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 21, 2018

Brantley Shattuck, Administrator
Cascadia Of Nampa
900 N Happy Valley Rd,
Nampa, ID 83687

Provider #: 135144

FILE COPY

Dear Mr. Shattuck:

On **June 6, 2018**, a survey was conducted at Cascadia Of Nampa by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actnal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 1, 2018**. Failure to submit

an acceptable PoC by **July 1, 2018**, may result in the imposition of civil monetary penalties by **July 24, 2018**.

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

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

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.
- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

Civil Money Penalty
Denial of payment for new admissions effective Septermbe 6, 2018

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 6, 2018**, if substantial compliance is not achieved by that time.

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

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

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

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

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

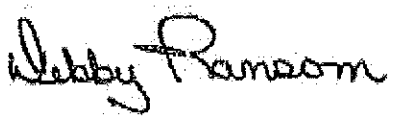
- BFS Letters (06/30/11)

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

This request must be received by **July 1, 2018**. If your request for informal dispute resolution is received after **July 1, 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

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

AGENCIES ATION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135144		C 06/06/2018

PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADIA OF NAMPA	900 N HAPPY VALLEY RD NAMPA, ID 83687

(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 a complaint survey conducted at the facility from June 5, 2018 to June 6, 2018. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Teresa Kobza, RD Abbreviations: CNA = Certified Nursing Assistant DNS = Director of Nursing ER = Extended Release g = grams HCL = Hydrochloride MAR = Medication Administration Record mcg = Micrograms mg = milligrams PRN = as needed Q = every RN = Registered Nurse TID = Three times a day	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cascadia of Nampa does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655	F655 Resident Specific The clinical Interdisciplinary Team (IDT) reviewed resident #1-4 and conducted pain evaluations. Care plans were updated with diagnosis for actual and potential pain. Non-pharmacological interventions were added to the care plans as appropriate. Resident #3 orders for advanced directives were obtained and the care plan was updated. Other Residents The clinical IDT conducted new pain evaluations for other residents. The team also reviewed care plans for inclusion of advanced directives per resident choice and physician orders. Adjustments to the care plan have been made as indicated. Facility Systems Nursing personnel are educated to complete baseline care plans within 48 hours of admission. Re-education was provided by the DNS/designee to include but not limited to fully completing the tool, do not leave blanks on the baseline care plan, including pain management, advanced directives, and other pertinent diagnosis/ care areas. The system is amended to complete review of new admission charts the next business day. For Friday and Saturday admissions, the nursing on-call staff will review. Monitor The DNS and/or designee will audit all initial care plans within 48 hours of admission for pain diagnosis, interventions, and advance directives for 4 weeks, then 50% of admissions per week for 8 weeks. Starting the week of July 24, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed and reported to the QAPI Committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. RECEIVED JUL - 2 2018 FACILITY STANDARDS	Date of Compliance: July 18, 2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 07/01/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 655	Continued From page 1 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure baseline care plans included pain management and advance directive resuscitation code status (Full Code or Do Not Resuscitate). This was true for 4 of 4 (#1 - #4) sample residents whose	F 655		

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F 655	Continued From page 2 baseline care plans were reviewed. This created the potential for residents' pain management needs to go unmet and resuscitation measures to be initiated, or not initiated, contrary to the residents' wishes. Findings include: 1. Resident #1 was admitted to the facility on 5/24/18 with diagnoses which included stage 4 pressure ulcer, lower back pain, muscle weakness, polyneuropathy (disease involving several nerves), and fibromyalgia (widespread muscle pain and tenderness). A History and Physical Note, dated 5/25/18, documented Resident #1 had chronic back pain, a stage 4 pressure ulcer on her right calf with was painful, and fibromyalgia. A Pain Evaluation, dated 5/24/18, documented Resident #1 had pain at times due to chronic osteoarthritis, occasional headaches, and the pressure ulcer on her posterior right calf. The baseline care plan, dated 5/24/18, did not include Resident #1's pain management plans. On 6/6/18 at 11:04 AM, the DNS and the Clinical Resource Nurse stated the baseline care plan did not have a section for pain management. 2. Resident #4 was admitted to the facility on 5/24/18 with diagnoses which included rheumatoid arthritis (chronic inflammatory disorder that affects joints, and can affect other tissue and organs). The baseline care plan, dated 5/24/18, did not include Resident #4's pain management plans.	F 655		

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F 655	Continued From page 3 On 6/6/18 at 11:04 AM, the DNS and the Clinical Resource Nurse stated the baseline care plan did not have a section for pain management. 3. Resident #2 was admitted to the facility with multiple diagnoses, including arthritis and a hip replacement. The admission Pain Evaluation, dated 5/24/18, documented Resident #2 had acute pain to the right hip, post-surgical pain to the right hip, and chronic low back pain. A History and Physical evaluation, dated 5/25/18, documented Resident #2's past medical history was significant for fibromyalgia, muscle spasms, and osteoarthritis in general, particularly the right hip. The evaluation stated Resident #2 complained of right hip pain which was not well controlled with his current pain regimen. The baseline care plan, dated 5/24/18, did not include pain management for Resident #2. On 6/6/18 at 11:04 AM, the DNS and the Clinical Resource Nurse stated the baseline care plan did not have a section for pain management. 4. Resident #3 was admitted to the facility on 6/1/18 with multiple diagnoses, including a hip replacement. The baseline care plan, dated 6/1/18, did not include pain management. Additionally, Resident #3's resuscitation code status was not included on the plan. The section to document code status was left blank. On 6/6/18 at 11:04 AM, the DNS and the Clinical	F 655		

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F 655	Continued From page 4 Resource Nurse stated the baseline care plan did not have a section for pain management. The DNS stated if the code status section was left blank, if meant Resident #4 was a full code.	F 655	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cascadia of Nampa does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and review of residents' records and narcotic count sheets, it was determined the facility failed to ensure professional standards of practice were followed for 4 of 4 sampled residents (#1-#4) reviewed for standards of practice: * Resident #1 experienced increased pain and the physician was not notified for two days. * Resident #1's physician's orders were transcribed incorrectly. * A delay in transcribing physician's orders for Resident #2 for pain management and Resident #4 for a change in dietary texture resulted in delay of treatment. * Resident #2's and Resident #3's medication	F 684	F684 Resident Specific The clinical Interdisciplinary Team (IDT) reviewed resident #1-3. Orders were reviewed and corrected. Physician was updated and additional orders/care directives received as indicated. New orders were accurately transcribed and implemented timely. Resident #4 was discharged. Other Residents The IDT review other residents: New pain evaluations were conducted, needs assessed for potential routine pain medication, physician updated, orders received, and transcribed timely and accuretely. Individual resident order summaries were reviewed for order input accuracy to include wound sites. Physician order clarification was received as indicated.The medication administration record (MAR) was reviewed for residents prescribed acetaminophen or other medications containing acetaminophen for dosages potentially exceeding 3 grams per 24 hours. These orders were corrected to validate proper dosage guidelines are followed. Alerts to evaluate volume of acetaminophen received were placed on acetaminophen orders. Narcotic records were reviewed for and administration instructions entered onto the log. Diet orders for texture downgrade were reviewed for stop dates end to validate proper assessment by the speech therapist prior to upgrade. Adjustments have been made as indicated.	

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F 684	Continued From page 5 orders were transcribed incorrectly. * Resident #4's diuretic medication was not held per physician's orders. Additionally, she was not assessed during and after the physician ordered a full liquid diet trial for dysphagia, and during and after her diet was changed to a regular diet. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include: 1. Resident #2 was admitted to the facility on 5/24/18 with multiple diagnoses, including osteoarthritis and a hip replacement. An Admission physician's order, dated 5/24/18, documented Resident #2 received Meloxicam 7.5 mg twice a day for arthritis; Percocet 10/325 mg two tablets every 4 hours as needed for pain; Lyrica 225 mg every 12 hours for neuropathy; and Oxycontin ER (extended release) 20 mg one tablet three times a day for 7 days for pain. a. Resident #2's May 2018 MAR documented Resident #2 did not receive Oxycontin ER 20 mg on the following dates: * 5/29/18 at 10:00 PM * 5/30/18 at 8:00 AM * 5/30/18 at 2:00 PM A nurse's progress note, dated 5/29/18 at 4:41 PM, documented a physician's order for Norco (Hydrocodone/Acetaminophen) 10/325 mg two tablets every 4 hours as needed for 3 doses for Resident #2's moderate pain.	F 684	Facility Systems Licensed nurses have been reviewed and validated to have skills to meet or exceed medication pass professional standards by the DNS, designee, and/or pharmacist/ pharmacy nurse. Nursing staff are educated on professional standards of practice. Re-education was provided by the DNS/designee to include but not limited to order input procedures, accuracy, end dates as appropriate, when to seek clarification, if no response from physician how/when to re-approach, and timeliness. There must be no delay in treatment. In addition diet upgrade procedures, documentation of medication administration, provision of medication within 1 hour of the assigned time, reading the order carefully to administer the correct number of tablets, need for all narcotic records to include administration instructions, holding medications as ordered when parameters are in place, timely physician notification for requested order changes and patterns identified of low SBPs, do not administer acetaminophen if greater than 3 grams per 24 hours, evaluation of PRN use trends to update physician for possible routine pain medication. The system is amended to check new orders, physician response, and resident change of conditions at the clinical care meeting. Licensed nurse skills checks will be completed with on-going surveillance. Monitor The DNS and/or designee will audit medication management system, timeliness in physician response and transcription, notification when resident response is outside of parameters set, accuracy of documentation and transcription twice weekly for 4 weeks, then weekly for 8 weeks. Medication pass monitoring will also occur twice weekly for 4 weeks, then weekly for 8 weeks. Starting the week of July 18, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	Date of Compliance: July 18, 2018

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F 684	Continued From page 6 Resident #2's narcotic record, dated 5/29/18 at 11:30 PM, documented, "Hydrocodone/apap (Norco) 2 tabs Q 4 Hours PRN x 3 Doses." Six doses were removed from the emergency kit. Resident #2 received Norco two tablets on 5/30/18 at 12:00 AM, 4:00 AM, and 12:20 PM. A nurse's progress note, dated 5/30/18 at 7:15 PM, documented Resident #2 "missed doses of Oxycontin 20 mg ER as the pharmacy had made a mistake when sending his original order. They sent 19 pills of 10 mg and staff had to use 2 per dose. He was getting these TID and the first card they sent only lasted 3 days, when staff tried to reorder pharmacy stated that they needed a new script...Pharmacy states that they had run out of these meds and that is why they only sent 19 and that the remaining were supposed to be sent out the next day but for some reason it was missed. This was all explained to the pt (patient) and he now has the meds that he is supposed to have." On 6/5/18 at 9:15 AM, Resident #2 stated he had not received his routine pain medications as scheduled per physician's orders. On 6/6/18 at 9:00 AM, the DNS stated Resident #2 did not receive his routine Oxycontin 20 mg for three doses. The DNS stated she received a physician's order for Resident #2 to use Norco 10/325 mg for the three doses of the Oxycontin. The DNS stated the scheduled administration times for the Norco should have been the same as the Oxycontin administration times. b. Resident #2 physician's order, dated 5/24/18, documented he was to receive Oxycodone/Acetaminophen 10/325 mg 2 tablets	F 684		

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F 684	Continued From page 7 every 4 hours as needed for pain not to exceed 3 grams of APAP (Tylenol) in 24 hours. Resident #2 physician's order, dated 5/29/18, documented he was to receive Hydrocodone/Acetaminophen 2 tablets every 4 hours as needed for pain for three doses. The May 2018 MAR documented Resident #2 received Oxycodone/Acetaminophen 10/325 mg two tablets on 5/30/18 at 7:38 AM and 8:55 PM. Resident #2 received Hydrocodone/Acetaminophen 10/325 mg two tablets on 5/30/18 at 12:00 AM and 12:21 PM. A narcotic record for Oxycodone/Acetaminophen 10/325 mg, documented on 5/30/18, Resident #2 received two tablets at 7:40 AM, 4:30 PM, and 8:55 PM. A narcotic record for Hydrocodone/Acetaminophen 10/325 mg documented on 5/30/18, Resident #2 received two tablets at 12:00 AM, 4:00 AM, and 12:20 PM. Resident #2 received six doses of 650 mg of Acetaminophen, which equaled 3.9 grams of Tylenol in a 24 hour period on 5/30/18. On 6/6/18 at 9:10 AM, the DNS and the Clinical Resource Nurse were unaware Resident #2 received 3.9 grams of Tylenol on 5/30/18. The DNS stated Resident #2 received too much Tylenol on 5/30/18 and the physician should have been notified. c. Resident #2 physician's orders, dated 5/24/18, documented Lyrica 225 mg twice daily for neuropathy. Resident #2's narcotic record documented Lyrica	F 684		

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F 684	Continued From page 8 75 mg 3 tabs to equal 225 mg twice a day. The narcotic record, dated 5/24/15, documented 18 doses were received from the pharmacy. The narcotic record documented as follows: * 5/25/18 at 9:15 AM one tablet with 17 remaining, * 5/25/18 at 8:40 PM one tablet with 16 remaining, * 5/26/18 at 8:45 PM one tablet with 15 remaining, * 5/27/18 at 8:10 AM one tablet with 12 remaining, * 5/27/18 at 8:25 PM one tablet with 11 remaining. Resident #2 was administered 1 tablet, not 3 tablets at each administration, as ordered by the physician. Resident #2 did not receive a morning administration of Lyrica on 5/26/18, as ordered. On 5/26/18 at 8:45 PM 15 tablets of Lyrica remained. On 5/27/18 at 8:10 AM 1 tablet was administered bringing the count down to 14. Twelve 12 tablets were documented as remaining. There was no documentation of administration of tablet 13, resulting in 1 tablet unaccounted for. On 6/6/18 at 9:15 AM, the DNS and the Clinical Resource Nurse stated the Pharmacist reviewed Resident #2's medications and brought it to the facility's attention that the nurses were administering one tablet of the Lyrica 75 mg, not three tablets to equal 225 mg per the physician's orders. The Clinical Resource Nurse stated there were several medication errors, inaccurate calculations, and initiated an investigation. The DNS and the Clinical Resource Nurse stated Resident #2's pain was not controlled when he did not receive the correct dose.	F 684		

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F 684	Continued From page 9 d. Resident #2's physician's orders, dated 5/24/18, documented Oxycodone/Acetaminophen 10/325 mg 1 tablet every 4 hours as needed and Oxycodone/Acetaminophen 10/325 mg 2 tablets every 4 hours as needed for pain. The two orders were to indicate Resident #2 could have 1-2 tablets of Oxycodone/Acetaminophen 10/325 mg every 4 hours as needed. Resident #2's narcotic record, dated 5/31/18 at 2:00 PM, documented Oxycodone/Acetaminophen 10/325, directions for use "See Mar." The quantity received from the pharmacy was 21. The narcotic record did not include the directions for use of the medication, for example, 2 tablets every 4 hours as needed for pain. On 6/6/18 at 9:20 AM, the Clinical Resource Nurse stated the narcotic record should include the directions for use of the medication. e. A physician's order, dated 5/30/18, documented Resident #2 was to receive Percocet 10/325 mg 2 tablets every 8 hours for 7 days. The June 2018 MAR for Resident #2, dated 6/2/18, documented Percocet 10/325 mg 2 tablets three times a day for pain control. The times were set up for Resident #2 to receive Percocet at 8:00 AM, 2:00 PM, and 10:00 PM on 6/2/18 and 6/3/18. This schedule included 6 hours only between the 8:00 AM and 2:00 PM doses, instead of 8 hours as ordered. Starting 6/4/18, the time changed to 6:00 AM, 2:00 PM, and 10:00 PM. The narcotic record for the Percocet 10/325 mg,	F 684		

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F 684	Continued From page 10 documented Resident #2 received 1 tablet on 6/2/18 at 9:50 PM, 6:28 AM and 3:45 PM. The times of administration were not documented in chronological order. The times of administration of the Percocet documented on the narcotic record did not coincide with the times established for the Percocet (8:00 AM, 2:00 PM, and 10:00 PM on 6/2/18 and 6/3/18). Additionally, Resident #2 was not administered 2 tablets of Percocet per the physician's orders. A narcotic record for Percocet 10/325 mg, dated 5/29/18, documented Resident #2 received 2 tablets on 6/3/18 at 8:35 AM, 3:20 PM, and 10:10 PM. The Percocet 10/325 mg was given on 6/3/18 at 3:20 PM. The Percocet was scheduled to be given at 2:00 PM. The Institute for Safe Medicine Practices website www.ismp.org, accessed on 6/19/18, stated medications administered more frequently than daily, but not for more frequently than every 8 hours, should be administered within 1 hour before or after the scheduled time. Resident #2 was administered Percocet 1 hour and 20 minutes after the scheduled time of 2:00 PM. On 6/6/18 at 11:15 AM, the Clinical Resource Nurse stated the Percocet was not transcribed correctly on the MAR to reflect administration every 8 hours and Resident #2 did not receive the Percocet as scheduled. The Clinical Resource Nurse did not know the reason the routine order for the Percocet was not processed until 6/2/18. 2. Resident #3 was admitted to the facility on	F 684		

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F 684	Continued From page 11 6/1/18 with multiple diagnoses, including a hip replacement. Resident #3's June 2018 MAR, documented she was to receive Alprazolam 0.5 mg 1 tablet daily for anxiety, Fentanyl Patch 25 mcg to be changed every 3 days, and Oxycodone 15 mg 1 tablet every 4 hours as needed for pain. Resident #3's narcotic record, dated 6/1/18 at 3:00 PM, documented she was to receive Alprazolam 0.5 mg. The narcotic record did not include the directions for use of the medication. Resident #3's narcotic record, dated 6/1/18 at 3:00 PM, documented a Fentanyl Patch 25 mcg was to be applied every 72 hours. The directions for use documented, "See MAR." Resident #3's narcotic record, dated 6/1/18 at 3:00 PM, documented Oxycodone HCL 15 mg. The directions for use documented, "See MAR". On 6/6/18 at 9:20 AM, the Clinical Resource Nurse stated the narcotic record should include the directions for use of the medication. 3. Resident #1 was admitted to the facility on 5/24/18 with diagnoses which included a stage 4 pressure ulcer, lower back pain, muscle weakness, polyneuropathy (disease involving several nerves), and fibromyalgia (widespread muscle pain and tenderness). A History and Physical Note, dated 5/25/18, documented Resident #1 had chronic back pain, a stage 4 pressure ulcer to her right calf which caused her pain, and fibromyalgia.	F 684		

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F 684	Continued From page 12 Resident #1's Transfer orders to the facility, dated 5/23/18, documented the following regarding pain: * Resident #1 was to receive 650 mg Tylenol [pain relief] every 4 hours as needed for mild pain, (pain score 1-3) not to exceed 3 grams in 24 hours, ordered 4/27/18. * Resident #1 was to receive lidocaine cream 4% as needed for wound debridement, ordered 4/29/18. Resident #1's admission May 2018 Physician orders documented the following regarding pain: * Resident #1 was to receive 650 mg Tylenol every 4 hours as needed for mild pain, ordered 5/24/18. * Resident #1 was to receive lidocaine cream 4% applied to her heel wound as needed for pain with wound debridement, ordered 5/24/18. Resident #1's pressure ulcer was located on her right calf and not on her heel. Resident #1's physician's order was not transcribed for the correct wound location of the right calf. Resident #1's physician orders did not include other pain medications to include scheduled pain medications or medications to be administered if she experienced greater than mild pain. A Progress Note, dated 6/3/18 at 9:54 PM, documented Resident #1 stated the 650 mg of Tylenol for pain was not effective and her pain level was as high as a 7 out of 10 at times. The note included a request for an order for Tramadol. On 6/5/18 at 9:43 AM, Resident #1 was observed	F 684		

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F 684	Continued From page 13 speaking with a Physician's Assistant and complained about her leg hurting. On 6/5/18 at 3:49 PM, Resident #1 stated her leg was hurting around her knee and down to her ankle. Resident #1 stated staff had not offered her pain medications that day or the previous day. She said the medication provided prior to that had been ineffective. Resident #1 stated her pain had not been managed well. On 6/5/18, two days after an order for Tramadol was requested, a Physician order was documented for Resident #1 was to receive 50 mg of Tramadol every 6 hours as needed for pain. On 6/6/18 at 9:10 AM, the Clinical Resource Nurse stated the Lidocaine cream was to be applied to Resident #1's right calf wound. She stated Resident #1 did not currently have pressure ulcers on her heels. The Clinical Resource Nurse stated the order should have been clarified. The Clinical Resource Nurse did not know the reason Resident #1's pain medication was ordered two days after it was requested. The Clinical Resource Nurse stated the facility should have called the physician on 6/3/18 to obtain an order for the Tramadol. 4. Resident #4 was admitted to the facility on 5/24/18 with diagnoses which included rheumatoid arthritis, hypertension, congestive heart failure (CHF), muscle weakness, and gastro-esophageal reflux disease. The baseline care plan, dated 5/24/18, documented Resident #4 was at risk for swallowing concerns related to her complaints of	F 684		

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F 684	Continued From page 14 difficulties with swallowing food and food could stick in her throat "at times." The care plan documented Speech Therapy was following Resident #4 for dysphagia (difficulty swallowing) concerns. On 6/5/18 at 9:45 AM, Resident #4 was observed in bed with a plate of two pancakes and a bowl of oatmeal. Resident #4 had consumed 1 bite of a pancake and stated she had issues swallowing since admission to the facility. Resident #4 stated the food would get "stuck" in her throat. Resident #4 stated she could drink liquids easily. Resident #4 stated prior to admission to the facility a speech therapist was working with her on her swallowing problems in the hospital. Resident #4 stated Speech Therapy was not currently working with her to address her swallowing difficulties. a. The Admission orders to the facility, dated 5/24/18, documented Resident #4 was to receive a Heart Healthy diet with regular texture and consistency. A Physician's Order, dated 5/29/18, documented Speech Therapy was to evaluate and treat Resident #4. On 5/30/18 the physician changed the diet order to "full liquid diet x [for] 3 days" for [related to] dysphagia. The order stated Resident #4 was to have an evaluation by a gastrointestinal specialist. A Physician Progress Note, dated 5/30/18, documented Resident #4 was diagnosed with dysphagia and to change her diet to "full liquid" with no end date noted.	F 684		

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F 684	Continued From page 15 A Speech Therapy Note, dated 5/31/18, documented Resident #4 was experiencing swallowing issues and had a need for a gastrointestinal consultation. The note documented, "At this time, no therapy is warranted until the cause of this issue is determined. She is currently on 3 day full fortified liquid diet. May need to make diet changes." Resident #4's 6/1/18 and 6/4/18 Speech Therapy Progress Notes did not include documentation of monitoring of her swallowing. Resident #4's 5/30/18 through 6/1/18 Progress Notes did not document if nursing assessed Resident #4 to verify if she was tolerating the full liquid diet with the exception of one late entry on 6/2/18 at 1:46 PM. On 6/2/18 Resident #4's diet was changed back to a Heart Healthy diet with regular texture and consistency. Resident #4's clinical record did not contain documentation she was assessed for safety after the Heart Healthy, regular texture and consistency, diet was restarted on 6/2/18. On 6/5/18 a physician's order documented Resident #4's diet was changed to a "full liquid diet." On 6/6/18 at 11:04 AM, the Clinical Resource Nurse stated Speech Therapy was following Resident #4 for cognitive issues and was going to see her for swallowing concerns after the gastrointestinal consultation was completed. The Clinical Resource Nurse was unable to provide documentation of a safety assessment of	F 684		

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F 684	Continued From page 16 Resident #4 after the full liquid diet three day trial and subsequent diet upgrade. The Clinical Resource Nurse stated she expected staff to document the resident's diet changes during and after the three day trial and to update the physician. b. A Progress Note, dated 5/31/18 at 9:30 AM, documented Resident #4's diet was downgraded to a full liquid diet due to difficulties with swallowing and poor appetite. The note documented the Registered Dietitian (RD) recommended 180 milliliters (ml) fluids enhancements TID with medication pass and 1 can of fortified shake TID with medication pass. Resident #4's June 2018 Physician orders documented she was to receive supplements as follows: * 180 ml fluids enhancements TID with medication pass, ordered 6/5/18. * 1 can of fortified shake TID with medication pass, ordered 6/5/18. Resident #4's supplements were transcribed 5 days after the RD made the recommendations. On 6/6/18 at 10:19 AM, the Clinical Resource Nurse stated when the RD made a recommendation the nursing staff should enter the orders into the system the same day for the physician to review. c. On 5/31/18 a physician's order documented Resident #4 was to receive Spironolactone 0.5 milligrams in the morning for CHF. Staff were to hold the medication if her systolic blood pressure (SBP) was less than 110.	F 684		

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F 684	Continued From page 17 The June 2018 MAR documented Resident #4's SBP was less than 110 as follows: * 6/1/18 - 103/78 * 6/3/18 - 100/64 * 6/5/18 - 104/71 Resident #4's June 2018 MAR documented the Spironolactone was administered on the dates listed above. On 6/6/18 at 11:15 AM, the Clinical Resource Nurse stated staff should have held the medication when Resident #4's SBP was less than 110. The Clinical Resource Nurse stated if there was a pattern of low SBPs, the medical practitioner should be notified.	F 684		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 and resident interview, review of narcotic count records and residents' clinical records, it was determined the facility failed to ensure a method for evaluating the effectiveness of residents' pain management plans was in place. This was true for 2 of 4 residents (#1 and #2) sampled for pain. Resident #1 and Resident #2 were harmed when they experienced increased pain and the facility did not identify and	F 697		

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F 697	Continued From page 18 treat it timely. Findings include: 1. Resident #1 was admitted to the facility on 5/24/18, with diagnoses which included a stage 4 pressure ulcer, lower back pain, muscle weakness, polyneuropathy (disease involving several nerves), and fibromyalgia (widespread muscle pain and tenderness). The baseline care plan, dated 5/24/18, did not include Resident #1's pain management plan and documented she had a stage 4 pressure ulcer to her lower calf. A Pain Evaluation, dated 5/24/18, documented Resident #1 had pain at times due to chronic osteoarthritis, occasional headaches, and her posterior right calf. The evaluation documented an acceptable pain level for Resident #1 was 6 out of 10 and her pain occurred mostly in the morning. A History and Physical Note, dated 5/25/18, documented Resident #1 had chronic back pain, a stage 4 pressure ulcer to her right calf which caused her pain, and fibromyalgia. Resident #1's Transfer orders to the facility, dated 5/23/18, documented the following regarding pain: * Resident #1 was to receive 650 mg Tylenol [pain relief] every 4 hours as needed for mild pain, (pain score 1-3) not to exceed 3 grams in 24 hours, ordered 4/27/18. * Resident #1 was to receive lidocaine cream 4% as needed for wound debridement, ordered 4/29/18.	F 697	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cascadia of Nampa does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F697 Resident Specific The clinical Interdisciplinary Team (IDT) reviewed resident #1 and 2 for accurate pain assessment, shift to shift monitoring, evaluation of pain regimen effectiveness, physician update, and care implementation. Adjustments were made as indicated. Other Residents The clinical IDT reviewed other residents related to the methods to evaluate effectiveness of residents' pain management. Adjustments have been made as indicated. Facility Systems Licensed nurses are educated to evaluate, treat and provide pain remedies per the care plan and document effectiveness in a timely manner. Re-education was provided by the DNS/ designee to include but not limited to identification of pain trending on the shift-to-shift monitor, accurate dosing with number of pills, no missed or late dosing, treatment regimen implementation, effectiveness of administration documentation, proper procedure for validating physician timely response and accurate transcription of orders, non-pharmacological interventions, and timely re-evaluation and response when residents express pain. The system is amended to include review of PRN pain medication use, progress notes, and evaluation of pain management program effectiveness in clinical care meeting. Then review of shift-to-shift pain monitor trending weekly. Monitor The DNS and/or designee will audit eMAR for PRN pain medications administered, timely evaluation of effectiveness, and physician notification and response regarding pain if indicated on 5 residents twice weekly for 4 weeks, then weekly for 8 weeks. Starting the week of July 24, 2018, the review will be documented on the QAPI audit tool. Audits will be addressed and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	Date of Compliance July 18, 2018

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F 697	Continued From page 19 Resident #1's admission May 2018 Physician orders documented the following regarding pain: * Resident #1 was to receive 650 mg Tylenol every 4 hours as needed for mild pain, ordered 5/24/18. * Resident #1 was to receive lidocaine cream 4% applied to her heel wound as needed for pain with wound debridement, ordered 5/24/18. * Staff were to monitor and document Resident #1's pain ratings at the start of each shift using verbal and non-verbal scale of 0-10, ordered 5/24/18. Resident #1's pressure ulcer was located on her right calf and not on her heel. Resident #1's physician's order was not transcribed for the correct wound location of the right calf. Resident #1's physician orders did not include other pain medications to include scheduled pain medications or medications to be administered if she experienced greater than mild pain The May and June 2018 MARs documented Resident #1's pain was consistently greater than 3 and ranged between 4 and 8 on a 0-10 pain scale. Resident #1 was administered a dose of PRN Tylenol on 5/25/18 at 1:52 AM and 2:04 PM, 5/26/18 at 12:15 AM, and 6/3/18 at 4:30 PM. A Progress Note, dated 6/3/18 at 9:54 PM, documented Resident #1 stated the 650 mg of Tylenol for pain was not effective and her pain level was as high as a 7 out of 10 at times. The note included a request for an order for Tramadol. On 6/5/18 at 9:43 AM, Resident #1 was observed speaking with a Physicians Assistant (PA) and complained about her leg hurting. Two CNAs	F 697		

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F 697	Continued From page 20 were present in the room with the PA. A Progress Note, dated 6/3/18 at 1:44 PM, documented a PA visited Resident #1 and she received new orders for Tramadol 50 mg every 6 hours for pain. A 6/5/18 Physician order documented Resident #1 was to receive 50 mg of Tramadol every 6 hours as needed for pain. On 6/5/18 at 3:49 PM, Resident #1 stated she her leg was hurting around her knee and down to her ankle. Resident #1 stated staff had not offered her pain medications that day or the previous day, and she would like some. She stated the medication provided prior to that had been ineffective. Resident #1 stated her pain had not been managed well. Resident #1 stated she had told a staff member that morning about the pain in her leg and they had not provided her with pain medications as of the time of the interview. Resident #1 stated her pain had not been managed well. On 6/5/18 at 3:52 PM, the Activities Director visited Resident #1 and did not ask Resident #1 if anything she could do for her. On 6/5/18 at 3:53 PM, a laundry staff member entered Resident #1's room and did not ask Resident #1 if there was anything she could do for her. On 6/5/18 at 3:56 PM, RN #1 was notified of Resident #1's pain in her leg and her request for pain medications. RN #1 stated she would have to call the pharmacy to verify when the pain medications would be delivered.	F 697		

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	135144		C 06/06/2018

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F 697	Continued From page 21 On 6/6/18 at 9:10 AM, the Clinical Resource Nurse stated the Lidocaine cream was supposed to be applied to Resident #1's right calf wound. She stated Resident #1 did not currently have pressure ulcers on her heels. The Clinical Resource Nurse stated the order should have been clarified. The nurse did not know why Resident #1's pain medication was ordered two days after it was requested. The Clinical Resource Nurse stated the facility should have called the physician on 6/3/18 to obtain an order for the Tramadol pain medication. b. Resident #1 was to receive 650 mg Tylenol every 4 hours as needed for mild pain, ordered 5/24/18. A 6/5/18 Physician orders documented Resident #1 was to receive 50 mg of Tramadol every 6 hours as needed for pain. The May and June 2018 MARs documented the time of the administration of Resident #1's PRN pain medications. Resident #1's MAR documented she was administered a dose of PRN Tylenol on 6/3/18 at 4:30 PM. Resident #1's MAR documented she was administered a dose of PRN Tramadol on 6/5/18 at 4:22 PM. A Progress Note, dated 6/5/18 at 10:44 PM, documented the effectiveness of the medication, 6 hours after the medication was administered. On 6/6/18 at 9:10 AM, the Clinical Resource Nurse stated staff should be monitoring for efficacy of pain medications within 1-2 hours after	F 697		

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F 697	Continued From page 22 giving the medications. The Clinical Resource Nurse stated 6 hours was too long to wait. 2. Resident #2 was admitted to the facility on 5/24/18 with multiple diagnoses, including osteoarthritis and a hip replacement. An admission Physician's Orders, dated 5/24/18, documented Resident #2 received Meloxicam 7.5 mg twice a day for arthritis; Lyrica 225 mg every 12 hours for neuropathy; Oxycontin ER (extended release) 20 mg one tablet three times a day for 7 days for pain; and Oxycodone/APAP (Percocet) 10/325 mg two tablets every 4 hours as needed for pain. Resident #2's narcotic record documented Lyrica 75 mg 3 tabs to equal 225 mg twice a day. The narcotic record, dated 5/24/18, documented 18 doses were received by the pharmacy. The narcotic record documented Resident #2 received Lyrica as follows on: * 5/25/18 at 9:15 AM one tablet with 17 remaining, * 5/25/18 at 8:40 PM one tablet with 16 remaining, * 5/26/18 at 8:45 PM one tablet with 15 remaining, * 5/27/18 at 8:10 AM one tablet with 12 remaining, * 5/27/18 at 8:25 PM one tablet with 11 remaining. Resident #2 was administered 1 tablet, not 3 tablets at each administration, as ordered by the physician. Resident #2 did not receive a morning administration of Lyrica on 5/26/18, as ordered. A May 2018 MAR, dated 5/29/18 at 12:41 AM,	F 697		

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F 697	Continued From page 23 documented Resident #2 received non-pharmacological interventions: repositioning, dim light/quiet environment, and hot/cold applications that were ineffective. On 6/5/18 at 9:20 AM, Resident #2 stated the facility was not managing his pain with medications or ice. Resident #2 stated he rarely received his scheduled pain medications on time and only received ice once for his right hip. On 6/6/18 at 9:15 AM, the DNS and the Clinical Resource Nurse stated the Pharmacist reviewed Resident #2's medications and brought it to the facility's attention that the nurses were administering one tablet of the Lyrica 75 mg, not three tablets to equal 225 mg per the physician's orders. The Clinical Resource Nurse stated there were several medication errors, inaccurate calculations, and initiated an investigation. The DNS and the Clinical Resource Nurse stated Resident #2's pain was not controlled when he did not receive the correct dose of Lyrica. The DNS stated the CNA's applied ice to Resident #2's hip daily, but was unable to provide documentation.	F 697		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		

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F 842	Continued From page 24 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when	F 842	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cascadia of Nampa does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F842 Resident Specific The clinical Interdisciplinary Team (IDT) reviewed Resident #1 and 2. Orders were clarified and updated for Resident #1. The schedule was adjusted in the system to reflect proper medication scheduling for Resident #2. Other Residents The clinical IDT reviewed other residents for order accuracy and medication timing. Adjustments have been made as indicated. Facility Systems LNs are educated to input orders and validate accuracy. Re-education was provided by the DNS/designee to include correct order transcription to the medical record, physician order clarification if indicated, and validation of timing for medication administration. The system is amended to include review of all new orders by the clinical IDT in clinical care meeting. Monitor The DNS and/or designee will audit new orders on 5 residents twice weekly for 4 weeks, then weekly for 8 weeks. Starting the week of July 24, 2018, the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	Date of Compliance July 18, 2018

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F 842	Continued From page 25 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure accurate and complete clinical records were maintained for each resident. This was true for 2 of 4 sample residents (#1 and #2) whose records were reviewed. The deficient practice created the potential for harm should inappropriate care and/or treatment be provided based on inaccurate information in the resident's clinical record. Findings include: 1. Resident #1 was admitted to the facility on 5/24/18 with diagnoses which included a stage 4 pressure ulcer, lower back pain, muscle weakness, polyneuropathy (disease involving several nerves), and fibromyalgia (widespread muscle pain and tenderness). A History and Physical Note, dated 5/25/18, documented Resident #1 had chronic back pain, a stage 4 pressure ulcer to her right calf which	F 842		

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F 842	Continued From page 26 caused her pain, and fibromyalgia. Resident #1's transfer orders to the facility, dated 5/23/18, documented Resident #1 was to receive lidocaine cream 4% as needed for wound debridement, ordered 4/29/18. An admission May 2018 Physician Orders documented Resident #1 was to receive lidocaine cream 4% applied to her heel wound as needed for pain with wound debridement, ordered 5/24/18. Resident #1's pressure ulcer was located on her right calf and not on her heel. Resident #1's physician's order was not transcribed for the correct wound location of the right calf. On 6/6/18 at 9:10 AM, the Clinical Resource Nurse stated the Lidocaine cream was supposed to be applied to Resident #1's right calf wound. She stated Resident #1 did not currently have pressure ulcers on her heels. The Clinical Resource Nurse stated the order should have been clarified. 2. Resident #2 was admitted to the facility on 5/24/18 with multiple diagnoses, including osteoarthritis and a hip replacement. A History and Physical evaluation, dated 5/25/18, documented Resident #2's past medical history was significant for fibromyalgia, muscle spasms, and osteoarthritis, particularly in the right hip. The evaluation documented Resident #2 complained of right hip pain that was not well controlled with his current pain regimen. A Physician's Order, dated 5/30/18, documented	F 842		

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F 842	Continued From page 27 Resident #2 was to receive Percocet 10/325 mg 2 tablets every 8 hours for 7 days. The June 2018 MAR for Resident #2, dated 6/2/18, documented Percocet 10/325 mg 2 tablets three times a day for pain control. The times were set up for Resident #2 to receive at 8:00 AM, 2:00 PM, and 10:00 PM on 6/2/18 and 6/3/18. This schedule included 6 hours only between the 8:00 AM and 2:00 PM doses, instead of 8 hours as ordered. On 6/6/18 at 11:15 AM, the Clinical Resource Nurse stated the Percocet was not transcribed accurately on the MAR to reflect every 8 hours and Resident #2 did not receive the Percocet per physician's orders. The Clinical Resource Nurse the floor nurse should have processed the order the day it was prescribed.	F 842		