | | |

Bureau of Facility Standards

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001505 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/01/2018 |
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| NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION | STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|--|--------------------|
| C 000 | <p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual licensure survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Presie Billington, RN</p> <p>The survey team entered the facility on 5/29/18, and exited the facility on 6/1/18.</p> <p>Abbreviations:</p> <p>ICN - Infection Control Nurse</p> | C 000 | | |
| C 664 | <p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure the Pharmacist participated in the facility's Infection Control Committee meetings. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings include:</p> <p>On 5/31/18 at 2:07 PM, the ICN said the facility held their Infection Control Meetings on a quarterly basis. Attendance sheets for the last four quarterly meetings documented the Pharmacist had not attended any of the quarterly meetings. The ICN said she did not know why the Pharmacist did not attend any of the</p> | C 664 | <p>C664</p> <p>This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly</p> | 7/2/18 |

| | | |
|--|-------|---------------------------|
| Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed | TITLE | (X6) DATE 06/27/18 |
|--|-------|---------------------------|

Bureau of Facility Standards

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001505 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/01/2018 |
|--|--|---|---|

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| NAME OF PROVIDER OR SUPPLIER ASPEN TRANSITIONAL REHABILITATION | STREET ADDRESS, CITY, STATE, ZIP CODE 2867 EAST COPPER POINT DRIVE MERIDIAN, ID 83642 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|--|--------------------|
| C 664 | Continued From page 1 meetings. | C 664 | <p>applied.</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p> <ol style="list-style-type: none"> 1. No residents were found to have been affected. 2. A root cause analysis revealed the facility's contracted pharmacist is willing and able to attend quarterly Infection Control Committee meetings but was not on the invitation list. The pharmacist was added to the invitation list and will be invited to all future Infection Control Committee meetings. 3. The pharmacist will attend in person or by phone all quarterly Infection Control Committee meetings. 4. The Quality Assurance and Performance Improvement committee will review all quarterly Infection Control Committee meeting notes to ensure the pharmacist was in attendance. 5. Completion Date: July 2, 2018 | |



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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January 8, 2019

Joseph Frasure, Administrator
Aspen Transitional Rehabilitation
2867 East Copper Point Drive
Meridian, ID 83642-1716

Provider #: 135130

Dear Mr. Frasure:

On **June 1, 2018**, an unannounced on-site complaint survey was conducted at Aspen Transitional Rehabilitation. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted on May 29, 2018 to June 1, 2018.

Direct care staff interactions with the current residents in the facility were observed. Meals were also observed.

The medical records for 12 residents, including the identified resident; the facility's grievance files, and incident and accident reports were reviewed. The staffing hours record from October 29, 2017 to November 18, 2017 was also reviewed. There were no concerns the facility did not provide adequate staffing

The Dietary Manager was interviewed regarding the identified resident's nutritional requirements. The Director of Nursing, Clinical Nurse Manager, Administrator, four direct care staff, and twelve residents were interviewed regarding quality of care concerns. There were no concerns expressed to the surveyor.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007683

Allegation: #1:

There was not enough staff to take care of the residents. There were four staff including the licensed staff for 42 residents.

Findings: #1:

The facility was licensed for 30 beds, and based on observation, record review, staff and resident interviews, it was determined the facility provided appropriate care to the residents and the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation: #2:

Since admission of the identified resident to the facility, the facility did not ensure the resident had enough to eat and drink. Family brought in a refrigerator and additional food, however staff did not offer additional food to the resident. The resident was dehydrated.

Findings: #2

The identified resident's 11/4/18 through 11/13/18 fluid and meal intake record, as well as the 11/7/17 through 11/13/18 caregiver notes were reviewed. Records documented the resident had variable amount of intake and with documented refusal of meals. The record also documented he was offered fluid and foods frequently. The Nurse Practitioner's assessment of the resident dated 11/13/18, documented the resident had warm, dry skin with good turgor, and his oral mucosa and tongue were moist. Review of the resident's hospital record dated 11/13/18, documented normal results of the identified resident's urine analysis and blood test. Current residents in the facility and two family representative were interviewed. No concerns regarding snacks and meals were expressed during the interviews. The Administrator said all of the residents' rooms were equipped with a refrigerator, and he did not recall any residents having a refrigerator brought in to the facility.

Based on record review, staff, family representative, and resident interviews, it was determined the allegation was unsubstantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation: #3

On admission of the identified resident to the facility, the nurse was heard by family to say "Oh my God they have given us a corpse." The nursing assistant on duty when asked about the resident's eating and weight, appeared pleased he had lost 11 pounds since admission.

Findings: #3

The identified resident's clinical record documented his weight had been monitored daily in the facility from November 8, 2017 through November 13, 2017. His admit weight was 162.4 pounds. On November 13, 2017 the day he was sent to the hospital per family representative's request, the resident weighed 155.4 pounds. The resident lost seven pounds or 4.3 % of his weight since admission to the facility. The resident was evaluated by the Dietary Manager on 11/4/17 and again on 11/11/17. The Dietary Manager recommended an addition of cream soup and juice with lunch and dinner to increase resident's fluid and caloric consumption. On November 13, 2017, the Dietitian ordered a magic cup (a fortified nutrition snack) two times daily for the resident.

Several residents were interviewed and said they were pleased with the quality of care they received from the facility. Staff were respectful of residents and no one heard any staff making unnecessary comments towards the residents.

Based on record review and staff and resident interviews, the allegation could not be substantiated and no deficient practice was identified.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation: #4

When staff assisted the identified resident to eat, the family observed the resident coughing and spitting pureed food.

Findings: #4

During the investigation, two meal observations were conducted. Staff were observed to be attentive to residents' needs and requests. One certified nursing assistant was observed seated next to a resident who required assistance to eat. The CNA was observed to be aware of the resident's needs and was taking time in helping the resident to eat. The resident was not observed in any kind of distress while eating.

Review of the identified resident's clinical record documented he was on puree diet with honey thick liquids and be in upright position 20 - 30 minutes after meals and he required a one to one feeding assistant with aspiration precautions at all times.

Review of the identified resident's hospital record dated 11/3/18 documented he had mild edema on chest x-ray which could be cause of his coughing.

Based on observation and review of record, it could not be established that staff were not knowledgeable of residents needs who required assistance during meals. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Allegation #5:

The facility did not get any information from the identified resident's Power of Attorney, and the facility did not know the resident had a urethral pump.

Findings #5:

The identified resident was admitted to the facility on 11/4/18, accompanied by the resident's two family members. One family member was also the responsible party for the resident and provided information to the admitting nurse. The responsible party said the resident was independent prior to his admission to the hospital, drove his own car, did not use any assistive devices.

The identified resident's care plan documented he had urethral pump which was turned off. A registered nurse was interviewed and said the facility was aware the resident had a urethral pump which was replaced recently prior to his admission to the hospital. The nurse said it was turned off because the resident had difficulty opening it. Nursing notes also documented the resident had the urethral pump.

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

Joseph Frasure, Administrator
January 8, 2019
Page 5 of 5

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,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj