



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](mailto:fsb@dhw.idaho.gov)

July 6, 2018

Troy Thayne, Administrator  
Desert View Care Center of Buhl  
820 Sprague Avenue  
Buhl, ID 83316-1827

Provider #: 135089

Dear Mr. Thayne:

On **June 15, 2018**, a survey was conducted at Desert View Care Center of Buhl 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 **July 16, 2018**. Failure to submit an acceptable PoC by **July 16, 2018**, may result in the imposition of additional civil monetary penalties by **July 9, 2018**.

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

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

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

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

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

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

Denial of Payment for New Admissions effective September 15, 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 15, 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:

**F0604 -- S/S: F -- 483.10(e)(1), 483.12(a)(2) -- Right To Be Free From Physical Restraints;  
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 # **#2, #8, #10, #12, #18, #19, #24, #25, #26, #28, #31, #83** 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.

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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:

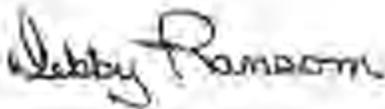
- BFS Letters (06/30/11)

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

This request must be received by **July 16, 2018**. If your request for informal dispute resolution is received after **July 16, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

dr/lj  
Enclosures

cc: Chairman, Board of Examiners - Nursing Home Administrators

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

PRINTED: 07/27/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135089</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DESERT VIEW CARE CENTER OF BUHL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 SPRAGUE AVENUE BUHL, ID 83316</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification survey conducted on-site at the facility on June 11, 2018 to June 15, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Presie Billington, RN</p> <p>On 6/15/18, two surveyors joined the team and they were:</p> <p>Jenny Walker, RN Bradley Perry, LSW</p> <p>Abbreviations:</p> <p>ADL = Activities of Daily Living ADM = Administrator DM = Dietary Manager DON = Director of Nursing DOR = Director of Rehabilitation COTA = Certified Occupational Therapy Assistant LE = Lower extremity LPN = Licensed Practical Nurse mcg = microgram(s) MDS = Minimum Data Set OT = Occupational Therapy PRN = As needed PT = Physical Therapy RN = Registered Nurse RNA = Restorative Nursing Assistant ROM = Range of Motion RSP #1 = Rehabilitation Services Provider #1 RSP #2 = Rehabilitation Services Provide #2 SBA = Stand by assist w/c = wheelchair</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>07/16/2018</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 604 SS=F	<p>Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)</p> <p>§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, clinical record review, and policy review, it was determined the facility failed to ensure residents were free from restraints. This</p>	F 604	<p>1- Residents #2, 8, 10, 24, 18, 19, 25, 26, 28, 31,&amp; 83's beds were assessed and documented on the restraint assessment, and were found to be</p>	7/31/18	

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F 604	<p>Continued From page 2</p> <p>was true for 12 of 12 sample residents (#2, #8, #10, #12, #18, #19, #24, #25, #26, #28, #31, and #83) and 25 other residents living in the facility whose beds were against the wall during the survey. The failure to recognize beds against the wall as a potential restraint represented a systemic failure and constituted substandard quality of care. The practice of placing a bed against the wall without first determining if it was a restraint for each individual resident increased the risk for residents to experience physical injury and psychological decline due to restricted movement. Findings include:</p> <p>On 6/13/18 at 4:20 PM, LPN #2 said the facility did not assess Resident #28's bed against the wall as a possible restraint because it did not consider a bed against the wall as a potential restraint.</p> <p>On 6/13/18 at 5:00 PM, RN #2 said the nurses ensured a resident with weakness or no movement on one side was not positioned against the wall on their "good side." She said the facility did not consider a bed against the wall to be a restraint and had not assessed beds against the wall as such.</p> <p>On 6/13/18 at 4:15 PM, the DON provided the facility's Use of Physical Restraints and Involuntary Seclusion policy. The policy documented, "...Physical restraints and involuntary seclusion are prohibited..."1. Physical Restraints" are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily,</p>	F 604	<p>restraint free.</p> <p>2- All residents have the potential to be affected. All residents received a bed assessment to determine if their beds were restraints.</p> <p>3- The facility will add beds against the wall and halo bars to the restraint policy and procedures to include consents, physician orders, and assessment. Nurses will be educated to perform bed/restraint assessments per the policy and procedures. All residents upon admission will receive a bed/restraint assessment to determine bed safety and to assure that any resident with a bed against the wall is restraint free. A bed/restraint assessment will be conducted at least quarterly and upon significant change of condition of every resident. Restraint audits will be completed weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter by the DON/designee.</p> <p>4- The audits will be reviewed at least quarterly during the facility QAPI meeting for compliance.</p>		

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F 604	<p>Continued From page 3</p> <p>which restricts freedom of movement or restricts normal access to one's body...3. The definition of a restraint is based on the functional status of the resident and not the device...4. Examples of devices that are/may be considered physical restraints include: leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove. 5. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: ...Placing a resident who uses a wheelchair so close to the wall that the wall prevents the resident from rising." The policy did not address beds against the wall as potential restraints and the DON said the facility did not have a policy regarding beds against the wall as potential restraints.</p> <p>On 6/14/18 at 11:00 AM, the DON said their practice was to position beds against the wall to provide more space in resident rooms. She said she had not considered a bed against the wall as a potential restraint and that residents were not being assessed to determine if a bed against the wall was a restraint for them individually.</p> <p>Residents beds were positioned against a wall prior to completion of assessments of the bed's position as a possible restraint, consents garnered, and physician orders in place, as follows:</p> <p>a) Resident #8 was originally admitted to the facility in 2012 with multiple diagnoses which included chronic ischemic heart disease, dementia, anxiety disorder, major depressive disorder, generalized muscle weakness, and</p>	F 604			

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F 604	<p>Continued From page 4</p> <p>abnormal gait and mobility. She was readmitted on 1/11/18 following hospitalization for pneumonia.</p> <p>Resident #8's significant change MDS assessment, dated 4/3/18, documented moderately impaired cognition; she was understood by others and was able to understand others; she required extensive assistance of 1 person for bed mobility, dressing, and personal hygiene and assistance of 2 or more people for transfers and toileting; she had functional limitation in ROM in both lower extremities; she had frequent bladder incontinence and was always incontinent of bowel; and no restraints were in use.</p> <p>Resident #8's care plan, initiated 1/16/18, documented revisions on 4/20/18 regarding medications, 4/4/18 regarding toileting, and 3/19/18 regarding an RNA plan. The resident's care plan did not include or address the bed against the wall.</p> <p>Resident #8's bed was observed against the wall on the resident's right side as follows: * on 6/11/18 at 3:33 PM and 4:22 PM, * on 6/12/18 ay 9:20 AM, 10:11 AM, and 11:06 AM, and * on 6/13/18 at 9:26 AM, 10:03 AM, 11:14 AM, 1:12 PM, 2:55 PM, 3:15 PM, and 4:00 PM.</p> <p>Resident #8's paper and electronic clinical records did not contain an assessment, a consent, or a physician's order for the bed against the wall.</p> <p>On 6/13/18 at 4:15 PM, CNA #1 said Resident</p>	F 604			

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F 604	<p>Continued From page 5</p> <p>#8's legs were weak and she needed extensive assistance with transfers in and out of bed.</p> <p>b) Resident #12 was originally admitted to the facility in 2014 with multiple diagnoses which included heart failure and generalized muscle weakness. She was readmitted on 6/11/18 following hospitalization for cellulitis.</p> <p>A 4/26/18 re-entry admission MDS assessment documented Resident #12's cognition was intact, she required supervision and set-up help only for most ADLs, including bed mobility and transfers, she had functional limitation in both lower extremities, she had occasional bladder incontinence, and no restraints were in use.</p> <p>Resident #12's care plan, initiated on 3/31/18, had numerous revisions on 4/30/18 and other revisions on 5/3/18 and 6/11/18. The care plan did not include the resident's bed against the wall.</p> <p>On 6/12/18 at 9:59 AM, Resident #12's bed was observed against the wall on her right side. The resident, who was in her recliner by the bed, said her bed had "always" been against the wall. The resident's bed was observed against the wall through out the rest of the survey.</p> <p>Resident #12's paper and electronic clinical records did not contain an assessment, a consent, or a physician's order for the bed to be against the wall.</p> <p>c) Resident #18 was readmitted to the facility in 2015 with multiple diagnoses which included persistent vegetative state.</p>	F 604			

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F 604	Continued From page 6  Resident #18's bed was observed against the wall, on the resident's left side, during all days of the survey.  A 5/1/18 annual MDS assessment document Resident #18 was in a persistent vegetative state, he required total assistance for all ADLs, he had functional limitation in ROM in both upper and both lower extremities, he was always incontinent of bowel and bladder, and no restraints were in use.  Resident #18's care plan, initiated in 2015, documented his family liked the bed against the wall to make room for his belonging (revised 5/2/18) and the bed was against the wall to provide more room for cares (revised 1/26/18).  Resident #2's paper and electronic clinical records did not contain an assessment, a consent, or a physician's order for the bed to be against the wall.  d) Resident #26 was admitted to the facility on 7/20/17 with multiple diagnoses which included dementia, epilepsy, major depressive disorder, anxiety disorder, generalized muscle weakness, urinary retention, and repeated falls.  Resident #26's quarterly MDS assessment, dated 5/21/18, documented severely impaired cognition, he required extensive assistance by one person with bed mobility and toileting and limited assistance by one person was required for transfers, he had functional limitation in ROM in both lower extremities, he had occasional urinary incontinence, and no restraints were in	F 604			

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F 604	<p>Continued From page 7 use.</p> <p>Resident #26's care plan for falls, initiated on 8/2/17, documented a revised intervention on 5/25/18 for the bed to be against the wall, "...so that everything will fit in my room."</p> <p>Resident #26's bed was observed against the wall during all days of the survey.</p> <p>Resident #26's paper and electronic clinical records did not contain an assessment, a consent, or a physician's order for the bed to be against the wall.</p> <p>e) Resident #31 was admitted to the facility in 2016 with multiple diagnoses which included generalized muscle weakness, major depressive disorder, morbid obesity, cerebral infarction (stroke), and restless leg syndrome. She was readmitted on 5/3/17 with a new diagnosis of pain.</p> <p>Resident #31's quarterly MDS assessment, dated 5/29/18, documented intact cognition, she required extensive assistance by one person with bed mobility and total assistance by one person for toileting and personal hygiene, she had functional limitation in ROM in both lower extremities, she was always incontinent of bowel and bladder, and no restraints were in use.</p> <p>Resident #31's care plan for falls, initiated in 2016, included an revised intervention (6/4/18) for the bed to be against the wall for a "home-like environment so all my belongings fit."</p> <p>Resident #31 was observed in bed and the bed</p>	F 604			

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F 604	<p>Continued From page 8</p> <p>was against the wall on her right side during all days of the survey.</p> <p>Resident #31's paper and electronic clinical records did not include an assessment, a consent, or a physician's order for the bed to be against the wall.</p> <p>f) Resident #83 was admitted to the facility on 5/29/18 with multiple diagnoses which included aftercare following pericardial effusion (excess fluid between the heart and the sac surrounding the heart), heart failure, pain, and morbid obesity.</p> <p>Resident #83's admission MDS assessment, dated 6/5/18, documented he had moderately impaired cognition, he required limited assistance of one person for bed mobility, transfers, toileting, and personal hygiene, he had functional limitation in ROM in both lower extremities, he had occasional urinary incontinence, and no restraints were in use.</p> <p>Resident #83's care plan for falls, initiated 6/11/18, documented an intervention for the bed to be against the wall "to provide a more home-like environment, it is not a restraint as I can get out of it by myself." The resident's paper and electronic clinical records did not contain an assessment or a consent for the bed to be against the wall.</p> <p>Resident #83's bed was observed against the wall, on the resident's right side, during all days of the survey.</p> <p>The resident's paper and electronic clinical record did not include an assessment, a consent,</p>	F 604			

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F 604	<p>Continued From page 9 or a physician's order for the bed to be against the wall.</p> <p>g) Resident #2 was admitted to the facility on 11/29/17 with multiple diagnoses, including dementia with behavioral disturbances.</p> <p>Resident #2's quarterly MDS assessment, dated 6/5/18, documented his cognition was moderately impaired and was independent with most ADLs.</p> <p>On 6/11/18 at 4:24 PM and 6/13/18 at 9:09 PM, Resident #2 was observed resting in bed with the bed positioned against the wall on his left side.</p> <p>Resident #2's care plan dated 12/26/17, documented his bed was positioned against the wall and was not a restraint because he can get out of his bed anytime he chooses.</p> <p>Resident #2's clinical record did not include an assessment, consent or physician's order for his bed against the wall.</p> <p>h) Resident #10 was admitted to the facility on 4/3/18 with multiple diagnoses, including asthma and chronic pain.</p> <p>Resident #10's admission MDS assessment, dated 4/10/18, documented her cognition was intact and required the extensive assistance of 1 to 2 staff members with most ADLs.</p> <p>On 6/11/18 at 5:32 PM and on 6/12/18 at 6/12/18 at 9:54 AM, Resident #10 was observed in bed with his bed positioned against the wall on his right side.</p>	F 604			

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F 604	Continued From page 10  Resident #10's care plan did not address the positioning of her bed against the wall.  A Mobility Assessment, dated 4/3/18, documented Resident #10 was unable to stand or walk, and she used a wheelchair for locomotion.  Resident #10's clinical record did not include an assessment, consent or physician's order for her bed against the wall.  i) Resident #19 was admitted to the facility on 7/26/17 with multiple diagnoses, including multiple sclerosis (disabling disease of the brain and spinal cord).  On 6/11/18 at 3:59 PM and on 6/12/18 PM at 9:47 AM, Resident #19's was observed in his wheel chair in his room, and his bed was observed positioned against the wall.  Resident #19's care plan initiated on 8/8/17, documented his bed was positioned against the wall so that all of his belongings fit in his room and it was more homelike.  A Mobility Assessment, dated 4/30/18, documented Resident #19 could not stand or walk, and he used a wheelchair for locomotion.  Resident #19's clinical record did not include an assessment, consent or physician's order for her bed against the wall.  j) Resident #24 was admitted to the facility on 2/20/18 with multiple diagnoses, including anoxic	F 604			

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F 604	<p>Continued From page 11 (low oxygen) brain damage.</p> <p>Resident #24's admission MDS assessment dated, dated 3/1/18, documented her cognition was moderately impaired and she needed extensive assistance of 1 to 2 staff with most ADLs.</p> <p>On 6/11/18 at 1:08 PM, Resident #24 was not in her room and her bed was observed positioned against the wall.</p> <p>Resident #24's care plan did not address the positioning of her bed against the wall.</p> <p>A Mobility Assessment, dated 2/20/18, documented Resident #24 was not steady in moving from seated to standing position, but able to stabilize with staff member assistance, and she used a wheelchair for locomotion.</p> <p>Resident #24's clinical record did not include an assessment and consent of her bed against the wall as a possible restraint.</p> <p>k) Resident #25 was admitted to the facility on 5/8/18, with multiple diagnoses, including hemorrhagic stroke with left sided weakness.</p> <p>Resident #25's admission MDS assessment dated, 5/15/18, documented his cognition was moderately impaired, and required the assistance of one staff member with bed mobility, dressing and eating.</p> <p>On 6/11/18 at 2:48 PM, 6/12/18 at 9:36 AM and on 6/13/18 at 11:03 AM, Resident #25 was observed resting in bed which was positioned</p>	F 604			

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F 604	<p>Continued From page 12 against the wall on his left side.</p> <p>Resident #25's care plan did not address the positioning of his bed against the wall.</p> <p>A Mobility Assessment, dated 5/8/18, documented Resident #25 was not steady with standing and walking and only able to stabilize with staff member assistance, and he used a wheelchair for locomotion.</p> <p>Resident #25's clinical record did not include an assessment, consent or physician's order for his bed against the wall.</p> <p>I) Resident #28 was admitted to the facility on 5/18/18, with multiple diagnoses, including traumatic brain hemorrhage.</p> <p>Resident #28's admission MDS assessment, dated 5/25/18, documented his cognition was severely impaired, required the assistance of two staff members for bed mobility, transfer and dressing, and had history of falls.</p> <p>On 6/11/18 at 1:13 PM, Resident #28 was not in his room and his bed was observed positioned against the wall.</p> <p>On 6/11/18 at 1:31 PM, Resident #28 was observed resting in bed with his left side and bed positioned against the wall on his left side.</p> <p>Resident #28's care plan did not address the positioning of his bed against the wall.</p> <p>A Mobility Assessment, dated 5/18/18, documented Resident #28 was not steady in</p>	F 604			

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F 604	Continued From page 13 moving from seated to standing position but able to stabilize with staff member assistance, and he used a wheelchair for locomotion.	F 604			
F 636 SS=F	Resident #28's clinical record did not include an assessment, consent or physician's order for his bed against the wall.  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 the following: (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.	F 636		7/31/18	

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F 636	<p>Continued From page 14</p> <p>(xv) Special treatments and procedures.</p> <p>(xvi) Discharge planning.</p> <p>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).</p> <p>(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> <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> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no 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' beds positioned against a wall and halo bars (bed rail in the shape of a circle) were assessed prior to implementation. This was true for 12 of 12 sample (#2, #10, #19, #24, #25, #28, #8, #12,</p>	F 636	<p>1- Residents #2, 8, 10, 24, 18, 19, 25, 26, 28, 31, &amp; 83's beds were assessed and documented, and were found to be restraint free. Resident #10's halo bar was assessed and documented and was found to not be a restraint. The care plan was updated to reflect the use of the halo</p>		

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F 636	<p>Continued From page 15</p> <p>#18, #26, #31, &amp; #83) residents whose beds were positioned against the wall, the other 25 residents residing in the facility, whose beds were also positioned against a wall , and 1 of 4 (#10) residents sampled for halo bars. This deficient practice placed the residents at risk of having their beds placed against a wall and halo bars as a method of restraint without assessment of the need and safety of the restraint. Findings include:</p> <p>Residents' with beds against a wall and halo bed rails were not assessed as follows:</p> <p>a) Resident #10 was admitted to the facility on 4/3/18 with multiple diagnoses, including asthma and chronic pain.</p> <p>Resident #10's admission MDS assessment, dated 4/10/18, documented she was cognitively intact and dependent on staff for all cares except for eating and drinking. She needed "set-up" only for eating and drinking.</p> <p>Resident #10's clinical record did not include an assessment of her bed against the wall as possible restraint.</p> <p>On 6/11/18 at 5:32 PM, and on 6/12/18 at 6/12/18 at 9:54 AM, Resident #10 was observed in bed with the right side of her bed against the wall. A bilateral halo bars were also observed in the raised position.</p> <p>b) Resident #2 was admitted to the facility on 11/29/17 with multiple diagnoses, including dementia with behavioral disturbances.</p>	F 636	<p>bar.</p> <p>2- All residents have the potential to be affected. All residents received a bed assessment to determine if their beds/halo bars were restraints.</p> <p>3- The facility will add beds against the wall and halo bars to the restraint policy and procedures to include consents, physician orders, and assessment. Nurses will be educated to perform bed/restraint assessments per the policy and procedures. All residents upon admission will receive a bed/restraint assessment to determine bed safety and to assure that any resident with a bed against the wall is restraint free. A bed/restraint assessment will be conducted at least quarterly and upon significant change of condition of every resident. Restraint audits will be completed weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter by the DON/designee.</p> <p>4- The audits will be reviewed at least quarterly during the facility QAPI meeting for compliance.</p>		

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F 636	<p>Continued From page 16</p> <p>Resident #2's quarterly MDS assessment, dated 6/5/18, documented he was moderately cognitively impaired and was independent with most ADLs.</p> <p>On 6/11/18 at 4:24 PM and 6/13/18 at 9:09 PM, Resident #2 was observed resting in bed with the bed positioned against the wall on his left side.</p> <p>Resident #2's clinical record did not include an assessment of his bed against the wall as a possible restraint.</p> <p>c) Resident #19 was admitted to the facility on 7/26/17 with multiple diagnoses, including multiple sclerosis (disabling disease of the brain and spinal cord).</p> <p>Resident #19 quarterly MDS assessment, dated 5/1/18, 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.</p> <p>On 6/11/18 at 3:59 PM and on 6/12/18 PM at 9:47 AM, Resident #19's was observed in his wheel chair in his room, and his bed was observed positioned against the wall.</p> <p>Resident #19's clinical record did not include an assessment of his bed against the wall as a possible restraint.</p> <p>d) Resident #24 was admitted to the facility on 2/20/18 with multiple diagnoses, including anoxic (low oxygen) brain damage.</p> <p>Resident #24's admission MDS assessment</p>	F 636			

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F 636	<p>Continued From page 17 dated, dated 3/1/18, documented she had moderate cognitive impairment and was dependent on staff with most ADLs.</p> <p>On 6/11/18 at 1:08 PM, Resident #24 was not in her room and her bed was observed positioned against the wall.</p> <p>Resident #24's clinical record did not include an assessment of her bed against the wall as a possible restraint.</p> <p>e) Resident #25 was admitted to the facility on 5/8/18, with multiple diagnoses, including hemorrhagic stroke with left sided weakness.</p> <p>Resident #25's admission MDS assessment dated, 5/15/18, documented his cognition was moderately impaired, and he required the assistance of one staff with bed mobility, dressing and eating.</p> <p>On 6/11/18 at 2:48 PM, 6/12/18 at 9:36 AM and on 6/13/18 at 11:03 AM, Resident #25 was observed in bed which was positioned positioned against the wall on his left side.</p> <p>Resident #25's clinical record did not include an assessment of his bed against the wall as a possible restraint.</p> <p>f) Resident #28 was admitted to the facility on 5/18/18, with multiple diagnoses, including traumatic brain hemorrhage.</p> <p>Resident #28's admission MDS assessment, dated 5/25/18, documented he was severely cognitively impaired, and required the assistance</p>	F 636			

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F 636	<p>Continued From page 18 of two staff members for bed mobility, transfer and dressing, and had history of falls.</p> <p>On 6/11/18 at 1:13 PM, Resident #28 was not in his room and his bed was observed positioned against the wall.</p> <p>On 6/11/18 at 1:31 PM, Resident #28 was observed in bed with the left side of the bed against the wall.</p> <p>Resident #28's clinical record did not include an assessment of his bed against the wall as a possible restraint.</p> <p>g) Resident #8 was originally admitted to the facility in 2012 with multiple diagnoses which included chronic ischemic heart disease, dementia, anxiety disorder, major depressive disorder, generalized muscle weakness, and abnormal gait and mobility. She was readmitted on 1/11/18 following hospitalization for pneumonia.</p> <p>Resident #8's significant change MDS assessment, dated 4/3/18, documented moderately impaired cognition; she was understood by others and was able to understand others; she required extensive assistance of 1 person for bed mobility, dressing, and personal hygiene and assistance of 2 or more people for transfers and toileting; she had functional limitation in ROM in both lower extremities; she had frequent bladder incontinence and was always incontinent of bowel; and no restraints were in use.</p> <p>Resident #8's bed was observed against the wall</p>	F 636			

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F 636	<p>Continued From page 19</p> <p>on the resident's right side as follows:</p> <ul style="list-style-type: none"> <li>* on 6/11/18 at 3:33 PM and 4:22 PM,</li> <li>* on 6/12/18 ay 9:20 AM, 10:11 AM, and 11:06 AM, and</li> <li>* on 6/13/18 at 9:26 AM, 10:03 AM, 11:14 AM, 1:12 PM, 2:55 PM, 3:15 PM, and 4:00 PM.</li> </ul> <p>Resident #8's paper and electronic clinical record did not include an assessment to determine if the bed against the wall restrained the resident's movement.</p> <p>h) Resident #12 was originally admitted to the facility in 2014 with multiple diagnoses which included heart failure and generalized muscle weakness. She was readmitted on 6/11/18 following hospitalization for cellulitis.</p> <p>A 4/26/18 re-entry admission MDS assessment documented Resident #12's cognition was intact, she required supervision and set-up help only for most ADLs, including bed mobility and transfers, she had functional limitation in both lower extremities, she had occasional bladder incontinence, and no restraints were in use.</p> <p>On 6/12/18 at 9:59 AM, Resident #12's bed was observed against the wall on her right side. The resident, who was in her recliner by the bed, said her bed had "always" been against the wall. The resident's bed was observed against the wall through out the rest of the survey.</p> <p>Resident #12's paper and electronic clinical record did not include an assessment to determine if the bed against the wall restrained the resident's movement.</p>	F 636			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135089</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>DESERT VIEW CARE CENTER OF BUHL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 SPRAGUE AVENUE BUHL, ID 83316</b>		
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F 636	<p>Continued From page 20</p> <p>i) Resident #18 was readmitted to the facility in 2015 with multiple diagnoses which included persistent vegetative state.</p> <p>A 5/1/18 annual MDS assessment document Resident #18 was in a persistent vegetative state, he required total assistance for all ADLs, he had functional limitation in ROM in both upper and both lower extremities, he was always incontinent of bowel and bladder, and no restraints were in use.</p> <p>Resident #18's bed was observed against the wall, on the resident's left side, during all days of the survey.</p> <p>Resident #18's paper and electronic clinical record did not include an assessment to determine if the bed against the wall was a restraint for the resident.</p> <p>j) Resident #26 was admitted to the facility on 7/20/17 with multiple diagnoses which included dementia, epilepsy, major depressive disorder, anxiety disorder, generalized muscle weakness, urinary retention, and repeated falls.</p> <p>Resident #26's quarterly MDS assessment, dated 5/21/18, documented severely impaired cognition, he required extensive assistance by one person with bed mobility and toileting and limited assistance by one person was required for transfers, he had functional limitation in ROM in both lower extremities, he had occasional urinary incontinence, and no restraints were in use.</p> <p>Resident #26's bed was observed against the</p>	F 636			

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F 636	<p>Continued From page 21 wall during all days of the survey.</p> <p>Resident #26's paper and electronic clinical record did not include an assessment to determine if the bed against the wall restrained the resident's movement.</p> <p>k) Resident #31 was admitted to the facility in 2016 with multiple diagnoses which included generalized muscle weakness, major depressive disorder, morbid obesity, cerebral infarction (stroke), and restless leg syndrome. She was readmitted on 5/3/17 with a new diagnosis of pain.</p> <p>Resident #31's quarterly MDS assessment, dated 5/29/18, documented intact cognition, she required extensive assistance by one person with bed mobility and total assistance by one person for toileting and personal hygiene, she had functional limitation in ROM in both lower extremities, she was always incontinent of bowel and bladder, and no restraints were in use.</p> <p>Resident #31 was observed in bed and the bed was against the wall on her right side during all days of the survey.</p> <p>Resident #31's paper and electronic clinical records did not include an assessment to determine if the bed against the wall restricted or restrained the resident's movement.</p> <p>l) Resident #83 was admitted to the facility on 5/29/18 with multiple diagnoses which included aftercare following pericardial effusion (excess fluid between the heart and the sac surrounding the heart), heart failure, pain, and morbid obesity.</p>	F 636			

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F 636	Continued From page 22  Resident #83's admission MDS assessment, dated 6/5/18, documented he had moderately impaired cognition, he required limited assistance of one person for bed mobility, transfers, toileting, and personal hygiene, he had functional limitation in ROM in both lower extremities, he had occasional urinary incontinence, and no restraints were in use.  Resident #83's bed was observed against the wall, on the resident's right side, during all days of the survey.  The resident's paper and electronic clinical record did not include an assessment for the bed to be against the wall.  On 6/13/18 at 4:20 PM, LPN #2 said the facility did not assess Resident #28's bed against the wall as a possible restraint because they did not consider a bed against the wall as a potential restraint.  On 6/13/18 at 5:00 PM, RN #2 said the nurses ensured a resident with weakness or no movement on one side was not positioned against the wall on their "good side." She said the facility did not consider a bed against the wall to be a restraint and had not assessed beds against the wall as such.  On 6/14/18 at 11:00 AM, the DON said their practice was to position beds against the wall to provide more space in resident rooms. She said she had not considered a bed against the wall as a potential restraint and that residents were not being assessed to determine if a bed against the	F 636			

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F 636	Continued From page 23 wall was a restraint for them individually.	F 636			
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		7/31/18	

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F 656	<p>Continued From page 24</p> <p>local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure a comprehensive person-centered care plan was developed and implemented for 6 of 12 sample residents (#8, #10, #12, #24, #25 and #28) whose beds were against the wall, and for 1 of 4 sample residents (#10) with halo bars (bed rail in the shape of a circle) in use. The residents' care plans did not address their bed against the wall and Resident #10's care plan did not address the use of halo side rails. The failure created the potential for residents to experience adverse events from lack of direction in their care plan about potentially restrictive devices. Findings include:</p> <p>1. Resident #10 was admitted to the facility on 4/3/18 with multiple diagnoses, including asthma and chronic pain.</p> <p>Resident #10's admission MDS assessment, dated 4/10/18, documented she was cognitively intact and dependent on staff for all cares except for eating and drinking. She needed "set-up" only for eating and drinking.</p> <p>On 6/11/18 at 5:32 PM and on 6/12/18 at 6/12/18 at 9:54 AM, Resident #10 was observed in bed with the right side of her bed against the wall.</p>	F 656	<p>1- Residents #8, 10, 12, 24, 25, &amp; 28's beds were assessed and documented in the care plan to reflect assistive devices in use such as bed against the wall, halo bars, etc., and were found to be restraint free. #10's halo bar was assessed and found to not be a restraint, and was updated in the care plan.</p> <p>2- All residents have the potential to be affected. All residents received a bed against the wall and/or halo bar assessment to determine if their beds or halo bars were restraints.</p> <p>3- The facility will add beds against the wall and halo bars to the restraint policy and procedures to include consents, physician orders, and assessment. Nurses will be educated to perform bed/restraint assessments per the policy and procedures. All residents upon admission will receive a bed/restraint assessment to determine bed safety and to assure that any resident with a bed against the wall is restraint free. A bed/restraint assessment will be conducted at least quarterly and upon significant change of condition of every resident. Restraint audits will be</p>		

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F 656	<p>Continued From page 25</p> <p>On 6/12/18 at 9:54 AM, Resident #10 said her bed had always been positioned against the wall since her admission to the facility, and bilateral halo bars were always in the raised position.</p> <p>Resident #10's care plan did not address positioning of her bed against the wall and the use of halo bars.</p> <p>On 6/15/18 at 12:10 PM, LPN #1 said they always documented halo bars for mobility and bed against the wall in the care plan. LPN #1 also stated it was an oversight that it was not included in the care plan of Resident #10.</p> <p>2. Resident #8 was originally admitted to the facility in 2012 with multiple diagnoses which included chronic ischemic heart disease, dementia, anxiety disorder, major depressive disorder, generalized muscle weakness, and abnormal gait and mobility. She was readmitted on 1/11/18 following hospitalization for pneumonia.</p> <p>Resident #8's significant change MDS assessment, dated 4/3/18, documented moderately impaired cognition; she was understood by others and was able to understand others; she required extensive assistance of 1 person for bed mobility, dressing, and personal hygiene and assistance of 2 or more people for transfers and toileting; she had functional limitation in ROM in both lower extremities; she had frequent bladder incontinence and was always incontinent of bowel; and no restraints were in use.</p> <p>Resident #8's bed was observed against the wall</p>	F 656	<p>completed weekly for four (4) weeks, then monthly for three (3) months, then quarterly thereafter by the DON/designee.</p> <p>4- The audits will be reviewed at least quarterly during the facility QAPI meeting for compliance.</p>		

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F 656	<p>Continued From page 26</p> <p>on the resident's right side as follows:</p> <ul style="list-style-type: none"> <li>* on 6/11/18 at 3:33 PM and 4:22 PM,</li> <li>* on 6/12/18 ay 9:20 AM, 10:11 AM, and 11:06 AM, and</li> <li>* on 6/13/18 at 9:26 AM, 10:03 AM, 11:14 AM, 1:12 PM, 2:55 PM, 3:15 PM, and 4:00 PM.</li> </ul> <p>On 6/13/18 at 4:15 PM, CNA #1 said Resident #8 legs were weak and she needed extensive assistance with transfers in and out of bed.</p> <p>Resident #8's care plan, initiated 1/16/18, documented revisions on 4/20/18 regarding medications, 4/4/18 regarding toileting, and 3/19/18 regarding an RNA plan. The resident's care plan did not include or address the bed against the wall.</p> <p>On 6/14/18 at 11:00 AM, the DON said the facility's practice was to position beds against the wall to provide more space in resident rooms and that should have been included the residents' care plans.</p> <p>3. Resident #12 was originally admitted to the facility in 2014 with multiple diagnoses which included heart failure and generalized muscle weakness. She was readmitted on 6/11/18 following hospitalization for cellulitis.</p> <p>A 4/26/18 re-entry admission MDS assessment documented Resident #12's cognition was intact, she required supervision and set-up help only for most ADLs, including bed mobility and transfers, she had functional limitation in both lower extremities, she had occasional bladder incontinence, and no restraints were in use.</p>	F 656			

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F 656	<p>Continued From page 27</p> <p>On 6/12/18 at 9:59 AM, Resident #12's bed was observed against the wall on her right side. The resident, who was in her recliner by the bed, said her bed had "always" been against the wall. The resident's bed was observed against the wall through out the rest of the survey.</p> <p>Resident #12's care plan, initiated on 3/31/18, had numerous revisions on 4/30/18 and other revisions on 5/3/18 and 6/11/18. The care plan did not include the resident's bed against the wall.</p> <p>On 6/13/18 at 5:00 PM, RN #2 said the nurses ensured a resident with weakness or no movement on one side was not positioned against the wall on their "good side."</p> <p>4. Resident #24 was admitted to the facility on 2/20/18 with multiple diagnoses, including anoxic (low oxygen) brain damage.</p> <p>Resident #24's admission MDS assessment dated, dated 3/1/18, documented her cognition was moderately impaired and she needed extensive assistance with most ADLs.</p> <p>On 6/11/18 at 1:08 PM, Resident #24 was not in her room and her bed was observed positioned against the wall.</p> <p>Resident #24's care plan did not address the positioning of her bed against the wall.</p> <p>On 6/15/18 at 12:10 PM, LPN #1 said they always included bed against the wall in the care plan and it was an oversight it was not documented in Resident #24's care plan.</p>	F 656			

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F 656	Continued From page 28  5. Resident #25 was admitted to the facility on 5/8/18, with multiple diagnoses, including hemorrhagic stroke with left sided weakness.  Resident #25's admission MDS assessment dated, 5/15/18, documented his cognition was moderately impaired, and he required the assistance of one staff with bed mobility, dressing and eating.  On 6/11/18 at 2:48 PM, 6/12/18 at 9:36 AM and on 6/13/18 at 11:03 AM, Resident #25 was observed in bed with the left side of his bed against the wall.  Resident #25's care plan did not address the positioning of his bed against the wall.  On 6/15/18 at 12:10 PM, LPN #1 said the care plan should have included Resident #25's bed against the wall.  6. Resident #28 was admitted to the facility on 5/18/18, with multiple diagnoses, including traumatic brain hemorrhage.  Resident #28's admission MDS assessment, dated 5/25/18, documented he was severely cognitively impaired, required the assistance of two staff members for bed mobility, transfer and dressing, and had history of falls.  On 6/11/18 at 1:13 PM, Resident #28 was not in his room and his bed was observed positioned against the wall.  On 6/11/18 at 1:31 PM, Resident #28 was	F 656			

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F 656	Continued From page 29 observed in bed with the left side of his bed against the wall.  Resident #28's care plan did not address the positioning of his bed against the wall.  On 6/15/18 at 12:10 PM, LPN #1 said the care plan should have included Resident #25's bed against the wall.	F 656			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure residents whose bed were positioned against the wall were securely locked. This was true for 6 of 12 (#8, #19, #24, #25, #31, & #28) sample residents whose beds were positioned against the wall. The facility also failed to provide sufficient supervision to prevent falls. This was true for 1 of 12 (#26) residents reviewed for falls. This failure created the potential for harm if residents were to become entrapped between the walls and their bed, and/or experience falls and injuries. Findings include:  On 6/15/18 from 10:25 AM to 11:10 AM, the brakes on residents beds were reviewed. The	F 689	1- Resident #26 was moved to the BCU for greater supervision and less stimulation. Beds were checked for residents #8, 19, 24, 25, 28, and 31, and were locked for safety. Staff were educated on 7/10/18 to check brakes on all resident beds as they complete cares.  2- All residents in beds are at risk and have the potential to be affected.  3- Staff will be educated on performing and documenting 15 minute checks, and will be required to perform them as scheduled. The DON/designee will review the 15 minute log daily, 5 days per week	7/31/18	

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F 689	<p>Continued From page 30 following were observed:</p> <p>1. Resident #19 was admitted to the facility on 7/26/17 with multiple diagnoses, including multiple sclerosis (disabling disease of the brain and spinal cord).</p> <p>Resident #19's care plan initiated on 8/8/17, documented his bed was positioned against the wall so that all of his belongings fit in his room and it was more homelike.</p> <p>Resident #19's bed was observed positioned against the wall and the brakes were unlocked. RN #1 said she did not know if the bed brakes had to be locked or unlocked, she then paused for a moment, and said if the resident moves he could be trapped between the bed and wall. RN #1 then locked the brakes of Resident #19's bed.</p> <p>2. Resident #24 was admitted to the facility on 2/20/18 with multiple diagnoses, including anoxic (low oxygen) brain damage.</p> <p>Resident #24's admission MDS assessment dated, dated 3/1/18, documented her cognition was moderately impaired and she needed extensive assistance of 1 to 2 staff with most ADLs.</p> <p>Resident #24's bed was observed positioned against the wall and the bed brakes were unlocked. RN #1 said she did not know if the bed brakes had to be locked or unlocked and she then paused for a moment, and said if the resident moves she could be trapped between the bed and wall. RN #1 then locked the brakes of Resident #24's bed.</p>	F 689	<p>during the morning clinical meeting for compliance for one (1) month, then weekly thereafter, and will document the findings. Any staff member assigned to perform 15 minute checks, and is found not completing them will be disciplined per the facility's progressive disciplinary policy.</p> <p>Staff will be educated on the importance of setting the brakes on beds upon hire, and quarterly during the monthly All Staff meeting beginning on 7/10/18. The maintenance director/designee will perform bed brake audits twice weekly for two (2) months, then weekly for one month, then quarterly thereafter or sooner as needed.</p> <p>4- The audit results will be placed in the quarterly QAPI minutes for review and compliance.</p> <p>4-</p>		

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F 689	Continued From page 31  3. Resident #25 was admitted to the facility on 5/8/18, with multiple diagnoses, including hemorrhagic stroke with left sided weakness.  Resident #25's admission MDS assessment dated, 5/15/18, documented his cognition was moderately impaired, and required the assistance of one staff with bed mobility, dressing and eating.  Resident #25's bed was observed positioned against the wall and brakes were unlocked. RN #1 said she did not know if the bed brakes had to be locked or unlocked and she then paused for a moment and said if the resident moves he could be trapped between the bed and wall. RN #1 then locked the brakes of Resident #25's bed.  4. Resident #28 was admitted to the facility on 5/18/18, with multiple diagnoses, including traumatic brain hemorrhage.  Resident #28's admission MDS assessment, dated 5/25/18, documented his cognition was severely impaired, required the assistance of two staff members for bed mobility, transfer and dressing, and had history of falls.  Resident #28's bed was observed positioned against the wall and brakes were unlocked. RN #1 said she did not know if the bed brakes had to be locked or unlocked and she then paused for a moment and said if the resident moves he could be trapped between the bed and wall. RN #1 then locked the brakes of Resident #28's bed.  On 6/15/18 at 11:30 AM, the Administrator said	F 689			

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F 689	<p>Continued From page 32</p> <p>Maintenance Supervisor was on vacation and could not reach him, The Administrator said he was unable to find the maintenance logs for beds inspections.</p> <p>On 6/15/18 at 11:55 AM, LPN #2 was asked what would she do before putting a resident to bed. The LPN said she would bring the resident to the toilet and would make sure call light was within reach before leaving the resident in bed. When asked if she would lock the brakes on resident's bed. LPN #2 said "maybe". When asked if the brakes on residents' bed should be locked, the LPN said she was not sure and stated she had never seen a policy regarding the brakes on residents' beds.</p> <p>5. Resident #8 was originally admitted to the facility in 2012 with multiple diagnoses which included chronic ischemic heart disease, dementia, anxiety disorder, major depressive disorder, generalized muscle weakness, and abnormal gait and mobility. She was readmitted on 1/11/18 following hospitalization for pneumonia.</p> <p>Resident #8's significant change MDS assessment, dated 4/3/18, documented moderately impaired cognition; she was understood by others and was able to understand others; she required extensive assistance of 1 person for bed mobility and 2 or more people for transfers and toileting; she had functional limitation in ROM in both lower extremities; and she had frequent bladder incontinence and was always incontinent of bowel.</p>	F 689			

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F 689	<p>Continued From page 33</p> <p>On 6/15/18 at 10:25 am, RN #1 accompanied 2 surveyors to Resident #8's room. The resident's bed was against the wall and the RN easily moved it away from the wall. RN #1 moved the bed back against the wall and locked the brakes on the bed.</p> <p>6. Resident #31 was admitted to the facility in 2016 with multiple diagnoses which included generalized muscle weakness, major depressive disorder, morbid obesity, cerebral infarction (stroke), and restless leg syndrome. She was readmitted on 5/3/17 with a new diagnosis of pain.</p> <p>Resident #31's quarterly MDS assessment, dated 5/29/18, documented intact cognition, she required extensive assistance by one person with bed mobility and total assistance by one person for toileting and personal hygiene, she had functional limitation in ROM in both lower extremities, she was always incontinent of bowel and bladder, and no restraints were in use.</p> <p>On 6/15/18 at about 10:45 AM, RN #1 accompanied 2 surveyors to Resident #31's room. The resident's bed was against the wall and the RN was able to move the bed away from the wall. RN #1 moved the bed back against the wall then locked the brakes on the bed.</p> <p>7. Resident #26 was admitted to the facility on 7/20/17 with multiple diagnoses which included dementia, epilepsy, major depressive disorder, anxiety disorder, generalized muscle weakness, urinary retention, and repeated falls.</p> <p>Resident #26's quarterly MDS assessment, dated</p>	F 689			

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F 689	<p>Continued From page 34</p> <p>5/21/18, documented severely impaired cognition, extensive assistance by one person was required with bed mobility and toileting and limited assistance by one person was required for transfers, he had functional limitation in ROM in both lower extremities, and he had occasional urinary incontinence.</p> <p>Resident #26's care plan for falls, initiated on 8/2/17, included the following interventions:            * "I have dementia and I can't always remember to ask for help and so I will try and self-transfer myself and I have been falling down."            * "Place my bed against the wall so that everything will fit in my room, keep my room clutter free. I wander about the halls as I can self-propel myself in my wheelchair. Most of the time I want to be in front of the nurses station, eating, sleeping, or looking at my photo album."            * "Watch for me to be looking for the bathroom, I do not remember to ask for help and will transfer myself."            * "My wheelchair has anti-roll back bars applied because I do not remember to apply the brakes." The interventions were documented as initiated on 8/2/17 and revised on 5/25/18.</p> <p>The resident's toileting care plan, initiated 8/2/17 and revised 1/26/18 included the following interventions:            * "I have dementia...I transfer myself...Sometimes I remember to ask for help, but sometimes I can't remember...I even start stripping in the bathroom. I am...mostly continent of bladder, and I do require limited one person assist."            * "I have to toilet very frequently...toileting program...not appropriate. The staff need to watch me for seeking bathrooms, I may leave</p>	F 689			

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F 689	<p>Continued From page 35</p> <p>one bathroom and go to find another after I just went."</p> <p>* Referred to urologist and nothing more they can do, already "given all the medication that they can."</p> <p>The interventions were dated as initiated 8/2/17 and revised 5/24/18.</p> <p>Fall Incident and Accident Reports documented Resident #26 had 7 unwitnessed falls between 12/21/7 and 4/26/18 as follows:</p> <p>* 12/21/17 at 7:45 PM - The resident was attempting to self transfer from the toilet to his wheelchair when he "slipped on scarf" and fell in the west shower room toilet area. No injuries were identified and every 15 minute checks were documented as already in place.</p> <p>* 1/24/18 at 10:30 PM - The resident was found on the floor in the doorway to the common bathroom on the north hall and his w/c was across the hallway from the resident. A small skin tear to the coccyx was identified and treated. A 1/25/18 review of the incident documented the w/c brakes were not on when the resident transferred himself. Anti roll back brakes were applied to the w/c.</p> <p>* 4/8/18 at 6:30 PM - The resident was found sitting on the floor in front of his w/c in the south hall bathroom. "Patient is continuously [sic] going to the bathroom transferring himself on and off the toilet...Keep patient close and try to assist him to the restroom when he needs to go..." No injuries were identified and every 15 minute checks were documented as already in place.</p>	F 689			

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F 689	<p>Continued From page 36</p> <p>* 4/11/18 at 9:00 PM - The resident was found in a hallway sitting on the floor leaning against the wall with his w/c behind him and the "nearest restroom not far from the residents [sic] position." No injuries were identified and "Initiate q [every] 15 min[ute] checks as applicable" was documented. A 4/12/18 review of the incident documented, "...frequent self transfers, confusion prevents safety education" and "staff to try &amp; keep in line of sight as much as possible."</p> <p>* 4/13/18 at 1:30 PM - Several witness statements documented the resident was asleep in his w/c in the hallway near the nurses' station moments before he was found on the floor in the same area. No injuries were identified. A 4/16/18 review of the incident documented the staff were inserviced to "watch for non-verbal cues."</p> <p>* 4/14/18 at 1:00 AM - The resident was found laying on his left side on the floor by the door to the employee break room and said he was trying to go to the bathroom. No injuries were identified. He was assisted into his w/c then to the restroom and rested in his w/c by the nurses' station after that. A 4/16/18 review of the incident documented, "Inservice to staff to pay attention to non verbal cues of need."</p> <p>A 4/16/18 staff inservice documented, "In watching the video leading up to the fall on 4-13-18, there were 7 people within sight of him as he fell to the floor, 2 aides walked by as he was in the process of falling. 1 aide had her back to him...A resident watched him fall. 3 nurses were behind the desk as he fell...Leading up to this fall, he had fallen asleep, head fell off his pillow/table, and he very slowly tipped over onto</p>	F 689			

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F 689	Continued From page 37 the floor. The fall on nights 4/14/18, he was showing signs of needing something, bathroom or food. Both the nurse and the aide missed these cues multiple times. He stood and tried to go into the break room 4 times. Stood and tried to go into the laundry room 1 time, each time the aide or the nurse took him back to his "spot". They did not notice that he was sitting sideways on his pillow and blankets. He kept shifting himself trying to get comfortable. The last time he tried to stand and fix his pillow and blanket, he missed his seat and fell to the floor. This is a simple case of looking but not seeing. Please try to see the residents, pay attention to what they are doing as this can be just as loud as words.  * 4/26/18 at 3:30 AM - The resident was found laying on his left side on the floor by his recliner near the nurses' station. No injuries were identified. A review of incident later on 4/26/18 documented, "On camera review he stood & was trying to pick something off of floor - he lowered himself to his knees holding handrail & chair." The review documented, "Care plan reviewed & was being followed" and a PT evaluation for ambulation would be done.  Resident #26's paper and electronic clinical record did not contain documentation that every 15 minute checks were done or that staff kept the resident in the line of sight.  On 6/14/18 at 8:30 AM, the DON said she did not find documentation of every 15 minute checks or that line of sight was maintained for Resident #26.	F 689			
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4)	F 700			7/31/18

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F 700	Continued From page 38  §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.  §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.  §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.  §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.  §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure that prior to the installation of halo bars (bed rails in the shape of a circle), residents were assessed for the risk of entrapment, and a consent was in place. This was true for 1 of 3 sample residents (#10) who had halo bars in use and created the potential for harm from entrapment or injury related to the use of the halo bars. Findings include:  Resident #10 was admitted to the facility on 4/3/18 with multiple diagnoses, including asthma	F 700	1- Resident #10's halo bar was assessed and determined to not be a restraint, and documented in the resident's care plan. Resident signed a consent for the halo bar.  2- All residents with halo bars were reassessed for appropriate alternatives. Any resident with halo bars have the potential to be affected.  3- Nursing staff will be educated to utilize the restraint assessment tool and to	

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F 700	Continued From page 39 and chronic pain.  Resident #10's admission MDS assessment, dated 4/10/18, documented she was cognitively intact and dependent on staff for all cares except for eating and drinking. She needed "set-up" only for eating and drinking and did not use a side rails.  On 6/11/18 at 5:32 PM and on 6/12/18 at 6/12/18 at 9:54 AM, Resident #10 was observed in bed with bilateral halo bars in the raised position.  On 6/12/18 at 9:54 AM, Resident #10 said bilateral halo bars were always in the raised position.  Resident #10's Physician's orders documented bilateral halo bars were ordered on 4/4/18 to promote mobility.  There was no documentation in Resident #54's clinical record that the halo bars were assessed for safety or the resident consented to the use of the halo bars. In addition there was no documentation of alternatives used and failed prior to the installation of the halo bars.  On 6/13/18 at 3:47 PM, RN #1, together with LPN #1, said she did not find the assessment for Resident #10's halo bar. LPN #1 said she did not document halo bars in Resident #10's MDS assessment because it was not a side rail.	F 700	assess for the least restrictive interventions. A new restraint assessment will be performed on all residents to determine the least restrictive interventions. A consent form has been added to the admission packet to help with acquiring consent upon admission. A restraint committee meeting will be held once weekly to audit restraints for two (2) months, then monthly for three (3) months, then quarterly thereafter to review all new restraint assessments in perpetuity.  4- The restraint assessment audits will be reviewed at each QAPI meeting until compliance is achieved.		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)  §483.35(b) Registered nurse §483.35(b)(1) Except when waived under	F 727		7/31/18	

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F 727	<p>Continued From page 40</p> <p>paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of staffing records and staff interview, it was determined the facility failed to ensure an RN was on duty at least 8 hours a day, 7 days a week. This was true for 1 of 21 days reviewed. The failure created the potential for harm if routine and/or emergency nursing needs went unmet for 14 of 14 sample residents (#2, #8, #10, #12, #17, #18, #19, #23, #24, #25, #26, #28, #31, and #83) and the other 23 residents living in the facility. Findings include:</p> <p>The facility provided a Three-Week Nursing Schedule for 5/20/18 to 6/9/18 which documented RN coverage was 4.75 hours on 5/26/18.</p> <p>On 6/14/18 at 9:15 AM, the DON said she was aware that an RN was on duty less than 8 hours on 5/26/18. The DON said the RN had to leave early that day and had arranged for another RN to cover her on the wrong date.</p>	F 727	<p>1- The nursing schedule was reviewed, and there is at least 8 hours of scheduled RN coverage each day, 7 days a week.</p> <p>2- All residents have the potential to be affected.</p> <p>3- RN coverage will be scheduled every day for at least 8 hours. If there are circumstances that prevent an RN from completing scheduled shifts, the DON will be notified, and RN staff will be called in to help cover missing hours. Sister facilities will be used to help cover any open shifts necessary and the need arises. Nursing staff will be educated to call the DON/designee to inform them of any shortages in RN coverage. Time clock audits will be performed daily, 5 days a week by the Payroll Coordinator/designee to review RN hours.</p> <p>4- The RN time clock audits will be</p>		

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F 727	Continued From page 41	F 727	reviewed during the facility QAPI meeting for compliance.	7/31/18	
F 758 SS=D	<p>Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)</p> <p>§483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs</p>	F 758			

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F 758	<p>Continued From page 42</p> <p>are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure residents receiving PRN clonazepam (anti-anxiety medication) had clear indication for use of the medication and clinical rationale supporting the continued use of the medication beyond 14 days. This was true for 1 of 5 sample residents (#25) reviewed for unnecessary medications. This deficient practice had the potential for harm should residents received psychotropic medications that are unwarranted and used for excessive duration. Finding include:</p> <p>Resident #25 was admitted to the facility on 5/8/18, with multiple diagnoses, including hemorrhagic stroke with left sided weakness.</p> <p>Resident #25's admission MDS assessment dated, 5/15/18, documented he was moderately cognitively impaired and received psychotropic medications.</p> <p>Resident #25's care plan dated 5/15/18,</p>	F 758	<p>1- Resident #25 had his anti-anxiety medication usage reviewed and dc'd by the PA.</p> <p>2- All residents on PRN medication have the potential to be affected. A review of patients with PRN anti-psychotic drugs was completed to determine if any others were affected.</p> <p>3- Medical Records will add a stop date to all psychotropic medications upon admit and as new orders are received. A PRN psychotropic drug audit will be completed weekly by the DON/designee during the IDT meeting in perpetuity to monitor end/stop dates.</p> <p>4- Audits will be reviewed during the facility QAPI meeting until compliance is achieved.</p>		

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PRINTED: 07/27/2018  
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OMB NO. 0938-0391

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F 758	Continued From page 43 documented, he had depression, anxiety and a history of panic attacks.  A physician's order dated 5/8/18, documented Resident #25 was to received clonazepam 0.5 mg tablet, orally every 12 hours as needed for anxiety.  A Pharmacist review of medications from 5/1/18 through 5/15/18, recommended justification for the necessity of continuing PRN (as necessary) clonazepam beyond 14 days.  A physician's progress notes dated 5/16/18, documented Resident #25's depression and anxiety were fairly controlled and felt better with current medication.  A nurse practitioner's order dated 5/23/18, documented for Resident #25 to continue clonazepam 0.5 mg twice a day as necessary. There was no documentation in Resident #25's clinical record to support the continuation of clonazepam beyond 14 days.  On 6/14/18 at 3:15 PM, RN #1 said she was aware of the new regulations regarding psychotropics medications. RN #1 said the psychiatrist was to come in last week but was not feeling well and would come next week.	F 758			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)  §483.45(f) Medication Errors. The facility must ensure that its-  §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759		7/31/18	

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F 759	<p>Continued From page 44</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure the medication error rate was less than 5%. This was true for 2 of 28 medications (7.14%) which affected 2 of 7 residents (#12 &amp; #17) whose medication administration was observed. The failure created the potential for sub-therapeutic effect when Resident #17's Levothyroxine (medication to treat thyroid hormone deficiency) was not administered as ordered, and Resident #12's inhaled medication was not administered according to accepted professional standards of care. Findings include:</p> <p>1. On 6/13/18 at 8:32 AM, LPN #3 was observed as she prepared, then administered four oral medications including Levothyroxine 50 mcg (micrograms) to Resident #17.</p> <p>Resident #17's physician order dated 3/16/18, documented Resident #17's Levothyroxine 50 mcg was to be given 30 minutes to 1 hour before breakfast on an empty stomach or if resident had slept in past breakfast and/or nurse unable to administer medication it was to be given two hours after eating.</p> <p>On 6/13/18 at 8:50 AM, Resident 12 said she had her breakfast at about 7:30 AM.</p> <p>On 6/13/18 at 8:55 AM, LPN #3 read the physician's order regarding Levothyroxine and said Resident #12 does not want her medication on an empty stomach. When asked if she asked the resident what time she finished her breakfast,</p>	F 759	<p>1- Resident #17's Levothyroxine was changed to bedtime by the physician after the medication timing error was reported. Resident #12 was educated to wait for one minute prior to taking another puff of Symbicort, and nurses were educated to provide medication as prescribed and/or directed on the label and manufacturer's recommendation to wait at least one minute between puffs.</p> <p>2- Any resident on inhaled medications, or medications to be given on an empty stomach have the potential to be affected.</p> <p>3- Education to nursing staff was provided beginning 7/10/18 regarding inhaled medications and giving medications on an empty stomach. Audits will be completed by the DON/designee on inhaled medications and those to be given on an empty stomach will be completed at least twice weekly for one month, then once a week for one month, then monthly until compliance is achieved.</p> <p>4- The audits will be reviewed during the facility's QAPI meeting until compliance is achieved.</p>		

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F 759	Continued From page 45 LPN #2 read the physician's order again and said she should have asked the resident first before giving the Levothyroxine.  2. On 6/13/18 at 4:05 PM, RN #3 was observed as she handed the Symbicort inhaler to Resident #12. Resident #12 was observed to take a puff of Symbicort orally, shook it then took another puff which was about 3 seconds in between puffs. Resident #12 then rinsed her mouth with water.  A physician's order dated 6/11/18, documented an order for Symbicort 2 puffs inhale orally two times a day for COPD (chronic pulmonary obstructive disease) wait at least one minute between puffs and rinse mouth after use.  On 6/13/18 at 4:16 PM, RN #3 said she should have told Resident #12 to wait one minute before taking another puff of Symbicort.	F 759			
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)  §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)  This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A	F 801		7/31/18	

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F 801	<p>Continued From page 46</p> <p>qualified dietitian or other clinically qualified nutrition professional is one who-</p> <p>(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.</p> <p>(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.</p> <p>(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.</p> <p>(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.</p> <p>§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-</p> <p>(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations</p>	F 801			

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F 801	<p>Continued From page 47 after November 28, 2016, is:</p> <p>(A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview, it was determined the facility failed to ensure the DM was qualified. The failure created the potential for a negative affect for 13 of 13 sample residents (#2, #8, #10, #12, #17, #19, #23, #24, #25, #26, #28, #31, and #83) and the other 23 residents living in the facility who ate food prepared in the kitchen. Findings include:</p> <p>On 6/11/18 at 12:55 PM, the DM said she was in school to become a Certified Dietary Manager (CDM). The DM said a corporate CDM came to the facility at least once a month and a corporate Registered Dietitian (RD) came to the facility every other week.</p> <p>On 6/13/18 at 9:00 AM, with the Administrator present, the DM said she had started an</p>	F 801	<p>1- The contracted dietary company (HCSG) has assigned a full time CDM to work in the facility.</p> <p>2- All residents have the potential to be affected.</p> <p>3- The contracted CDM will remain assigned full time until our current dietary manager acquires the accepted/required credentialing per the state and federal guidelines. In the future, any dietary manager will be required to hold the proper certification or other qualifying requirements per the Federal and State regulation.</p> <p>4- The administrator and/or HR manager</p>		

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F 801	Continued From page 48 18-month on-line nutrition program course in June 2017.  On 6/13/18 at 12:30 PM, the DM said she was promoted to the DM position between 5/24/17 and 5/28/17 and she could not begin the on-line course until 2 preceptors signed off on her training. The DM said the facility's previous Certified Dietary Manager (CDM) continued to work in the building in a different position and was available to answer questions until about 1 1/2 months ago when the previous CDM quit. The DM said the previous CDM was not involved in managing or running the kitchen after May 2017.	F 801	will review certification or other eligible substitutions prior to hiring a dietary manager.		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		7/31/18	

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F 812	<p>Continued From page 49</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure the commercial can opener blade was clean and sanitized when it was ready to use and the front panel on the steam table was maintained in a sanitary manner. The failure increased the risk for 13 of 13 sample residents (#2, #8, #10, #12, #17, #19, #23, #24, #25, #26, #28, #31, and #83) and the other 25 residents who ate food prepared in the facility's kitchen to develop a foodborne illness. Findings include:</p> <p>On 6/14/18 at 11:20 AM, the following was observed in the kitchen:</p> <p>* A dried, reddish-brown substance was on the entire point end of the commercial can opener blade when the DM lifted it out of its holder.</p> <p>Cook #1 said he had used the can opener to open a can of tomato juice for breakfast that morning. The DM said the can opener should have been cleaned and sanitized before it was put back in use. The DM moved the can opener to the dirty dish area.</p> <p>* Sticky, raised, black and black-brown vertical streaks covered the entire front panel below the wooden preparation shelf on the steam table. The steam table was about 6 feet long.</p> <p>The DM said the steam table was cleaned weekly and that it was last cleaned on 6/8/18. The DM said the vertical streaks would come off and that the front panel could be cleaned better and more often.</p>	F 812	<p>1- The can opener and steam table were immediately cleaned.</p> <p>2- All residents eating meals from the kitchen have the potential to be affected.</p> <p>3- The kitchen staff were in-serviced on the importance of maintaining cleanliness of utensils and equipment. The administrator/designee will perform weekly sanitation audits for four (4) weeks, then once monthly to maintain compliance.</p> <p>4 Audits will be reviewed during the facility QAPI meeting until compliance is achieved.</p>		

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F 812	Continued From page 50  On 6/14/18 at 5:00 PM, the front panel on the steam table was observed to be clean with a few baked on vertical streaks remaining.  On 6/15/18 at 12:55 PM, the DM provided copies of the Cooks Weekly Deep Cleaning schedule which documented the steam table was cleaned on 6/1/18 and 6/8/18.	F 812			
F 825 SS=E	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2)  §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-  §483.65(a)(1) Provide the required services; or  §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and record review, it was determined the facility failed to ensure residents received rehabilitative services as ordered by a physician, and services	F 825	1- Residents #25,10, 28, & 30 have been receiving therapy as ordered.  2- All residents with therapy orders have	7/31/18	

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F 825	<p>Continued From page 51</p> <p>were not interrupted when the facility's contract with their Physical Therapy provider ended abruptly. This was true for 4 of 8 (#10, #22, #28, &amp; #33) residents whose therapy services were reviewed. This failure created the potential for residents to experienced decline in their physical functioning when rehabilitative services and necessary assistive device were not provided. Findings include:</p> <p>1. Resident #10 was admitted to the facility on 4/3/18 with multiple diagnoses, including anoxic (absence of oxygen) brain injury and asthma.</p> <p>Resident #10's admitting MDS assessment dated 4/10/18, documented she was cognitively intact and required the assistance of 1 to 2 staff members with most ADL's, used wheelchair for locomotion, and received PT (Physical Therapy)/OT (Occupational Therapy).</p> <p>Resident #10's PT Notes documented the following:</p> <p>*4/3/18 - PT Evaluation and Plan of Treatment documented Resident #10's goals were to be able to stand-up, transfer better, and maybe even start walking again. Treatment approaches may include: therapeutic exercises, gait training therapy, manual therapy techniques, wheelchair management and therapeutic activities 6 x (times) a week for 100 days from 4/3/18 through 7/11/18.</p> <p>*4/3/18 - 4/30/18 PT Progress Notes, documented Resident #10 required skilled PT services to improve dynamic balance, increase functional activity tolerance, minimize falls,</p>	F 825	<p>the potential to be affected. An audit has been completed to ensure all others on therapy are receiving treatment as ordered.</p> <p>3- The DON/designee will audit and review therapy orders and treatments weekly in perpetuity. Any unexpected break from therapy due to therapy contracts or staffing will be reported to the physician and the therapy company for direction and/or implement new orders. The facility will contract with, and will utilize outpatient services as needed in the event where there is a break in service of more than 48 hours.</p> <p>4- Audits will be reviewed at each QAPI meeting until compliance is achieved.</p>		

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F 825	<p>Continued From page 52</p> <p>decrease complaint of pain, increase LE (lower extremities) ROM (range of motion) and strength, increased activity tolerance and functional activity tolerance to enhance quality of life.</p> <p>*5/1/18 - 5/15/18 PT Progress Notes, documented Resident #10 was progressing with current treatment interventions, demonstrated good rehabilitation potential and was motivated to participate and return to previous level of function, and skilled PT was warranted.</p> <p>*5/16/18 - 5/24/18 PT Progress Notes, documented Resident #10 showed significant progress from maximal assistance (50-60%) to stand by assist with close attention to safety needs. Her strength, positioning, scooting, bed mobility, and upright tolerance without fatigue responded appropriately to skilled interventions and were expected to continue to improve with receipt of the required transfer pole.</p> <p>*5/25/18 - PT Discharge Summary documented "Contract ending with provider. Recommend continued therapy and will set-up extensive RNA program for current needs." The discharge summary also documented Resident #10 needed further evaluation for transfer training when the transfer pole was received.</p> <p>On 6/11/18 at 5:25 PM, Resident #10 said she previously received PT except on the weekend but it stopped because the facility switched companies. She said she was told she needed a transfer pole to help herself transfer from her bed to her wheelchair. Resident #10 also added she would like to continue her PT so she could go home to her family.</p>	F 825			

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NAME OF PROVIDER OR SUPPLIER  <b>DESERT VIEW CARE CENTER OF BUHL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>820 SPRAGUE AVENUE BUHL, ID 83316</b>		
(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 825	<p>Continued From page 53</p> <p>On 6/15/18 at 1:09 PM, the DOR said Resident #10 met her maximum OT potential and they were waiting for her transfer pole.</p> <p>2. Resident #25 was admitted to the facility on 5/8/18, with multiple diagnoses, including hemorrhagic stroke with left sided weakness.</p> <p>Resident #25's admission MDS assessment dated, 5/15/18, documented he was moderately cognitively impaired and required the extensive assistance of one to two staff members with most ADL's. The MDS assessment also documented Resident #25 had limitation of range of motion on one side on both upper and lower extremities, used wheelchair for locomotion and received PT, TO and ST (speech therapy).</p> <p>On 6/11/18 at 3:11 PM, Resident #25's said he had only 3 PT sessions since his admission to the facility and did not remember the last time he had PT. He said he wanted his legs to get stronger and walk again. Resident #25 also said, he would rather go back to the hospital where he received PT every day.</p> <p>Resident #25's care plan created on 5/15/18, documented he was working with PT, TO and ST.</p> <p>Resident #25's OT notes documented the following:</p> <p>*5/9/18 - OT Evaluation and Plan of Treatment, documented Resident #25 demonstrated an excellent rehabilitation potential as evidenced by his previous level of function, recent onset,</p>	F 825			

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F 825	<p>Continued From page 54</p> <p>motivation to participate and ability to make his needs known. Treatment goals for Resident #25 were to position himself correctly while sitting in wheelchair and to propel himself safely in wheelchair within the facility. Treatment approaches included: therapeutic exercises, neuromuscular reeducation, self-care management and wheelchair management training 3 times a week for 100 days, from 5/9/18 to 8/16/18.</p> <p>*5/9/18 - 5/24/18 OT Progress Notes, documented Resident #25's functional abilities had potential to improve further as a result of skilled therapeutic interventions and continued OT services was necessary to assess his safety and independence with self-care, develop and instruct on compensatory strategies, assess the need for adaptations. minimize safety hazards/barriers, increase safety awareness facilitate sitting tolerance and postural control in order to enhance his quality of life.</p> <p>*5/24/18 - OT Progress Report, documented "Continued OT services are necessary in order to assess safety and independence with self-care and functional tasks of choice, develop and instruct on compensatory strategies, assess the need for adaptations, minimize hazards/barriers, restore cognitive and perceptual skills, increase safety awareness..."</p> <p>*5/25/18 - OT Discharge Summary, documented "Contract ending with provider. Recommend continuing with extensive RNA (Restorative Nursing Program)."</p> <p>Resident #25's PT notes documented the</p>	F 825			

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F 825	<p>Continued From page 55 following:</p> <p>*5/10/18 - A PT Evaluation and Plan of Treatment, documented Resident #25's goals were "I want to go to Mexico next week...I want to walk again." Treatment approaches included: therapeutic exercises, neuromuscular reeducation, gait training therapy and therapeutic activities 5 times a week for 100 days from 5/9/18 to 8/16/18.</p> <p>*5/10/18 - 5/15/18 PT Progress Notes, documented Resident #25 he was progressing with his current treatment interventions and skilled PT was necessary to improve his balance, increase his functional activity tolerance, increase his lower extremity range of motion and strength, promote safety awareness and facilitate all functional mobility to enhance his quality of life.</p> <p>*5/16/18 - 5/24/18 PT Progress Notes, documented Resident #25 was improving with his bed mobility, scooting in sitting and supine position. He demonstrated good rehabilitative potential and was motivated to return to his previous level of function. PT was recommended to be continued as he was at significant risk of falling and permanent disability.</p> <p>*5/24/18 A PT Discharge Summary, documented "Contract ending with provider. Recommend continued therapy with evaluation, and will set-up extensive RNA program for current needs." It was also documented Resident #25 showed significant progress with skilled intervention and required further evaluation and treatment for his impairments due to his appropriate response to</p>	F 825			

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F 825	<p>Continued From page 56</p> <p>this interventions to reduce his abnormal risks for mobility disability, rehospitalization, and falls.</p> <p>On 6/13/18 at 9:05 AM, Resident #25 was observed in his wheelchair in his room brushing his teeth using his right hand with COTA (Certified Occupational Therapist Assistant) #1 next to him. Resident #25 said it was always the nurses who helped him brush his teeth and this was the first time the COTA came to his room to help him.</p> <p>On 6/13/18 at 9:45 AM, Resident #25 was observed in the PT room with PTA (Physical Therapist Assistant) #1. Resident #25 was heard saying to PTA #1 he wanted to use his walker so he could go home soon.</p> <p>On 6/13/18 at 11:47 AM, PTA #1 said she started working in the facility 2 days before and it was the first time she saw Resident #25. PTA #1 said Resident #25 was scheduled to do his PT 6 times a week for eight weeks from 6/10/18 through 9/7/18.</p> <p>On 6/13/18 at 2:25 PM, the DOR said Rehabilitation Services Provider #1 (RSP #1) who was providing the PT program for the facility ended their contract on 5/25/18 and Rehabilitation Services Provider #2 (RSP #2) was to provide services. She said RSP #2 started seeing and evaluating residents on 5/30/18. The DOR was asked why Resident #25 started his PT on 6/13/18 and not earlier. The DOR said Resident #25 was re-evaluated on 6/10/18 and was to receive PT 6 times a week and OT 3 times a week. She said they were still hiring PTs, and evaluated and provided PT/OT first to those</p>	F 825			

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F 825	<p>Continued From page 57</p> <p>residents who were scheduled to be discharged during the transition period. The DOR said Resident #25 was recommended to receive the RNA program upon discharge from PT/OT by RSP #1. She did not know why Resident #25 did not receive the RNA program.</p> <p>On 6/13/18 at 2:50 PM, LPN #1 who joined in the conversation said she received a request for Resident #25 to have a dining RNA program. The LPN also said they did not receive a request for Resident #25 to continue his therapy in the RNA program and looked at the DOR. LPN #1 said she should know because she was the DOR for RSP #1. The DOR said she was hired by RSP #2 to be the DOR and on Friday morning of 5/25/18, RSP #1 told them to discharge the residents from PT/OT and be out of the building by noon because RSP #1's contract with the facility was officially ended. She said it was a short notice and it was unfortunate the residents were the ones affected by this event.</p> <p>3. Resident #28 was admitted to the facility on 5/18/18, with multiple diagnoses, including traumatic brain hemorrhage.</p> <p>Resident #28's admission MDS assessment, dated 5/25/18, documented his cognition was severely impaired, required the assistance of two staff members for bed mobility, transfer and dressing, set-up only for eating and drinking, and had history of falls. The MDS assessment also documented Resident #28 had an impairment in range of motion on both his lower extremities, received ST 3 times a week, OT 4 times a week and did not received PT.</p>	F 825			

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F 825	<p>Continued From page 58</p> <p>A physician's telephone order dated 5/18/18, documented "PT/OT/ST eval[uation]/tx[treat] as indicated for strengthening balance and cognition.</p> <p>Resident #28's care plan created on 5/31/18, documented Resident #28 was working with PT/OT to get stronger so he could go home.</p> <p>Resident #28's OT notes documented:</p> <p>*5/18/18 - An OT Evaluation and Plan of Treatment documented "Patient demonstrates good rehab[ilitation] potential as evidenced by ability to follow 1-step direction, able to make needs known..." Treatment approaches included: therapeutic exercises, therapeutic activities, self-care management and wheelchair management 3 times a week for 90 days from 5/18/18 through 8/15/18.</p> <p>*5/18/18, 5/19/18, 5/22/18, 5/23/18 and 5/24/18 OT Treatment Encounter Notes documented Resident #28 received OT for 5 days.</p> <p>*5/25/18 - OT Discharge Summary documented "Contract ending with provider. Recommend continue with RNA program to prevent decline from current skill level." The discharge summary also documented Resident #28 had a good prognosis to maintain current level of function with consistent staff follow through.</p> <p>There were no PT Evaluation Notes or PT Progress Notes in Resident #28's clinical record.</p> <p>On 6/15/18 at 12:50 PM, the DOR said she was sure Resident #28 received PT. She said she did</p>	F 825			

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F 825	<p>Continued From page 59</p> <p>not have access to RSP #1's records anymore but she would ask the Medical Records Department for Resident #28's PT report. The DOR also stated if Resident #28 did not have PT, he should have at least have received a PT evaluation.</p> <p>On 6/15/18 at 1:09 PM, the DOR said she did not find Resident #28's PT report. She said Resident #28 received OT, and she did not know why he was not evaluated by, or receive, PT.</p> <p>On 6/15/18 at 3:16 PM, the DON said she did not know why Resident #28 did not receive PT.</p> <p>4. Resident #33 was admitted to the facility on 5/13/18 with several diagnoses including cerebral infarction (stroke).</p> <p>An admission MDS assessment, dated 5/20/18, documented Resident #33's cognition was intact, she required limited assistance of one person for bed mobility and bathing, supervision of one person for transfers, walking in her room and in the corridor, dressing, toileting, personal hygiene, and extensive assistance of one person for locomotion on and off the unit, and she received 7 days of OT services and 6 days of PT services, which both began on 5/14/18.</p> <p>Resident #33's hospital Discharge Orders, dated 5/12/18, included orders for PT and OT to evaluate and treat. The facility's physician orders, dated "On or After Date: 06/15/18," included a 5/13/18 order for PT and OT to evaluate and treat.</p> <p>Resident #33's PT Evaluation &amp; Plan of</p>	F 825			

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F 825	<p>Continued From page 60</p> <p>Treatment, documentation included:</p> <ul style="list-style-type: none"> <li>* The start of care was 5/14/18.</li> <li>* The resident's goal was to go home and the potential for her to achieve the goal was good.</li> <li>* Treatment approaches included therapeutic exercises, neuromuscular reeducation, gait training therapy, moderate complexity evaluation, and therapeutic activities.</li> <li>* The frequency of treatments was 6 times per week for a duration of 69 days and the intensity was daily.</li> <li>* The certification period was 5/14/18 - 7/21/18.</li> </ul> <p>Resident #33's PT Treatment Encounter Notes documented she received PT services daily from 5/14/18 to 5/19/18 and daily from 5/21/18 to 5/25/18.</p> <p>A 5/25/18 PT Discharge Summary documented, "Patient discharged to reside in this...facility...Contract ending with provider. Recommend continued therapy with evaluation..." The short-term goal for "risk of fall and injury minimization" was not met and "further treatment required to increase safety..." Re-evaluation was recommended "in-facility or through home health..."</p> <p>On 6/14/18 at 11:40 am, a handwritten PT note, dated 5/27/18, was found on the table in the room where the survey team was working. The PT note documented, "...showed need for some additional practice...since a break in practice produced need for problem solving again...Continue with Physical Therapy."</p> <p>On 6/14/18 at 11:40 AM, LPN #4 said there were no other PT Treatment Encounter Notes,</p>	F 825			

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F 825	<p>Continued From page 61 evaluations, or discharge documents.</p> <p>Resident #33's OT Evaluation &amp; Plan of Treatment, documentation included:            * The start of care was 5/14/18.            * Four short-term goals and 3 long-term goals were identified as steps to achieve the resident's goal to get stronger, return home, and care for herself.            * Treatment approaches included therapeutic exercises and activities, moderately complex OT evaluation, self care management training, and community/work reintegration.            * The frequency of treatments was 6 times per week for a duration of 40 days and the intensity was daily.            * The certification period was 5/14/18 - 6/22/18.</p> <p>Resident #33's OT Treatment Encounter Notes documented OT services were provided daily from 5/14/18 to 5/25/18.</p> <p>A 5/25/18 OT Discharge Summary documented 2 of the short-term goals and all 3 of the long-term goals were discontinued on 5/25/18, the resident was discharged to reside in the facility, and a referral was made for restorative services in the facility.</p> <p>On 6/14/18 at 12:45 PM, the DON provided an OT Transitional Evaluation and Plan of Treatment, dated 5/25/18, for Resident #33. The DON said RSP #1's contract ended on 5/25/18 and RSP #2 completed the OT Transitional Evaluation and Plan of Treatment on 5/25/18.</p> <p>The 5/25/18 OT Transitional Evaluation and Plan of Treatment documented generalized muscle</p>	F 825			

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F 825	Continued From page 62 weakness and the need for OT therapeutic activities and self care management training 5 times a week for 2 weeks with daily intensity from 5/25/18 to 6/25/18.  May 25, 2018 was a Friday and the next OT Treatment Encounter Notes documented OT was provided on Wednesday 5/30/18 and Thursday 5/31/18. There was no documentation that OT treatment encounters were attempted on Monday 5/28/18, Tuesday 5/29/18, or Friday 6/1/18.  An OT Discharge Summary, dated 5/31/18, documented 1 of the 2 long-term goals was discontinued and the resident was "Discharged per Physician or Case Manager."  Nursing Notes documented the following: * 5/29/18 at 1:31 PM - The resident returned from a routine physician appointment with discharge orders to home on Friday (6/1/18). * 5/31/18 at 3:21 PM - To go home tomorrow, planned discharge.  On 6/14/18 at 12:00 PM, an interested party who wished to remain anonymous said Resident #33's PT and OT services were not provided as planned after the facility changed from RSP #1 to RSP #2.	F 825			
F 837 SS=E	Governing Body CFR(s): 483.70(d)(1)(2)  §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and	F 837			7/31/18

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F 837	<p>Continued From page 63</p> <p>§483.70(d)(2) The governing body appoints the administrator who is-</p> <p>(i) Licensed by the State, where licensing is required;</p> <p>(ii) Responsible for management of the facility; and</p> <p>(iii) Reports to and is accountable to the governing body.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident and staff interviews, record review, and review of contracts, it was determined the facility's Governing Body failed to ensure Rehabilitation Therapy Services were provided as ordered and without interruption for 4 of 8 residents (#10, #25, #28, &amp; #33) with orders for rehabilitation therapy. The failure created the potential for the residents to experience a decline in their functional status when PT and/or OT services were delayed several days, or not provided at all, after an abrupt change from Rehabilitation Service Provider (RSP) #1 to RSP #2. Findings include:</p> <p>Rehabilitation Therapy Services were interrupted and/or delayed when the Governing Body and RSP #1 abruptly ended their contract on 5/25/18.</p> <p>1. Resident #10 was admitted to the facility on 4/3/18 with multiple diagnoses which included anoxic (absence of oxygen) brain injury and asthma.</p> <p>Resident #10's PT Evaluation and Plan of Treatment, dated 4/3/18, documented PT would be provided 6 days a week for 100 days from 4/3/18 through 7/11/18.</p>	F 837	<p>1- Residents #10, 25, 28, &amp; 33 are receiving inpatient therapy from our new contracted therapy provider.</p> <p>2- All residents who require physical, occupational, and speech therapy have the potential to be affected by an interruption of therapy services.</p> <p>3- The Governing Body of Desert View Care Center of Buhl will enter into agreements or memorandums of understanding with one or more physical, occupational, and/or speech therapy providers to be a back-up therapy provider in the event of an interruption of service of more than 48 hours.</p> <p>4- The facility will forward the results of it's weekly review of therapy orders, and the QAPI audits to the corporate Chief Compliance Officer for review until such time that compliance is achieved.</p>		

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F 837	Continued From page 64  PT Treatment Encounter Notes documented PT was provided from 4/3/18 to 5/24/18 and that Resident #10 was motivated and demonstrated good rehabilitation potential. The PT notes documented the resident made significant progress, from maximal assistance to stand by assist with close attention to safety needs, and progress was expected to continue when a needed transfer pole was received.  A 5/25/18 PT Discharge Summary documented, "Contract ending with provider. Recommend continued therapy with evaluation, and will set-up extensive RNA program for current needs." The Discharge Summary documented 4 of 6 short-term goals and 1 of 3 long-term goals were met on or before 5/25/18 but that 2 short-term goals and 2 long-term goals were discontinued on 5/24/18 or 5/25/18. The discharge summary also documented a transfer pole was needed and evaluation for transfer training would be needed when the transfer pole arrived.  On 6/11/18 at 5:25 PM, Resident #10 said she used to receive PT but it stopped when the facility switched to a different rehabilitation company. The resident said she needed a transfer pole to help transfer herself from the bed to the wheelchair but was still waiting for the transfer pole to arrive. Resident #10 she would like PT to continue so she could go home to her family.  On 6/15/18 at 1:09 PM, the DOR said Resident #10 had met her maximum potential and they were still waiting for the transfer pole.	F 837			

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F 837	<p>Continued From page 65</p> <p>There was no documented evidence Resident #10 was evaluated or that PT was continued after the abrupt change of RSP on 5/25/18. There was no documented evidence of follow-up regarding the status of the transfer pole after the RSP change on 5/25/18.</p> <p>2. Resident #25 was admitted to the facility on 5/8/18, with multiple diagnoses which included hemorrhagic stroke with left sided weakness.</p> <p>On 6/11/18 at 3:11 PM, Resident #25 said he had only 3 PT sessions since his admission to the facility and he did not remember the last time he had PT. The resident said he wanted his legs to get stronger so he could walk again and he would rather go back to the hospital where he received PT every day.</p> <p>A 5/10/18 PT Evaluation and Plan of Treatment documented "I want to walk again" as one Resident #25's goals. Treatment approaches included: therapeutic exercises, neuromuscular reeducation, gait training therapy and therapeutic activities 5 times a week for 100 days from 5/9/18 to 8/16/18.</p> <p>A PT Therapy Progress Report for 5/9/18 - 5/15/18 documented PT was provided on 5/10/18, 5/11/18, 5/13/18 and 5/15/18. The Report documented Resident #25 was progressing and skilled PT was necessary to improve his balance, increase his functional activity tolerance, increase his lower extremity range of motion and strength, promote safety awareness and facilitate all functional mobility to enhance his quality of life.</p>	F 837			

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F 837	<p>Continued From page 66</p> <p>A PT Therapy Progress Report for 5/16/18 - 5/24/18 documented PT was provided daily from 5/16/18 to 5/18/18 and from 5/21/18 to 5/24/18. The report documented the resident was improving, his rehabilitation potential was good, he was motivated to return to his prior level of function, and the reason to continue PT was he was at significant risk of falling and permanent disability.</p> <p>A 5/25/18 PT Discharge Summary documented 2 of 2 short-term goals and 2 of 2 long-term goals were discontinued on 5/25/18 and, "Contract ending with provider. Recommend continued therapy with evaluation, and will set-up extensive RNA program for current needs." It documented Resident #25 showed significant progress with skilled intervention and required further evaluation and treatment for his impairments due to his appropriate response to this interventions to reduce his abnormal risks for mobility disability, rehospitalization, and falls.</p> <p>On 6/10/18, sixteen days after Resident #25 was abruptly discharged from PT, another PT Evaluation &amp; Plan of Treatment was done. The treatment approaches included therapeutic exercises and neuromuscular re-education 6 times a week for 8 weeks from 6/10/18 to 9/7/18. The Assessment Summary documented Resident #25 was dependent on manual assist in all activity, he was unable to safely or effectively perform any aspects of mobility, and he was at risk of fall and injury due to limitations in strength, balance, and functional mobility.</p> <p>Resident #25 was not evaluated by a PT and PT was not provided by the RSP #2, for over 2</p>	F 837			

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F 837	<p>Continued From page 67 weeks.</p> <p>A 5/9/18 OT Evaluation and Plan of Treatment documented Resident #25's rehabilitation potential was excellent, he was motivated, and could make his needs known. Treatment goals were for the resident to position himself correctly while sitting in his wheelchair and safely propel himself in the wheelchair. Treatment approaches included: therapeutic exercises, neuromuscular reeducation, self-care management and wheelchair management training 3 times a week for 100 days, from 5/9/18 to 8/16/18.</p> <p>A 5/9/18 - 5/24/18 OT Therapy Progress Report documented Resident #25 received OT daily from 5/9/18 to 5/11/18 and on 5/14/18, 5/16/18, 5/18/18, 5/22/18, and 5/24/18. It documented the resident had potential to improve functional abilities further as a result of skilled therapeutic interventions and continued OT services. The Justification for Skilled Services documented, "Continued OT services are necessary in order to assess safety and independence with self-care and functional tasks of choice, develop and instruct on compensatory strategies, assess the need for adaptations, minimize hazards/barriers, restore cognitive and perceptual skills, increase safety awareness..."</p> <p>A 5/25/18 OT Discharge Summary, documented, "Contract ending with provider. Recommend continuing with extensive RNA program."</p> <p>On 6/13/18 at 2:25 PM, the DOR said RSP #1 provided the facility's rehabilitation therapy services until 5/25/18 when the contract ended and that RSP #2, started on 5/30/18. The DOR</p>	F 837			

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F 837	<p>Continued From page 68</p> <p>said Resident #25 was re-evaluated on 6/10/18 to receive PT 6 times a week and OT 3 times a week. When asked why PT and OT was not restarted before 6/10/18, the DOR said that RSP #2 was still hiring staff, and residents who were scheduled to be discharged during the transition period were evaluated and provided services first. The DOR said she did not know why Resident #25 had not received the RNA program recommended when the resident was discharged from PT and OT services on 5/25/18 by RSP #1. At 2:50 PM, LPN #1 joined the conversation. The LPN said a request by a Speech Therapist for an RNA dining program had been received and started for Resident #25 but that nursing did not receive a referral from PT or OT to continue therapy in the RNA program. LPN #1 turned to the DOR and said she should know about the referral by PT and OT for the RNA program because she was the DOR for RSP #1. The DOR said on the morning of 5/25/18 (a Friday) RSP #2 told them to discharge the residents from services and be out of the building by noon because their contract with the facility ended that day. The DOR said she was later hired by RSP #2, as the DOR. The DOR said RSP 1's contract ended on "short notice" and it was "unfortunate" the residents were the ones affected by the event.</p> <p>3. Resident #28 was admitted to the facility on 5/18/18, with multiple diagnoses, including traumatic brain hemorrhage.</p> <p>A physician's telephone order dated 5/18/18, included orders for PT and OT to evaluate and treatment as indicated for strengthening and balance.</p>	F 837			

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F 837	<p>Continued From page 69</p> <p>A 5/18/18 OT Evaluation documented Resident #28's rehabilitation potential was good and treatment approaches included therapeutic exercises and activities, self care management training, and w/c management training 3 times a week for 90 days from 5/18/18 to 8/15/18.</p> <p>OT Progress Reports and Treatment Encounter Notes documented Resident #28 received OT as ordered until 5/25/18 when he was abruptly discharged from services.</p> <p>A 5/25/18 OT Discharge Summary documented "Contract ending with provider. Recommend continue with RNA program to prevent decline from current skill level." It documented the prognosis was good for Resident #28 to maintain his current level of function with consistent staff follow through.</p> <p>On 6/14/18, the DOR provided 2 other OT Treatment Encounter Notes, dated 6/12/18 and 6/13/18. The 6/12/18 note documented, "Transitional eval(uation)" and that the OT and COTA collaborated on goals. The 6/13/18 note documented the resident needed hand on hand facilitation to lock the brakes on his wheelchair.</p> <p>There was no documented evidence Resident #28 was evaluated or received OT services for 17 days after the change from RSP #1 to RSP #2 on 5/25/18.</p> <p>A PT Evaluation, PT Progress Reports, or Treatment Encounter Notes documented prior to 5/25/18, were not found in Resident #28's clinical record. A PT Transitional Evaluation and Plan of</p>	F 837			

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F 837	<p>Continued From page 70</p> <p>Treatment, dated 6/10/18, documented generalized muscle weakness, therapeutic exercises, gait training therapy, and therapeutic activities were needed 2 times a week for 6 weeks from 6/10/18 to 7/22/18.</p> <p>There was no documented evidence Resident was evaluated or received PT services before 5/25/18 or for 15 days after the change from RSP #1 to RSP #2 on 5/25/18.</p> <p>On 6/15/18 at 12:50 PM, the DOR said she was sure Resident #28 had received PT but she did not have access to RSP #1's records anymore. The DOR said she would ask Medical Records to look for Resident #28's PT records and the resident would at least have had a PT evaluation. At 1:09 PM, the DOR said no PT records were found for Resident #28.</p> <p>On 6/15/18 at 3:16 PM, the DON said she did not know why Resident #28 did not receive PT.</p> <p>4. Resident #33's PT Treatment Encounter Notes documented she received PT services daily from 5/14/18 to 5/19/18 and daily from 5/21/18 to 5/25/18.</p> <p>A 5/25/18 PT Discharge Summary documented, "Patient discharged to reside in this...facility...Contract ending with provider. Recommend continued therapy with evaluation..." The short-term goal for "risk of fall and injury minimization" was not met and "further treatment required to increase safety..." Reevaluation was recommended "in-facility or through home health..."</p>	F 837			

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F 837	<p>Continued From page 71</p> <p>On 6/14/18 at 11:40 am, the facility provided one other PT treatment note. The handwritten PT note, dated 5/27/18, documented, "...showed need for some additional practice...since a break in practice produced need for problem solving again...Continue with Physical Therapy."</p> <p>On 6/14/18 at 11:40 AM, LPN #4 said there were no other PT Treatment Encounter Notes, evaluations, or discharge documents for Resident #33.</p> <p>Resident #33's OT Treatment Encounter Notes documented OT services were provided daily from 5/14/18 to 5/25/18.</p> <p>A 5/25/18 OT Discharge Summary documented 2 of the short-term goals and all 3 of the long-term goals were discontinued on 5/25/18, the resident was discharged to reside in the facility, and a referral was made for restorative services in the facility.</p> <p>On 6/14/18 at 12:45 PM, the DON provided an OT Transitional Evaluation and Plan of Treatment, dated 5/25/18, for Resident #33. The DON said RSP #1's contract ended on 5/25/18 and RSP #2 completed the OT Transitional Evaluation and Plan of Treatment on 5/25/18.</p> <p>The 5/25/18 OT Transitional Evaluation and Plan of Treatment documented generalized muscle weakness and the need for OT therapeutic activities and self care management training 5 times a week for 2 weeks with daily intensity from 5/25/18 to 6/25/18.</p> <p>May 25, 2018 was a Friday and the next OT</p>	F 837			

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F 837	Continued From page 72 Treatment Encounter Notes documented OT was provided on Wednesday 5/30/18 and Thursday 5/31/18. There was no documented evidence that OT treatment encounters were attempted on Monday 5/28/18, Tuesday 5/29/18, or Friday 6/1/18.  An OT Discharge Summary, dated 5/31/18, documented 1 of the 2 long-term goals was discontinued and the resident was "Discharged per Physician or Case Manager."  On 6/15/18 at 10:50 AM, the facility's corporate General Counsel/Director of Compliance and Risk Management, provided a copy of an "Overnight Delivery" letter, dated 5/24/18, from RSP #1's General Counsel to the facility's corporate Chief Executive Office. The letter documented notice to terminate the Therapy Services Agreement with the facility's corporation due to "failure to make any payment hereunder when due" and the last date of service "will be the end of business May 25, 2018. The facility's corporate General Counsel/Director of Compliance and Risk Management said they had been making progress with payments and thought RSP #1 would wait until July when the contract was up for renewal. He said they thought they had more time but they did not.	F 837			
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3)  §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and	F 838		7/31/18	

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F 838	<p>Continued From page 73</p> <p>update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:</p> <p>§483.70(e)(1) The facility's resident population, including, but not limited to,</p> <ul style="list-style-type: none"> <li>(i) Both the number of residents and the facility's resident capacity;</li> <li>(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;</li> <li>(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;</li> <li>(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and</li> <li>(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.</li> </ul> <p>§483.70(e)(2) The facility's resources, including but not limited to,</p> <ul style="list-style-type: none"> <li>(i) All buildings and/or other physical structures and vehicles;</li> <li>(ii) Equipment (medical and non- medical);</li> <li>(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;</li> <li>(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their</li> </ul>	F 838			

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F 838	<p>Continued From page 74</p> <p>education and/or training and any competencies related to resident care;</p> <p>(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and</p> <p>(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.</p> <p>§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.</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 it's Facility Assessment identified the resources and equipment needed to provide person centered care and services required by the resident population. The failure had the potential to affect 12 of 12 sample residents (#2, #8, #10, #12, #18, #19, #24, #25, #26, #28, #31, and #83) and the other 25 residents whose beds were positioned against the wall. This placed the residents at risk of inappropriate restraint when they were not individually assessed to determine if the bed against the wall was a potential restraint for them. Findings include:</p> <p>The Facility Assessment, dated 11/15/17 and reviewed on 11/30/17, documented the following:</p> <p>* Part 3: - Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies -</p>	F 838	<p>1- The facility assessment was updated to include the size of rooms (single or double occupancy), determination of room usage by those residents who would or would not be appropriate for each room type, and the care required for residents in rooms to include bed usage against walls.</p> <p>2- All residents have the potential to be affected.</p> <p>3- The facility assessment will be updated as necessary at each quarterly QAPI meeting to include beds against walls, and any other issues that arise that may affect residents or functionality of the facility.</p> <p>4- The QAPI team will review the results of outcomes and concerns that arise, and add those items to the facility</p>		

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F 838	<p>Continued From page 75</p> <p>included staff training/education and competencies, and resident assessment and examination at admission, as well as assessments of skin, pressure injury, neurological check, lung sounds, nutritional check, pain, and observations of response to treatment;</p> <ul style="list-style-type: none"> <li>- Employee/Resident Safety - involved understanding of fire safety and emergency procedures, smoking policy/procedure, oxygen, hazardous material storage, the need and demonstrates ability to ensure alarms, seat belts, mats, etc. are in place per care plan, incident/accident forms, and knowledge of the telephone/paging system;</li> <li>- Resident Cares - Person-centered care, including but not limited to person-centered care planning, resident and family/representative education;</li> <li>- Resident Rights - including understanding chemical and physical restraint procedures;</li> <li>- Falls/Identifying Causes of a Fall or Fall Risk/Prioritizing Approaches to Managing Falls and Fall Risk/Monitoring Subsequent Falls and Fall Risk; and,</li> <li>- Physical environment and building/plant needs - included bariatric beds, bed frames, mattresses, room and common space furniture.</li> </ul> <p>The Facility Assessment did not address the facility's practice of routinely placing beds against the wall to increase the functional space in resident rooms. The assessment did not address the need to assess each individual resident to determine if their bed positioned against the wall may be a restraint.</p> <p>On 6/15/18 at 1:30 PM, the Administrator said</p>	F 838	assessment.		

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F 838	Continued From page 76 that beds against the wall in resident rooms in general and as a potential restraint were not addressed in the Facility Assessment.  This had the potential to negatively impact Residents #2, #8, #10, #12, #18, #19, #24, #25, #26, #28, #31, and #83, and the other 25 residents whose beds were placed against a wall.	F 838			
F 840 SS=E	Use of Outside Resources CFR(s): 483.70(g)(1)(2)  §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g) (2) of this section.  §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, it was determined the facility failed to ensure rehabilitation therapy services were provided consistently and in a timely manner for	F 840	1- A new rehab contract was signed on 5/26/18, and therapy is currently providing appropriate services to all residents with rehab orders.	7/31/18	

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F 840	<p>Continued From page 77</p> <p>4 of 8 sample residents who were receiving those services until an abrupt change from Rehabilitation Service Provider #1 to Rehabilitation Service Provider #2. This failure created the potential for residents to experience a decline in their functional status when they waited for days to be re-evaluated, or were not re-evaluated, after the change of RSP. Findings include:</p> <p>1. Resident #10 was admitted to the facility on 4/3/18 with multiple diagnoses which included anoxic (absence of oxygen) brain injury and asthma.</p> <p>Resident #10's PT Evaluation and Plan of Treatment, dated 4/3/18, documented PT would be provided 6 days a week for 100 days from 4/3/18 through 7/11/18.</p> <p>PT Treatment Encounter Notes documented PT was provided from 4/3/18 to 5/24/18 and that Resident #10 was motivated and demonstrated good rehabilitation potential. The PT notes documented the resident made significant progress, from maximal assistance to stand by assist with close attention to safety needs, and progress was expected to continue when a needed transfer pole was received.</p> <p>A 5/25/18 PT Discharge Summary documented, "Contract ending with provider. Recommend continued therapy with evaluation, and will set-up extensive RNA program for current needs." The Discharge Summary documented 4 of 6 short-term goals and 1 of 3 long-term goals were met on or before 5/25/18 but that 2 short-term goals and 2 long-term goals were discontinued</p>	F 840	<p>2- All residents with rehab orders have the potential to be affected. An audit was performed to determine compliance.</p> <p>3- In the event that in-house therapies or other services being provided internally at the facility are not available, the facility will utilize outside outpatient services to receive treatment, and/or request new orders from the physician as appropriate. The DON/designee will perform weekly therapy audits for one month to verify therapy services are provided as ordered, then will audit monthly thereafter until compliant.</p> <p>4- The weekly and monthly audits will be reviewed at the quarterly QAPI meetings until compliance is achieved.</p>		

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F 840	<p>Continued From page 78 on 5/24/18 or 5/25/18. The discharge summary also documented a transfer pole was needed and evaluation for transfer training would be needed when the transfer pole arrived.</p> <p>On 6/11/18 at 5:25 PM, Resident #10 said she used to receive PT but it stopped when the facility switched to a different rehabilitation company. The resident said she needed a transfer pole to help transfer herself from the bed to the wheelchair but was still waiting for the transfer pole to arrive. Resident #10 she would like PT to continue so she could go home to her family.</p> <p>On 6/15/18 at 1:09 PM, the DOR said Resident #10 had met her maximum potential and they were still waiting for the transfer pole.</p> <p>There was no documented evidence Resident #10 was evaluated or that PT was continued after the abrupt change of RSP on 5/25/18. There was no documented evidence of follow-up regarding the status of the transfer pole after the RSP change on 5/25/18.</p> <p>2. Resident #25 was admitted to the facility on 5/8/18, with multiple diagnoses which included hemorrhagic stroke with left sided weakness.</p> <p>On 6/11/18 at 3:11 PM, Resident #25 said he had only 3 PT sessions since his admission to the facility and he did not remember the last time he had PT. The resident said he wanted his legs to get stronger so he could walk again and he would rather go back to the hospital where he received PT every day.</p>	F 840			

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F 840	<p>Continued From page 79</p> <p>A 5/10/18 PT Evaluation and Plan of Treatment documented "I want to walk again" as one Resident #25's goals. Treatment approaches included: therapeutic exercises, neuromuscular reeducation, gait training therapy and therapeutic activities 5 times a week for 100 days from 5/9/18 to 8/16/18.</p> <p>A PT Therapy Progress Report for 5/9/18 - 5/15/18 documented PT was provided on 5/10/18, 5/11/18, 5/13/18 and 5/15/18. The Report documented Resident #25 was progressing and skilled PT was necessary to improve his balance, increase his functional activity tolerance, increase his lower extremity range of motion and strength, promote safety awareness and facilitate all functional mobility to enhance his quality of life.</p> <p>A PT Therapy Progress Report for 5/16/18 - 5/24/18 documented PT was provided daily from 5/16/18 to 5/18/18 and from 5/21/18 to 5/24/18. The report documented the resident was improving, his rehabilitation potential was good, he was motivated to return to his prior level of function, and the reason to continue PT was he was at significant risk of falling and permanent disability.</p> <p>A 5/25/18 PT Discharge Summary documented 2 of 2 short-term goals and 2 of 2 long-term goals were discontinued on 5/25/18 and, "Contract ending with provider. Recommend continued therapy with evaluation, and will set-up extensive RNA program for current needs." It documented Resident #25 showed significant progress with skilled intervention and required further evaluation and treatment for his impairments due</p>	F 840			

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F 840	<p>Continued From page 80</p> <p>to his appropriate response to this interventions to reduce his abnormal risks for mobility disability, rehospitalization, and falls.</p> <p>On 6/10/18, sixteen days after Resident #25 was abruptly discharged from PT, another PT Evaluation &amp; Plan of Treatment was done. The treatment approaches included therapeutic exercises and neuromuscular re-education 6 times a week for 8 weeks from 6/10/18 to 9/7/18. The Assessment Summary documented Resident #25 was dependent on manual assist in all activity, he was unable to safely or effectively perform any aspects of mobility, and he was at risk of fall and injury due to limitations in strength, balance, and functional mobility.</p> <p>Resident #25 was not evaluated by a PT and PT was not provided by the RSP #2, for over 2 weeks.</p> <p>A 5/9/18 OT Evaluation and Plan of Treatment documented Resident #25's rehabilitation potential was excellent, he was motivated, and could make his needs known. Treatment goals were for the resident to position himself correctly while sitting in his wheelchair and safely propel himself in the wheelchair. Treatment approaches included: therapeutic exercises, neuromuscular reeducation, self-care management and wheelchair management training 3 times a week for 100 days, from 5/9/18 to 8/16/18.</p> <p>A 5/9/18 - 5/24/18 OT Therapy Progress Report documented Resident #25 received OT daily from 5/9/18 to 5/11/18 and on 5/14/18, 5/16/18, 5/18/18, 5/22/18, and 5/24/18. It documented the resident had potential to improve functional</p>	F 840			

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F 840	<p>Continued From page 81</p> <p>abilities further as a result of skilled therapeutic interventions and continued OT services. The Justification for Skilled Services documented, "Continued OT services are necessary in order to assess safety and independence with self-care and functional tasks of choice, develop and instruct on compensatory strategies, assess the need for adaptations, minimize hazards/barriers, restore cognitive and perceptual skills, increase safety awareness..."</p> <p>A 5/25/18 OT Discharge Summary, documented, "Contract ending with provider. Recommend continuing with extensive RNA program."</p> <p>On 6/13/18 at 2:25 PM, the DOR said RSP #1 provided the facility's rehabilitation therapy services until 5/25/18 when the contract ended and that RSP #2, started on 5/30/18. The DOR said Resident #25 was re-evaluated on 6/10/18 to receive PT 6 times a week and OT 3 times a week. When asked why PT and OT was not restarted before 6/10/18, the DOR said that RSP #2 was still hiring staff, and residents who were scheduled to be discharged during the transition period were evaluated and provided services first. The DOR said she did not know why Resident #25 had not received the RNA program recommended when the resident was discharged from PT and OT services on 5/25/18 by RSP #1. At 2:50 PM, LPN #1 joined the conversation. The LPN said a request by a Speech Therapist for an RNA dining program had been received and started for Resident #25 but that nursing did not receive a referral from PT or OT to continue therapy in the RNA program. LPN #1 turned to the DOR and said she should know about the referral by PT and OT for the RNA program</p>	F 840			

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F 840	<p>Continued From page 82</p> <p>because she was the DOR for RSP #1. The DOR said on the morning of 5/25/18 (a Friday) RSP #2 told them to discharge the residents from services and be out of the building by noon because their contract with the facility ended that day. The DOR said she was later hired by RSP #2, as the DOR. The DOR said RSP 1's contract ended on "short notice" and it was "unfortunate" the residents were the ones affected by the event.</p> <p>3. Resident #28 was admitted to the facility on 5/18/18, with multiple diagnoses, including traumatic brain hemorrhage.</p> <p>A physician's telephone order dated 5/18/18, included orders for PT and OT to evaluate and treatment as indicated for strengthening and balance.</p> <p>A 5/18/18 OT Evaluation documented Resident #28's rehabilitation potential was good and treatment approaches included therapeutic exercises and activities, self care management training, and w/c management training 3 times a week for 90 days from 5/18/18 to 8/15/18.</p> <p>OT Progress Reports and Treatment Encounter Notes documented Resident #28 received OT as ordered until 5/25/18 when he was abruptly discharged from services.</p> <p>A 5/25/18 OT Discharge Summary documented "Contract ending with provider. Recommend continue with RNA program to prevent decline from current skill level." It documented the prognosis was good for Resident #28 to maintain his current level of function with consistent staff</p>	F 840			

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F 840	<p>Continued From page 83 follow through.</p> <p>On 6/14/18, the DOR provided 2 other OT Treatment Encounter Notes, dated 6/12/18 and 6/13/18. The 6/12/18 note documented, "Transitional eval(uation)" and that the OT and COTA collaborated on goals. The 6/13/18 note documented the resident needed hand on hand facilitation to lock the brakes on his wheelchair.</p> <p>There was no documented evidence Resident #28 was evaluated or received OT services for 17 days after the change from RSP #1 to RSP #2 on 5/25/18.</p> <p>A PT Evaluation, PT Progress Reports, or Treatment Encounter Notes documented prior to 5/25/18, were not found in Resident #28's clinical record. A PT Transitional Evaluation and Plan of Treatment, dated 6/10/18, documented generalized muscle weakness, therapeutic exercises, gait training therapy, and therapeutic activities were needed 2 times a week for 6 weeks from 6/10/18 to 7/22/18.</p> <p>There was no documented evidence Resident was evaluated or received PT services before 5/25/18 or for 15 days after the change from RSP #1 to RSP #2 on 5/25/18.</p> <p>On 6/15/18 at 12:50 PM, the DOR said she was sure Resident #28 had received PT but she did not have access to RSP #1's records anymore. The DOR said she would ask Medical Records to look for Resident #28's PT records and the resident would at least have had a PT evaluation. At 1:09 PM, the DOR said no PT records were found for Resident #28.</p>	F 840			

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F 840	<p>Continued From page 84</p> <p>On 6/15/18 at 3:16 PM, the DON said she did not know why Resident #28 did not receive PT.</p> <p>4. Resident #33's PT Treatment Encounter Notes documented she received PT services daily from 5/14/18 to 5/19/18 and daily from 5/21/18 to 5/25/18.</p> <p>A 5/25/18 PT Discharge Summary documented, "Patient discharged to reside in this...facility...Contract ending with provider. Recommend continued therapy with evaluation..." The short-term goal for "risk of fall and injury minimization" was not met and "further treatment required to increase safety..." Reevaluation was recommended "in-facility or through home health..."</p> <p>On 6/14/18 at 11:40 am, the facility provided one other PT treatment note. The handwritten PT note, dated 5/27/18, documented, "...showed need for some additional practice...since a break in practice produced need for problem solving again...Continue with Physical Therapy."</p> <p>On 6/14/18 at 11:40 AM, LPN #4 said there were no other PT Treatment Encounter Notes, evaluations, or discharge documents for Resident #33.</p> <p>Resident #33's OT Treatment Encounter Notes documented OT services were provided daily from 5/14/18 to 5/25/18.</p> <p>A 5/25/18 OT Discharge Summary documented 2 of the short-term goals and all 3 of the long-term goals were discontinued on 5/25/18, the resident</p>	F 840			

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F 840	<p>Continued From page 85</p> <p>was discharged to reside in the facility, and a referral was made for restorative services in the facility.</p> <p>On 6/14/18 at 12:45 PM, the DON provided an OT Transitional Evaluation and Plan of Treatment, dated 5/25/18, for Resident #33. The DON said RSP #1's contract ended on 5/25/18 and RSP #2 completed the OT Transitional Evaluation and Plan of Treatment on 5/25/18.</p> <p>The 5/25/18 OT Transitional Evaluation and Plan of Treatment documented generalized muscle weakness and the need for OT therapeutic activities and self care management training 5 times a week for 2 weeks with daily intensity from 5/25/18 to 6/25/18.</p> <p>May 25, 2018 was a Friday and the next OT Treatment Encounter Notes documented OT was provided on Wednesday 5/30/18 and Thursday 5/31/18. There was no documented evidence that OT treatment encounters were attempted on Monday 5/28/18, Tuesday 5/29/18, or Friday 6/1/18.</p> <p>An OT Discharge Summary, dated 5/31/18, documented 1 of the 2 long-term goals was discontinued and the resident was "Discharged per Physician or Case Manager."</p> <p>On 6/15/18 at 10:50 AM, the facility's corporate General Counsel/Director of Compliance and Risk Management, provided a copy of an "Overnight Delivery" letter, dated 5/24/18, from RSP #1's General Counsel to the facility's corporate Chief Executive Office. The letter documented notice to terminate the Therapy</p>	F 840			

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F 840	Continued From page 86 Services Agreement with the facility's corporation due to "failure to make any payment hereunder when due" and the last date of service "will be the end of business May 25, 2018. The facility's corporate General Counsel/Director of Compliance and Risk Management said they had been making progress with payments and thought RSP #1 would wait until July when the contract was up for renewal. He said they thought they had more time but they did not.	F 840			
F 883 SS=F	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)  §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or	F 883		7/31/18	

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F 883	<p>Continued From page 87 refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and record review, the facility failed to develop and implement an immunization program to ensure residents' Pneumococcal (bacterial pneumonia) vaccines were being tracked with receiving or declining the Pneumococcal vaccines PCV13 the first year, followed by the PPSV23 one year later. This was true for 4 of 5 residents (#8, #12, #24, and #31) reviewed for vaccination. These failed</p>	F 883	<p>1- A review of residents #8, 12, 24, and 31's pneumococcal immunization records was completed and updated. A pneumococcal program and tracking log have been implemented, and the facility is using an updated consent form. The medical director is reviewing immunization history of all patients, and has made recommendations for updating</p>		

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F 883	<p>Continued From page 88</p> <p>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. Findings include:</p> <p>The CDC website, updated 11/22/16, documented recommendations for Pneumococcal vaccination (PCV13 or Pevnar13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older:</p> <p>* "Adults 65 years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23."</p> <p>* "If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most recent dose of PPSV23."</p> <p>On 6/15/18 at 9:20 AM, the Infection Control Nurse provided the facility's policy for Pneumococcal Vaccine, revised 11/3/17, documented, "All residents will be offered the Pneumovax (Pneumococcal vaccine) to aid in preventing Pneumococcal infections (e.g., pneumonia). Prior to or upon admission, residents will be assessed for eligibility to receive the PCV13 or PPSV23 vaccine..."</p> <p>The facility's policy for Following Current CDC Recommendations, revised 11/2/17, documented, "Administration of the Pneumococcal vaccine or revaccinations will be made in accordance with current Centers for</p>	F 883	<p>vaccinations.</p> <p>2- All residents who are receiving/have received the pneumococcal vaccine have the potential to be affected.</p> <p>3- New consents are in place, and a tracking form has been developed for the facility. All residents will be offered the pneumococcal vaccine per physician recommendations. If after immunization history is reviewed, and it is unnecessary for further immunization, this information will be documented on consent form, tracking log, medical record, and resident and/or family will be notified. The immunization tracking log will be audited by DON/designee weekly for four (4) weeks, then monthly for (3) months.</p> <p>4- The immunization tracking log will be reviewed at least quarterly in QAPI until compliance is achieved.</p>		

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F 883	<p>Continued From page 89</p> <p>Disease Control and Prevention (CDC) recommendations at the time of the vaccination."</p> <p>The facility's policy for Tracking Immunizations, revised 11/2/17, documented, "The Director of Nursing Services or designee is responsible for tracking all immunizations on the facility immunization log."</p> <p>On 6/15/18 at 3:15 PM, the Infection Control Nurse provided a copy of the facility's policy and procedures that was in the infection control manual upon entrance of survey, revised September 2014, which documented, "All residents will be offered the Pneumovax (Pneumococcal vaccine) to aid in preventing Pneumococcal infections (e.g., pneumonia). Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax (Pneumococcal vaccine)."</p> <p>The facility's policy for "Following Current CDC Recommendations", revised September 2014, documented, "administration of the Pneumococcal vaccination or revaccinations will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination."</p> <p>The facility's policy for "Tracking Immunizations", revised September 2014, documented, "The Director of Nursing Services or designee is responsible for tracking all immunizations on the facility immunization log."</p> <p>The facility's Pneumococcal Resident Consent Form documented the resident or responsible party was to mark on the consent form as</p>	F 883			

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F 883	<p>Continued From page 90 follows:</p> <p>* "Have you ever had a life-threatening allergic reaction to a dose of this vaccine, to an earlier Pneumococcal vaccine called PCV7 (or Prevnar), or to any vaccine containing diphtheria toxoid (for example, DTaP)?"</p> <p>* "Do you have an allergy to any component of the vaccine?"</p> <p>* "Are you sick today?"</p> <p>* "Yes, I have been provided a copy of and have read or have had explained to me the information about Pneumococcal disease and the vaccine listed below. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine be given to me."</p> <p>* "No, I understand the benefits and risks of the Pneumococcal vaccine and do not wish to receive it."</p> <p>1. Resident #8 was admitted to the facility on 1/11/18 with multiple diagnoses, including heart failure and peripheral vascular disease.</p> <p>The significant change MDS assessment, dated 4/3/18, documented Resident #8 was "up to date" with the Pneumococcal Vaccination.</p> <p>Resident #8's June 2018 Immunization Record documented Resident #8 was administered the Pneumovax Dose 2 on 7/3/15.</p>	F 883			

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F 883	<p>Continued From page 91</p> <p>On 6/15/18 at 9:45 AM, the Infection Control Nurse provided Resident #8's Pneumococcal Vaccine Consent Form, dated 1/22/18, documented, "I hereby request that the Pneumococcal vaccine be given once as per facility policy to the resident named for who I am authorized to make the request." The Infection Control Nurse was unable to provide documentation Resident #8 received the Pneumococcal vaccine and which type of vaccine, the PCV13 vaccine or PPSV23 vaccine, was administered.</p> <p>2. Resident #12 was readmitted to the facility on 6/11/18 with multiple diagnoses, including diabetes mellitus and heart failure.</p> <p>A quarterly MDS assessment, dated 2/21/18, documented Resident #12 was "up to date" with the Pneumococcal Vaccination.</p> <p>Resident #12's June 2018 Immunization Record documented Resident #12 was administered the Pneumovax Dose 1 (Hx) on 10/22/13.</p> <p>On 6/15/18 at 10:00 AM, the Infection Control Nurse provided Resident #12's Pneumococcal Resident Consent Form, dated 6/11/18, which documented Resident #12 gave the facility permission for the vaccine to be administered. The Infection Control Nurse was unable to provide documentation Resident #12 received the Pneumococcal vaccine and which type of vaccine, the PCV13 vaccine or PPSV23 vaccine, was administered.</p> <p>3. Resident #24 was admitted to the facility on 2/20/18 with multiple diagnoses, including</p>	F 883			

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F 883	<p>Continued From page 92 anemia and diabetes mellitus.</p> <p>A significant change MDS assessment, dated 5/9/18, documented Resident #24 was "up to date" with the Pneumococcal Vaccination.</p> <p>Resident #24's June 2018 Immunization Record documented Resident #24 was administered the Pneumovax Dose 1 on 10/25/11.</p> <p>On 6/15/18 at 10:00 AM, the Infection Control Nurse provide Resident #24's Pneumococcal Resident Consent Form, dated 2/23/18, which documented Resident #24 gave the facility permission for the vaccine to be administered. The Infection Control Nurse was unable to provide documentation Resident #24 received the Pneumococcal vaccine and which type of vaccine, the PCV13 vaccine or PPSV23 vaccine, was administered.</p> <p>4. Resident #31 was admitted to the facility on 5/3/17 with multiple diagnoses, including hypertension and sleep apnea.</p> <p>A quarterly MDS assessment, dated 5/29/18, documented Resident #31 was "up to date" with the Pneumococcal Vaccination.</p> <p>Resident #31's June 2018 Immunization Record documented Resident #31 was administered the Pneumovax Dose 1 (Hx) on 1/1/14.</p> <p>On 6/15/18 at 10:00 AM, the Infection Control Nurse provided Resident #31's Pneumococcal Vaccine Consent Form, dated 5/3/17, documented, "The resident named below has had the Pneumococcal vaccine and was older</p>	F 883			

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F 883	<p>Continued From page 93</p> <p>than 59 years old at the time of the vaccination (if vaccine was administered prior to age 59, we will revaccinate as per Center for Disease Control guidelines)." The Infection Control Nurse was unable to provide documentation Resident #31 received the Pneumococcal vaccine and which type of vaccine, the PCV13 vaccine or PPSV23 vaccine, was administered.</p> <p>On 6/15/18 at 10:15 AM, the Infection Control Nurse was unaware of the most current CDC recommendations for the Pneumococcal Vaccination PCV13 and PPSV23, which included tracking all the residents receiving the Pneumococcal vaccination PCV13 dose first, followed by the PPSV23 one year later. The Infection Control Nurse stated she was unaware the corporation updated the Pneumococcal Resident Consent Form for the PCV13 and PPSV23.</p>	F 883			