



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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July 21, 2018

Bryan McNeil, Administrator
Caldwell Care Of Cascadia
210 Cleveland Boulevard,
Caldwell, ID 83605-3622

Provider #: 135014

Dear Mr. McNeil:

On **June 29, 2018**, a survey was conducted at Caldwell Care Of Cascadia by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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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 31, 2018**. Failure to submit an acceptable PoC by **July 31, 2018**, may result in the imposition of civil monetary penalties by **August 23, 2018**.

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

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

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

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

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

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

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**Civil Monetary Penalty
Denial of payment for new admissions effective September 29, 2018**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 29, 2018**, if substantial compliance is not achieved by that time.

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

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

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **July 31, 2018**. If your request for informal dispute resolution is received after **July 31, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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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,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive style with a large initial 'D'.

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

dr/
Enclosures

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

PRINTED: 08/02/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted June 25, 2018 to June 29, 2018. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Wendi Gonzales, RN Cecilia Stockdill, RN ABBREVIATIONS: CM = centimeters CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease CPR = Cardiopulmonary Resuscitation DNAR = Do Not Attempt Resuscitation DNR = Do Not Resuscitate DNS = Director of Nursing IM = Intramuscular L/min via n/c = Liters per minute via nasal cannula LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams MRR = Medical Record Review POST = Physician Orders for Scope of Treatment RLE = Right lower extremity Stat = Now TAR = Treatment Administration Record	F 000			
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive	F 558		8/22/18	

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

TITLE

(X6) DATE

Electronically Signed

07/30/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 558	<p>Continued From page 1</p> <p>services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interviews, it was determined the facility failed to ensure residents' needs were accommodated in the dining room. This was true for 1 of 16 sampled residents (#2) when staff did not assist her with eating in a timely manner. This failure created the potential for harm should the resident experience decreased satisfaction and nutrition intake related to the dining experience. Findings include:</p> <p>The facility's Dining Standards policy and procedure, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> * Adequate staff would be provided to assist residents during mealtimes. * Meals would be served to residents who required assistance with feeding "when a staff member is available to assist them." * Staff would be available to assist and supervise residents as needed. <p>Resident #2 was admitted to the facility on 8/5/16 with multiple diagnoses, including dysphagia (a swallowing disorder) and Alzheimer's disease.</p> <p>Resident #2's significant change MDS assessment, dated 3/8/18, documented short</p>	F 558	<p>The clinical management team reviewed resident #2 during meal time to validate needs were accommodated in the dining room. Tray delivery time is adjusted.</p> <p>The clinical management team reviewed other residents to validate their needs were accommodated in the dining room. Adjustments have been made as indicated.</p> <p>Nursing staff and department manager staff are educated to accommodate the resident's needs during meal time. Re-education was provided by the Director of Nursing and/or Designee to include but not limited to, accommodating resident needs during meal times, assigning staff to provide assistance to specific residents, and providing meal assistance when the plate is delivered to the table. The system is amended to include assignment of specific staff to assist residents as plates are delivered.</p> <p>The Director of Nursing and/or designee will audit 4 meals weekly for 4 weeks to validate staff are accommodating the needs of the residents. Starting the week of August 13th, the review will be documented on the audit tool. Any</p>		

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F 558	<p>Continued From page 2</p> <p>term and long term memory problems, moderate cognitive impairment with daily decision making, and she was totally dependent on the physical assistance of one staff for eating.</p> <p>Resident #2's current care plan documented she was at risk for nutritional decline related to Alzheimer's disease, dementia, significant weight loss, variable intake, history of refusing meals, and hospice care. The care plan directed staff to provide 1 staff to assist her to eat.</p> <p>On 6/25/18 at 12:30 PM, Resident #2 was sitting in her wheelchair at the dining table, and her plate of food was placed in front of her and was uncovered. At 12:51 PM, 21 minutes later, CNA #5 began assisting Resident #2 to eat.</p> <p>On 6/26/18 at 12:39 PM, Resident #2 was sitting in her wheelchair at the dining table, and her plate of food was placed in front of her and was uncovered. CNA #2 was sitting between Resident #2 and another resident and began assisting the other resident. Resident #2 sat in her wheelchair with her uncovered plate in front of her and was unassisted with eating until 12:54 PM, 15 minutes later.</p> <p>On 6/26/18 at 12:59 PM, CNA #4 said the facility's policy was that a staff member would only feed one resident at a time. CNA #4 said she was going to feed Resident #2 right away but she got called away.</p> <p>On 6/26/18 at 1:06 PM, the Unit Manager said usually the expectation was the residents who needed staff assistance to eat would receive their plate last at the table, then the aide would get a</p>	F 558	<p>concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>The date of compliance will be 8/22/2018.</p>		

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F 558	Continued From page 3 stool and assist them right away. The Unit Manager said mistakes were probably made in feeding residents in a timely manner.	F 558			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance	F 578		8/22/18	

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F 578	<p>Continued From page 4 with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, policy review, and staff interview, it was determined the facility failed to ensure the comprehensive care planning process included advance care directives, such as Full Code or DNR status. This was true for 1 of 5 (#59) residents sampled for review of advance directives. The failure created the potential for harm if a resident's wishes were not followed due to lack of direction in the clinical record. Findings include:</p> <p>The facility's Advance Directives/Health Care Decisions, policy and procedure, dated 10/1/17, stated that residents had the right to make decisions concerning medical care and the right to formulate advance directives. All residents were to receive resuscitation unless the resident had a valid DNR, No CPR, or DNAR order. If the resident or resident's representative had an advance directive, the facility would maintain the directive in the resident's medical record and communicate the resident's wishes to the care staff and physician.</p> <p>1. Resident #59 was initially admitted to the facility on 6/4/18 and readmitted on 6/8/18 with multiple diagnoses including, acute constipation, dementia, cerebrovascular accident (stroke), and obesity.</p>	F 578	<p>The clinical management team reviewed resident #59's comprehensive care plan. Resident #59's code status was clarified and comprehensive care plan was updated.</p> <p>The clinical management team reviewed all residents to validate code status is included in their comprehensive care plan. Updates have been made as indicated.</p> <p>Nurses are educated to advanced directives. The Director of Nursing and/or designee re-educated to addressing code status upon admission, to include but not limited to, code status clarified with the resident and/or responsible party, entered as an order into the clinical record, and care planned on the initial 48-hour care plan. The system is amended to include review of the code status and advanced directives for new admissions in clinical meeting, as well as perform reviews of current residents during quarterly and/or change of condition care plan reviews.</p> <p>The Director of Nursing and/or designee will audit the comprehensive or initial</p>		

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F 578	Continued From page 5 Resident #59's admission MDS assessment, dated 6/11/18, documented the resident was not cognitively intact, and family or significant other participated in the assessment. Resident #59's hospital physician's clinical summary, dated 5/31/18, documented a transfer order and instructions of DNAR code status. A physician note completed by the facility physician, dated 6/5/18, documented Resident #59's code status was Full Code until the family signed the necessary paperwork. Resident #59's care plan, and progress notes, dated 6/26/18, did not include the resident's advance care directive code status. On 6/27/18 at 12:36 and 4:40 PM, the Unit Manager reviewed Resident #59's medical record and care plan and was unable to provide documentation of the resident's code status. The Unit Manager stated it was common knowledge that the resident's code status was Full Code unless otherwise specified. On 6/27/18 at 4:50 PM, after review of Resident #59's clinical record, the DNS stated that the family had not provided an advance directive and the care plan did not include code status. The DNS stated the resident's code status was Full Code unless otherwise specified and should be documented in the resident's clinical record for staff to implement. She also stated that an agency staff person working should be able to look at the physician orders and care plan and identify the resident's advance directive, however, in Resident #59's case, they would not	F 578	48-hour care plans of 5 residents for advance care directives weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate. Date of compliance will be 8/22/2018.		

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F 578	Continued From page 6 be able to.	F 578			
F 604 SS=E	<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, policy review, and record review, it was</p>	F 604		8/22/18	
			The clinical management team reviewed residents #2, #11, #28, #31, and #53.		

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F 604	<p>Continued From page 7</p> <p>determined the facility failed to ensure residents were free from physical restraints. This was true for 5 of 15 sample residents (#2, #11, #28, #31, and #53) reviewed for restraints. The failure to recognize beds against the wall as a potential 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 6/27/18 at 11:00 AM, the DNS provided the facility's policy for "Restraints" and the DNS stated the policy did not address beds against the wall as a potential restraint and the facility did not have a policy addressing beds positioned against a wall as potential restraints.</p> <p>1. Resident #11 was admitted to the facility on 1/27/18 with multiple diagnoses, including anxiety, diabetes, generalized muscle weakness, and unsteadiness on feet.</p> <p>The quarterly MDS assessment, dated 3/21/18, documented Resident #11 was cognitively intact with supervision required for bed mobility and transfers.</p> <p>On 6/26/18 at 12:40 PM, Resident #11's bed was observed against the wall with the bed brakes locked. Resident #11 stated she liked her bed against the wall and it was easier to get in and out of bed.</p> <p>Resident #11's care plan, target dated 4/15/18, did not address the positioning of her bed against the wall.</p> <p>Resident #11's clinical record did not include an</p>	F 604	<p>Bed Safety Evaluations were performed and completed for residents #2, #11, #28, #31, and #53. As noted in the CMS-2567, residents were not restrained with the bed arrangement.</p> <p>The clinical management team reviewed all residents with beds against the wall for completed Bed Safety Evaluations. Adjustments have been made as indicated.</p> <p>Staff are educated that beds against the wall are a potential physical restraint. Re-education was provided by the Director of Nursing and/or designee to include but not limited to, beds against the wall are a potential physical restraint, a Bed Safety Evaluation must be completed prior to putting a bed against a wall. The system is amended to include review in stand-up regarding new admission that may be impacted by a bed against the wall prior to admissions, assessment on admission, and MDS nurse will initiate quarterly re-assessment for those currently in place in accordance with the MDS schedule.</p> <p>The Director of Nursing and/or designee will audit 4 residents who have their bed against the wall for a completed Bed Safety Evaluations weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may</p>		

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F 604	<p>Continued From page 8</p> <p>assessment, consent, or physician's order for the bed against the wall.</p> <p>On 6/27/18 at 11:50 AM, the Unit Manager stated Resident #11 did not need a consent or physician's orders for residents, because the bed against the wall was not a restraint. The Unit Manager stated the facility did not complete assessments related to beds being positioned against a wall. The Unit Manager was unable to provide an assessment, consent, care plan, or a physician order for Resident #11's bed against the wall.</p> <p>2. Resident #28 was admitted to the facility on 4/27/17 with multiple diagnoses, including cerebral palsy and muscle weakness.</p> <p>The annual MDS assessment, dated 4/26/18, documented Resident #28 was cognitively intact and required extensive assistance from two people for transfers and bed mobility.</p> <p>On 6/26/18 at 9:17 AM, Resident #28 was observed in bed lying on her right side with the bed against the wall.</p> <p>On 6/27/18 at 10:46 AM, Resident #28 was observed in bed lying on her right side with the bed against the wall. CNA #1 was observed unlocking the brakes to the bed frame to move the bed away from the wall to provide cares to Resident #28. CNA #1 stated Resident #28 wanted her bed against the wall.</p> <p>On 6/27/18 at 10:50 PM, Resident #28 stated she liked her bed against the wall to make the room more functional.</p>	F 604	<p>adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>Date of compliance will be 8/22/2018.</p>		

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NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
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F 604	<p>Continued From page 9</p> <p>Resident #28's care plan, target dated 8/6/18, did not document the bed against the wall.</p> <p>On 6/27/18 at 11:30 AM, the MDS Coordinator stated there was not a code for beds against the wall for the MDS assessments. The MDS Coordinator stated beds against the wall were not restraints and stated it should be included in residents' care plans. The MDS Coordinator was unable to provide an assessment to rule out beds against the wall as a restraint for Resident #28.</p> <p>Resident #28's clinical record did not include an assessment, consent, care plan, or physician's order for the bed against the wall.</p> <p>On 6/27/18 at 11:45 AM, the Unit Manager was unable to provide an assessment, consent, care plan, and a physician's order for Resident #28's bed to be against the wall.</p> <p>3. Resident #53 was admitted to the facility on 5/17/18 with multiple diagnoses, including traumatic brain injury with loss of consciousness and schizophrenia.</p> <p>Resident #53's admission MDS assessment, dated 5/30/18, documented severe cognitive impairment and extensive assistance of one person with bed mobility and transfers.</p> <p>On 6/25/18 at 2:24 PM, Resident #53's bed was positioned so the left side of the bed was against the wall.</p> <p>Resident #53's physician orders did not address the bed being against the wall.</p>	F 604			

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F 604	Continued From page 10 Resident #53's current care plan documented she was at risk for falls, and required "supervision, cueing, encouragement...with transferring." The care plan did not address her bed being against the wall. There was not a bed safety assessment documented in Resident #53's record prior to 6/28/18, the day before the survey exit conference on 6/29/18. 4. Resident #2 was admitted to the facility on 8/5/16 with multiple diagnoses, including Alzheimer's disease, dementia, dysphagia (difficulty swallowing), and as of 1/8/18 she began receiving hospice services. Resident #2's quarterly MDS assessment, dated 2/21/18, and significant change MDS, dated 3/8/18, documented the resident was not cognitively intact and required extensive assistance from two people for bed mobility and transfers. Resident #2's bed was observed against the wall on her left side on 6/25/18-6/29/18. Resident #2's clinical record did not contain an assessment, a physician's order, a consent or care plan for the positioning of her bed against the wall. 5. Resident #31 was admitted to the facility on 4/23/18 with multiple diagnoses, including bipolar disorder, post traumatic stress disorder, left hip prosthesis and morbid obesity.	F 604			

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F 604	Continued From page 11 Resident #31's admission MDS assessment, dated 5/4/18, documented she was cognitively intact and required limited assistance from one person for bed mobility and transfers. Resident #31's bed was observed against the wall on the resident's left side from 6/25/18-6/29/18. Resident #31's clinical record did not contain an assessment, a physician's order, a consent, or care plan for the bed to be against the wall. On 6/25/18 at 10:43 AM, Resident #31 stated she preferred her bed against the wall.	F 604			
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 636		8/22/18	

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F 636	<p>Continued From page 12</p> <p>(vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p> <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. (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.) (iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced</p>	F 636			

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F 636	<p>Continued From page 13</p> <p>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 the wall were assessed as potential restraints. This was true for 11 of 15 (#2, #11, #15, #28, #31, #39, #40, #53, #56, #59, and #62) residents sampled for potential restraints. This deficient practice placed the residents at risk of having their beds placed against a wall as a method of restraint without assessment of the need and safety of the restraint. Findings include:</p> <p>On 6/27/18 at 11:00 AM, the DNS provided the facility's policy for "Restraints" and the DNS stated the policy did not address beds against the wall as a potential restraint and the facility did not have a policy addressing beds positioned against a wall as potential restraints.</p> <p>1. Resident #11 was admitted to the facility on 1/27/18 with multiple diagnoses, including anxiety, diabetes, generalized muscle weakness, and unsteadiness on feet.</p> <p>The quarterly MDS assessment, dated 3/21/18, documented Resident #11 was cognitively intact with supervision required for bed mobility and transfers.</p> <p>On 6/26/18 at 12:40 PM, Resident #11's bed was observed against the wall with the bed brakes locked. Resident #11 stated she liked her bed against the wall and it was easier to get in and out of bed.</p> <p>Resident #11's clinical record did not include an assessment of the need and safety of the bed</p>	F 636	<p>The clinical management team reviewed residents #2, #11, #15, #28, #31, #39, #40, #53, #56, #59, and #62. Bed Safety Evaluations were performed for listed residents. The care plans were updated accordingly. No MDS modifications were indicated as the assessment demonstrated the wall was non-restrictive.</p> <p>The clinical management team reviewed other residents with beds against walls for completed Bed Safety Evaluations and according updated care plans. Adjustments have been made as indicated. No bed currently against the wall is restrictive.</p> <p>The MDS coordinator is educated by the Director of Nursing and/or the designee to include review of beds against the wall as potential restraints and code the MDS as indicated. The system is amended to include review of quarterly bed safety evaluations at the time of the MDS.</p> <p>The Director of Nursing and/or designee will audit 4 residents who have their bed against the wall for completed Bed Safety Evaluations weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p>		

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F 636	<p>Continued From page 14 positioned against the wall.</p> <p>On 6/27/18 at 11:50 AM, the Unit Manager stated the facility did not complete assessments related to beds being positioned against a wall.</p> <p>2. Resident #15 was admitted to the facility on 7/1/16 with multiple diagnoses, including a cerebrovascular disease and hemiparesis (paralysis on one side of the body) to the left side.</p> <p>The quarterly MDS assessment, dated 4/5/18, documented Resident #15 was cognitively intact and required extensive assistance from one person for bed mobility and transfers.</p> <p>On 6/26/18 at 2:27 PM, Resident #15 was observed with his bed against the wall on the left side. Resident #15 stated he liked his bed against the wall and demonstrated getting in and out of the bed safely.</p> <p>Resident #15's clinical record did not include an assessment of the need for, and safety of, his bed being positioned against the wall.</p> <p>On 6/27/18 at 11:55 AM, the Unit Manager stated there was no documentation of an assessment for Resident #15's bed against the wall.</p> <p>3. Resident #28 was admitted to the facility on 4/27/17 with multiple diagnoses, including cerebral palsy and muscle weakness.</p> <p>The annual MDS assessment, dated 4/26/18, documented Resident #28 was cognitively intact and required extensive assistance from two</p>	F 636	Date of compliance will be 8/22/2018		

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F 636	<p>Continued From page 15 people for transfers and bed mobility.</p> <p>On 6/26/18 at 9:17 AM, Resident #28 was observed in bed lying on her right side with the bed against the wall.</p> <p>On 6/27/18 at 10:46 AM, Resident #28 was observed in bed lying on her right side with the bed against the wall. CNA #1 was observed unlocking the brakes to the bed frame to move the bed away from the wall to provide cares to Resident #28. CNA #1 stated Resident #28 wanted her bed against the wall.</p> <p>On 6/27/18 at 10:50 PM, Resident #28 stated she liked her bed against the wall to make the room more functional.</p> <p>Resident #28's clinical record did not include an assessment for the bed against the wall.</p> <p>On 6/27/18 at 11:30 AM, the MDS Coordinator stated there was no documentation of an assessment for Resident #28's bed against the wall. The MDS Coordinator was unable to provide an assessment to rule out beds against the wall as a restraint for Resident #28.</p> <p>4. Resident #40 was admitted to the facility on 2/5/18 with multiple diagnoses, including COPD, anxiety, and muscle weakness.</p> <p>The quarterly MDS assessment, dated 5/15/18, documented Resident #40 was cognitively intact and independent with bed mobility.</p> <p>On 6/26/18 at 3:17 PM, Resident #40 was observed sitting on the edge of her bed with the</p>	F 636			

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F 636	<p>Continued From page 16</p> <p>bed against the wall. Resident #40 stated she liked her bed against the wall for the functionality of her room.</p> <p>Resident #40's clinical record did not include an assessment of the safety of, and need for, the positioning of her bed against the wall.</p> <p>On 6/27/18 at 11:52 AM, the Unit Manager was unable to provide an assessment for Resident #40's bed to be against the wall.</p> <p>5. Resident #62's was admitted to the facility on 6/11/18 with multiple diagnoses, including liver cancer and pain.</p> <p>The admission MDS assessment, dated 6/22/18, documented Resident #62 was cognitively intact and required supervision for bed mobility and transfers.</p> <p>On 6/25/18 at 3:00 PM, Resident #62 stated he liked his bed against the wall to make the bedroom bigger and more functional. Resident #62 stated he could get in and out of bed without difficulty.</p> <p>Resident #62's record did not include an assessment of the safety of, and need for, his bed to be positioned against the wall.</p> <p>On 6/27/18 at 11:51 AM, the Unit Manager stated Resident #62 should have had an assessment for his bed against the wall.</p> <p>6. Resident #53 was admitted to the facility on 5/17/18 with multiple diagnoses, including traumatic brain injury with loss of consciousness</p>	F 636			

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F 636	<p>Continued From page 17 and schizophrenia.</p> <p>Resident #53's admission MDS assessment, dated 5/30/18, documented severe cognitive impairment and extensive assistance of one person with bed mobility and transfers.</p> <p>On 6/25/18 at 2:24 PM, Resident #53's bed was positioned so the left side of the bed was against the wall.</p> <p>There was not a bed safety assessment documented in Resident #53's record prior to 6/28/18, the day before the survey exit conference on 6/29/18.</p> <p>7. Resident #2 was admitted to the facility on 8/5/16 with multiple diagnoses, including Alzheimer's disease, dementia, dysphagia (difficulty swallowing), and as of 1/8/18 she began receiving hospice services.</p> <p>Resident #2's quarterly MDS assessment, dated 2/21/18, and significant change MDS, dated 3/8/18, documented the resident was not cognitively intact and required extensive assistance from two people for bed mobility and transfers.</p> <p>Resident #2's bed was observed against the wall on her left side on 6/25/18 - 6/29/18.</p> <p>Resident #2's clinical record did not contain an assessment for the positioning of her bed against the wall.</p> <p>8. Resident #31 was admitted to the facility on 4/23/18 with multiple diagnoses, including bipolar</p>	F 636			

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F 636	<p>Continued From page 18</p> <p>disorder, post-traumatic stress disorder, left hip prosthesis and morbid obesity.</p> <p>Resident #31's admission MDS assessment, dated 5/4/18, documented she was cognitively intact and required limited assistance from one person for bed mobility and transfers.</p> <p>Resident #31's bed was observed against the wall on the resident's left side from 6/25/18 - 6/29/18.</p> <p>Resident #31's clinical record did not contain an assessment of the need and safety of the bed to be against the wall.</p> <p>On 6/25/18 at 10:43 AM, Resident #31 stated she preferred her bed against the wall.</p> <p>9. Resident #39 was admitted to the facility on 7/17/12 with multiple diagnoses including, Huntington's disease, Alzheimer's disease, depression, dysphagia (difficulty swallowing), contractures of bilateral knees and ankles, and obsessive-compulsive disorder.</p> <p>Resident #39's annual MDS assessment, dated 5/8/18, documented she was not cognitively intact, was totally dependent and required extensive assistance from two people for bed mobility and transfers.</p> <p>Resident #39's bed was observed against the wall on the resident's right side from 6/25/18 - 6/29/18.</p> <p>Resident #39's clinical record did not contain an assessment of the need for, and safety of, the</p>	F 636			

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F 636	<p>Continued From page 19 positioning of her bed against the wall.</p> <p>On 6/27/18 at 12:45 PM, the DNS stated an assessment had not been completed.</p> <p>10. Resident #56 was admitted to the facility on 9/11/12 with multiple diagnoses including, type 2 diabetes mellitus, dementia, epilepsy, dysphagia (difficulty swallowing), and legal blindness.</p> <p>Resident #56's quarterly MDS assessment, dated 6/3/18, documented she was not cognitively intact, totally dependent, and required extensive assistance from two people for bed mobility and transfers.</p> <p>Resident #56's bed was observed against the wall on the resident's left side from 6/25/18 - 6/29/18.</p> <p>Resident #56's clinical record did not contain an assessment for the positioning of her bed against the wall.</p> <p>11. Resident #59 was initially admitted to the facility on 6/4/18 and readmitted on 6/8/18 with multiple diagnoses including, acute constipation, dementia, cerebrovascular accident (stroke), and obesity.</p> <p>Resident #59's admission MDS assessment, dated 6/11/18, documented she was not cognitively intact and required extensive assistance from two people for bed mobility and transfers.</p> <p>Resident #59's bed was observed against the wall on her left side from 6/25/18 - 6/29/18.</p>	F 636			

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F 636	Continued From page 20	F 636			
F 655 SS=D	<p>Resident #59's clinical record did not contain an assessment of the need for, and safety of, her bed positioned against the wall.</p> <p>Baseline Care Plan CFR(s): 483.21(a)(1)-(3)</p> <p>§483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-</p> <ul style="list-style-type: none"> (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- <ul style="list-style-type: none"> (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <ul style="list-style-type: none"> (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). <p>§483.21(a)(3) The facility must provide the</p>	F 655		8/22/18	

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F 655	<p>Continued From page 21</p> <p>resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident.</p> <p>(ii) A summary of the resident's medications and dietary instructions.</p> <p>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.</p> <p>(iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, resident interview, and staff interview, it was determined the facility failed to ensure baseline care plans addressed the placement of residents' beds against walls. This was true for 1 of 2 (#62) residents sampled for review of baseline care plans. This failure created the potential for residents to experience physical injury and psychological decline due to restricted movement. Findings include:</p> <p>1. Resident #62's was admitted to the facility on 6/11/18 with multiple diagnoses, including liver cancer and pain.</p> <p>The admission MDS assessment, dated 6/22/18, documented Resident #62 was cognitively intact and required supervision for bed mobility and transfers.</p> <p>On 6/25/18 at 3:00 PM, Resident #62 stated he liked his bed against the wall to make the bedroom bigger and more functional. Resident #62 stated he was able to get in and out of bed without difficulty.</p>	F 655	<p>The clinical management team reviewed resident #62. The Bed Safety Evaluation was completed and care plan updated.</p> <p>The clinical management team reviewed other residents for completed baseline care plans, which address the placement of residents' beds against the walls. Adjustments have been made as indicated.</p> <p>Nursing Unit Mangers are educated to include the placement of residents' beds against walls in the baseline care plan. Re-education was provided by Director of Nursing and/or Designee to include but not limited to, including placement of residents' beds against walls in the baseline care plan. The system is amended to include review of baseline care plans at clinical meeting.</p> <p>The Director of Nursing and/or designee will audit new admissions for placement of residents' bed against wall inclusion in</p>		

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F 655	Continued From page 22 Resident #62's baseline care plan, dated 6/12/18, did not address the positioning of his bed against the wall. On 6/27/18 at 11:51 AM, the Unit Manager stated Resident #62's baseline care plan should have included bed against the wall for functionality of the room.	F 655	the baseline care plan for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate. Date of compliance will be 8/22/2018.		
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	F 656		8/22/18	

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F 656	<p>Continued From page 23</p> <p>rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, record review, and resident and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans that included the positioning of residents' beds against walls and residents' advanced directive code status, such as DNR or Full Code. This was true for 12 of 16 (#2, #7, #11, #15, #28, #31, #39, #40, #53, #56, #59, and #60) whose care plans were reviewed. The failures created the potential for harm if residents were resuscitated, or not resuscitated, against their wishes and/or experienced physical injury and psychological decline due restricted movement. Findings include:</p> <p>The facility's policy for Advanced Directives/Health Care Decisions, dated 10/1/17, documented the facility would identify, clarify, and review the resident's Advanced Directive information at intervals, "at least quarterly, after a</p>	F 656	<p>The Interdisciplinary team reviewed residents #2, #7, #11, #15, #28, #31, #39, #40, #53, #56, #59, and #60. The comprehensive resident-centered care plans were updated to include the positioning of residents' beds against walls and residents' advanced directive code status, such as DNR or Full Code.</p> <p>The Interdisciplinary team reviewed the comprehensive resident-centered care plans of all other residents for the positioning of residents' beds against walls and residents' advanced directive code status, such as DNR or Full Code. Adjustments have been made as indicated.</p> <p>Licensed nurses and social services staff are educated to develop a comprehensive care plan. Re-education was provided by</p>		

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F 656	<p>Continued From page 24</p> <p>life altering event...and after return from a hospitalization, as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions."</p> <p>1. Resident #53 was admitted to the facility on 5/17/18 with multiple diagnoses, including traumatic brain injury with loss of consciousness and schizophrenia.</p> <p>Resident #53's admission MDS assessment, dated 5/30/18, documented severe cognitive impairment and extensive assistance of one person with bed mobility and transfers.</p> <p>a. Resident #53's physician orders documented "Full Code" was ordered on 5/17/18.</p> <p>Resident #53's care plan did not address her code status.</p> <p>On 6/28/18 at 10:35 AM, the Unit Manager said the code status should be on the care plan for Resident #53 and it was not.</p> <p>b. On 6/25/18 at 2:24 PM, Resident #53's bed was positioned so the left side of the bed was against the wall.</p> <p>Resident #53's care plan did not address her bed being against the wall.</p> <p>On 6/27/18 at 11:30 AM, the MDS Coordinator stated beds against the wall were not restraints and stated it should be included in residents' care plans.</p>	F 656	<p>the Director of Nursing and/or the designee to include but not limited to, including potential restraints and advanced directives on the comprehensive care plan. The system is amended to include review of potential restraints and advanced directives for validation that they are on the comprehensive care plan at the time of MDS update.</p> <p>The Director of Nursing and/or designee will audit the comprehensive care plan of 4 residents for the positioning of residents' beds against walls and residents' advanced directive code status, such as DNR or Full Code weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4weeks, as it deems appropriate.</p> <p>Date of compliance will be 8/22/2018.</p>		

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F 656	<p>Continued From page 25</p> <p>2. Resident #7 was admitted to the facility on 10/4/16 with multiple diagnoses including Alzheimer's disease and generalized anxiety disorder.</p> <p>Resident #7's quarterly MDS assessment, dated 3/16/18, documented short and long term memory problems, moderate impairment in cognitive skills for daily decision making, and total dependence on physical assistance from 2 people for bed mobility and transfers.</p> <p>a. Resident #7's physician order, dated 5/15/17, documented "Do Not Resuscitate."</p> <p>Resident #7's current care plan did not address her code status.</p> <p>On 6/29/18 at 9:45 AM, the DNS said for all residents the Advanced Directive (code status) information should be on the care plan, and the bed against the wall should be on the care plan.</p> <p>b. On 6/25/18 at 1:58 PM, Resident #7's bed was observed positioned with the left side of the bed against the wall.</p> <p>On 6/29/18 at 9:45 AM, the DNS said the positioning of Resident #7 bed against the wall should be included on her care plan.</p> <p>3. Resident #59 was initially admitted to the facility on 6/4/18 and readmitted on 6/8/18 with multiple diagnoses including, acute constipation, dementia, cerebrovascular accident (stroke), and obesity.</p> <p>Resident #59's admission MDS assessment,</p>	F 656			

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F 656	<p>Continued From page 26</p> <p>dated 6/11/18, documented the resident was not cognitively intact, and family or significant other participated in the assessment.</p> <p>a. Resident #59's bed was observed against the wall on her left side from 6/25/18-6/29/18.</p> <p>Resident #59's care plan, dated 6/26/18 did not include a care plan for her bed to be positioned against the wall.</p> <p>On 6/27/18 at 11:30 AM, the MDS Coordinator stated beds against the wall should be included in residents' care plans.</p> <p>b. Resident #59's hospital physician's clinical summary, dated 5/31/18, documented a transfer order and instructions of DNAR code status. A physician note completed by the facility physician, dated 6/5/18, documented Resident #59's code status was Full Code until the family signed the necessary paperwork.</p> <p>Resident #59's care plan, dated 6/26/18, did not include the resident's advance care directive code status.</p> <p>On 6/27/18 at 12:36 and 4:40 PM, the Unit Manager reviewed Resident #59's care plan and was unable to provide documentation of the resident's code status. The Unit Manager stated it was common knowledge that the resident's code status was Full Code unless otherwise specified.</p> <p>4. Resident #11 was admitted to the facility on 1/27/18 with multiple diagnoses, including anxiety, diabetes, generalized muscle weakness,</p>	F 656			

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F 656	<p>Continued From page 27 and unsteadiness on feet.</p> <p>The quarterly MDS assessment, dated 3/21/18, documented Resident #11 was cognitively intact with supervision for bed mobility and transfers.</p> <p>On 6/26/18 at 12:40 PM, Resident #11's bed was observed against the wall with the bed brakes locked. Resident #11 stated she liked her bed against the wall and it was easier to get in and out of bed.</p> <p>Resident #11's care plan, target dated 4/15/18, did not address the bed against the wall.</p> <p>On 6/27/18 at 11:50 AM, the Unit Manager was unable to provide a care plan for Resident #11's bed against the wall.</p> <p>5. Resident #15 was admitted to the facility on 7/1/16 with multiple diagnoses, including cerebrovascular disease and hemiparesis (paralysis on one side of the body) to the left side.</p> <p>The quarterly MDS assessment, dated 4/5/18, documented Resident #15 was cognitively intact and required extensive assistance from one person for bed mobility and transfers.</p> <p>On 6/26/18 at 2:27 PM, Resident #15 was observed with his bed against the wall on the left side. Resident #15 stated he liked his bed against the wall and demonstrated getting in and out of the bed safely.</p> <p>Resident #15's care plan, target dated 5/6/18, did not document the bed against the wall.</p>	F 656			

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F 656	<p>Continued From page 28</p> <p>On 6/27/18 at 11:55 AM, the Unit Manager was unable to provide a care plan for Resident #15's bed to be against the wall.</p> <p>6. Resident #28 was admitted to the facility on 4/27/17 with multiple diagnoses, including cerebral palsy and muscle weakness.</p> <p>The annual MDS assessment, dated 4/26/18, documented Resident #28 was cognitively intact and required extensive assistance from two people for transfers and bed mobility.</p> <p>On 6/26/18 at 9:17 AM, Resident #28 was observed in bed lying on her right side with the bed against the wall.</p> <p>On 6/27/18 at 10:46 AM, Resident #28 was observed in bed lying on her right side with the bed against the wall. CNA #1 was observed unlocking the brakes to the bed frame to move the bed away from the wall to provide cares to Resident #28. CNA #1 stated Resident #28 wanted her bed against the wall.</p> <p>On 6/27/18 at 10:50 PM, Resident #28 stated she liked her bed against the wall to make the room more functional.</p> <p>Resident #28's care plan, target dated 8/6/18, did not address the bed against the wall.</p> <p>On 6/27/18 at 11:45 AM, the Unit Manager was unable to provide a care plan for Resident #28's bed to be against the wall.</p> <p>7. Resident #40 was admitted to the facility on</p>	F 656			

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F 656	<p>Continued From page 29</p> <p>2/5/18 with multiple diagnoses, including COPD, anxiety, and muscle weakness.</p> <p>The quarterly MDS assessment, dated 5/15/18, documented Resident #40 was cognitively intact and independent with bed mobility.</p> <p>On 6/26/18 at 3:17 PM, Resident #40 was observed sitting on the edge of her bed with the bed against the wall. Resident #40 stated she liked her bed against the wall for the functionality of her room.</p> <p>Resident #40's care plan, target dated 12/19/18, did not address the bed against the wall.</p> <p>On 6/27/18 at 11:52 AM, the Unit Manager was unable to provide a care plan for Resident #40's bed to be against the wall.</p> <p>8. Resident #2 was admitted to the facility on 8/5/16 with multiple diagnoses, including Alzheimer's disease, dementia, dysphagia (difficulty swallowing), and as of 1/8/18 she began receiving hospice services.</p> <p>Resident #2's quarterly MDS assessment, dated 2/21/18, and significant change MDS assessment, dated 3/8/18, documented she was not cognitively intact and required extensive assistance from two people for bed mobility and transfers.</p> <p>Resident #2's bed was observed against the wall on her left side on 6/25/18 - 6/29/18.</p> <p>Resident #2's current care plan did not address the positioning of her bed against the wall.</p>	F 656			

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F 656	<p>Continued From page 30</p> <p>On 6/27/18 at 11:30 AM, the MDS Coordinator stated beds against the wall should be included in residents' care plans.</p> <p>9. Resident #31 was admitted to the facility on 4/23/18 with multiple diagnoses, including bipolar disorder, post-traumatic stress disorder, left hip prosthesis and morbid obesity.</p> <p>Resident #31's admission MDS assessment, dated 5/4/18, documented she was cognitively intact and required limited assistance from one person for bed mobility and transfers.</p> <p>Resident #31's bed was observed against the wall on the resident's left side from 6/25/18 - 6/29/18.</p> <p>Resident #31's care plan did not address the positioning of her bed against the wall.</p> <p>On 6/25/18 at 10:43 AM, Resident #31 stated she preferred her bed against the wall.</p> <p>On 6/27/18 at 11:30 AM, the MDS Coordinator stated beds against the wall were not restraints and stated it should be included in residents' care plans.</p> <p>10. Resident #39 was admitted to the facility on 7/17/12 with multiple diagnoses including, Huntington's disease, Alzheimer's disease, depression, dysphagia (difficulty swallowing), contractures of bilateral knees and ankles, and obsessive-compulsive disorder.</p> <p>Resident #39's annual MDS assessment, dated</p>	F 656			

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F 656	<p>Continued From page 31</p> <p>5/8/18, documented she was not cognitively intact, was totally dependent and required extensive assistance from two people for bed mobility and transfers.</p> <p>Resident #39's bed was observed against the wall on the resident's right side from 6/25/18 - 6/29/18.</p> <p>Resident #39's care plan did not address the positioning of her bed against the wall.</p> <p>On 6/27/18 at 12:45 PM, the DNS provided Resident #39's care plan. The care plan did not address the positioning of her bed against the wall. The DNS stated the resident was unable to verbalize whether she wanted the bed against the wall. The DNS said since Resident #39 was unable to get out of bed without assistance, the facility did not consider it a restraint. The DNS stated a care plan had not been completed.</p> <p>11. Resident #56 was admitted to the facility on 9/11/12 with multiple diagnoses including, type 2 diabetes mellitus, dementia, epilepsy, dysphagia (difficulty swallowing), and legal blindness.</p> <p>Resident #56's quarterly MDS assessment, dated 6/3/18, documented she was not cognitively intact, totally dependent, and required extensive assistance from two people for bed mobility and transfers.</p> <p>Resident #56's bed was observed against the wall on the resident's left side from 6/25/18-6/29/18.</p> <p>Resident #56's current care plan did not address</p>	F 656			

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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	
F 656	Continued From page 32 the positioning of her bed against the wall. On 6/27/18 at 12:45 PM, the DNS stated on admission, usually beds are set up in the room based on the preference of the resident. The DNS stated that if the physician ordered a restraint a care plan would be initiated. 12. Resident #60 was admitted to the facility on 3/27/17 with multiple diagnoses, including Alzheimer's disease and dysphagia (a swallowing disorder). Resident #60's quarterly MDS assessment, dated 6/11/18, documented severe cognitive impairment and extensive assistance of 2 persons for bed mobility and transfers. Resident #60's physician orders documented "Do Not Resuscitate" was ordered on 4/27/17. Resident #60's current care plan did not address her code status. On 6/28/18 at 2:23 PM, the Unit Manager said Resident #60's code status was not on the care plan.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		8/22/18	

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F 657	<p>Continued From page 33</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, facility policy review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised and updated to maintain consistency and accuracy. This was true for 1 of 16 sampled residents (#52) whose care plans were reviewed, when the resident's wound status was not accurately reflected on the care plan. This had the potential for harm if cares and/or services were not provided due to incorrect information on the care plan. Findings include:</p> <p>Resident #52 was readmitted to the facility on 2/5/18 with multiple diagnoses, including muscle weakness and dementia.</p> <p>Resident #52's quarterly MDS assessment, dated</p>	F 657	<p>The clinical management team reviewed resident #52. The care plan was reviewed and updated to accurately reflect the resident's wound status.</p> <p>The clinical management team reviewed other residents to validate accurate wound status was reflected on the care plan. Adjustments have been made as indicated.</p> <p>Nurses are educated to review and revise the care plans with change of condition. Re-education was provided by Director of Nursing and/or the designee to include but not limited to, accurately reporting wound status with changes on the</p>		

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F 657	<p>Continued From page 34 5/18/18, documented the following:</p> <ul style="list-style-type: none"> * Severe cognitive impairment. * One unstageable pressure ulcer with suspected deep tissue injury. * Skin and ulcer treatments, including a pressure reducing device for the chair and bed, nutrition or hydration intervention, pressure ulcer care, application of non-surgical dressings. <p>Resident #52's current care plan documented the following:</p> <ul style="list-style-type: none"> * Initiated and last revised on 3/28/18: A wound on the left gluteal fold, and directed staff to float heels at all times, check that the head of the bed was not higher than 30 degrees, administer wound care as ordered by the physician, and turn side to side every two hours when in bed. * Initiated on 5/16/18 and last revised on 6/27/18: An area on the RLE being treated with a dressing, and directed staff to administer antibiotic per physician's order and dressing change per physician's order. <p>Resident #52's Weekly Skin Checks, dated 4/3/18 and 4/10/18, documented there were no skin conditions, changes, ulcers, or injuries. On 4/24/18 it was documented there was a dressing to a bruise on Resident #52's right calf. On 5/15/18 it was documented there was a sloughing bruise and Resident #52 was on an antibiotic. On 6/8/18 it was documented there were open wounds on Resident #52's right lower leg (rear), right ankle (outer) and left ankle (outer). The right and left ankle wounds were not addressed in Resident #52's care plan</p>	F 657	<p>resident's care plan. The system is amended to include review of the resident's care plan during clinical meeting for accurate wound status.</p> <p>The Director of Nursing and/or designee will audit the care plan of 4 residents for accurate wound status weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>Date of compliance will be 8/22/2018.</p>		

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F 657	Continued From page 35 On 6/26/18 at 9:47 AM, Resident #52's skin on his gluteal fold, buttocks, and scrotum was observed to be free of wounds. LPN #1 performed wound care to Resident #52's right ankle, left ankle, and right lateral leg. The wound on the right lateral leg appeared mildly reddened around the edges. The wound on the right ankle and left ankle appeared as ulcerations on the bony prominences of the outer ankles. On 6/27/18 at 9:35 AM, LPN #1 said Resident #52 had no wound on his bottom at that time. On 6/27/18 at 10:30 AM, the DNS said the care plan was done by the Nurse Manager and sometimes by the MDS nurse. The DNS said Resident #52's care plan could be more accurate and could be updated to reflect the areas involved with wounds.	F 657			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 4 of 16 residents (#2, #5, #11 and	F 684	The clinical management team reviewed residents #2, #5, #11 and #40. Resident #2, the oxygen saturation levels are consistently assessed. Resident #5,	8/22/18	

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F 684	<p>Continued From page 36</p> <p>#40) reviewed for standards of practice, as follows:</p> <p>a) Resident #5's lab values related to use anticoagulant medication were high and the physician was not notified. This deficient practice placed Resident #5 at increased risk of bleeding.</p> <p>b) Resident #2's and Resident #40's oxygen saturation levels were not consistently assessed, placing them at risk of undetected breathing difficulties.</p> <p>c) Resident #11 did not receive neurological assessments following an unwitnessed fall, placing her at risk of undetected neurological decline. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 7/20/17 with multiple diagnoses, including atrial fibrillation (irregular heartbeat).</p> <p>The quarterly MDS assessment, dated 6/11/18, documented Resident #5 was severely cognitively impaired, required extensive assistance with transfers and bed mobility, and received anticoagulants 7 days a week.</p> <p>A website www.heart.org/HEARTORG/Conditions/Arrhythmia/Prevention, dated September 2016, documented, "PT (Prothrombin Time) is a measure of how quickly your blood clots. An INR (international normalized ratio) is the unit of measure that's used to determine how quickly your blood is clotting. The therapeutic range for people receiving Warfarin/Coumadin for Atrial Fibrillation is 2.0 to 3.0 range. It is important to</p>	F 684	<p>Physician was notified of high lab values related to anticoagulant medication. Resident #11, neurological assessment was performed for latent impact. Resident #40, the oxygen saturation levels are consistently assessed.</p> <p>The clinical management team reviewed other residents for professional standards of practice with management of oxygen, physician notified of abnormal lab values, and complete neurological assessments performed after an unwitnessed fall. Adjustments have been made as indicated.</p> <p>Nurses are educated to professional standards of practice. Re-education was provided by Director of Nursing and/or the designee to include but not limited to, oxygen saturation levels with oxygen liter flow are consistently assessed and documented, physician notification for abnormal lab values to include anticoagulant therapy, and complete neurological assessments performed after an unwitnessed fall. The system is amended to include review of these items during clinical meeting.</p> <p>The Director of Nursing and/or designee will audit for compliance to professional standard of practice of 4 residents weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI</p>		

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F 684	<p>Continued From page 37</p> <p>monitor the INR (at least once a month and sometimes as often as twice weekly) to make sure that the level of Warfarin remains in the effective range. If the INR is too low, blood clots will not be prevented, but if the INR is too high, there is an increased risk of bleeding. This is why those who take Warfarin must have their blood tested so frequently."</p> <p>A June 2018 MAR documented Resident #5 received Coumadin 5 mg daily on Sundays, Tuesdays, Thursdays, and Saturdays for anticoagulant defect; Coumadin 7.5 mg daily on Mondays, Wednesdays, and Fridays for anticoagulant defect.</p> <p>A Physician's Order, dated 6/5/18 at 2:44 PM, documented PT/INR labs were to be completed in two weeks, on 6/19/18.</p> <p>A nurse's progress note, dated 6/5/18 at 2:43 PM, documented, "[Physician's name] ordered Coumadin 7.5 mg on Mon-Wed-Fri and 5 mg the other four days a week. Will do PT/INR on 6/19."</p> <p>On 6/28/18 at 5:45 PM, the DNS provided the PT/INR results, dated 6/20/18. Resident #5 had blood drawn on 6/19/18 at 4:51 PM and the laboratory reported the lab results on 6/20/18 at 10:20 AM. The PT results were 47.60, flagged as "high". The normal range for PT was 9.40-12.50. The INR results were 4.37, flagged "high". The normal range was 2.0-3.0. The DNS stated the laboratory was interfaced with their electronic system and also faxed a copy of the lab results to the facility. The DNS stated the laboratory would only call the facility if the lab results were critical values. The DNS stated the physician was not</p>	F 684	<p>committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>Date of compliance will be 8/22/2018</p>		

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F 684	<p>Continued From page 38 notified of the results on 6/20/18.</p> <p>On 6/28/18 at 6:06 PM, the Unit Manager received new orders to hold Coumadin today and repeat PT/INR "stat" and notify the physician with the results as soon as possible.</p> <p>On 6/29/18 at 10:04 AM, the DNS provided Resident #5's PT/INR results, dated 6/28/18 at 9:15 PM. The PT results were 38.2, flagged "high" and the INR results were 4.1 flagged "high". Resident #5 had no signs or symptoms of bleeding.</p> <p>A Physician's Order, dated 6/29/18, documented to hold Resident #5's Coumadin on 6/29/18 and 6/30/18. On 7/1/18 Resident #52 was to start Coumadin 5 mg daily on Sundays, Tuesdays, Thursdays, Saturdays and Coumadin 7.5 mg daily on Mondays, Wednesdays, and Fridays. The next PT/INR lab was due 7/3/18.</p> <p>On 6/29/18 at 10:05 AM, the DNS stated the above situation should not have happened.</p> <p>2. Resident #40 was admitted to the facility on 2/5/18 with multiple diagnoses, including COPD, anxiety, and muscle weakness.</p> <p>A care plan, revision date 5/30/18, documented, Resident #40 had COPD. The care plan interventions were documented as follows:</p> <p>* "Give oxygen therapy as ordered by the physician. [Resident #40] is on 2 L via nasal cannula."</p> <p>Resident #40's physician order, dated 2/28/18,</p>	F 684			

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F 684	<p>Continued From page 39</p> <p>documented she was to receive oxygen at 2 liters per minute via nasal cannula and staff were to attempt to wean her off the oxygen while maintaining her oxygen blood saturation levels at greater than 90% throughout day. Oxygen was to continue throughout the "night every shift."</p> <p>The June 2018 MAR did not include documentation Resident #40's oxygen saturations were assessed on 11 of 78 opportunities.</p> <p>On 6/27/18 at 3:50 PM, the DNS stated her expectations were the nurses document every shift and there should not be blanks on the MAR.</p> <p>3. Resident #11 was admitted to the facility on 1/27/18 with multiple diagnoses, including anxiety, diabetes, generalized muscle weakness, and unsteadiness on feet.</p> <p>The quarterly MDS assessment, dated 3/21/18, documented Resident #11 was cognitively intact with supervision needed for bed mobility and transfers.</p> <p>The facility's Fall Response and Management policy, dated 11/28/17, documented, "If the fall is un-witnessed, take the following actions:</p> <ul style="list-style-type: none"> * Confirm the patient's identity. * Evaluate for injury. * Monitor neurological assessments per physician's orders or monitor every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every hour for 2 hours or until condition 	F 684			

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F 684	<p>Continued From page 40 stabilizes, if patient has hit his or her head.</p> <p>* Follow-Up and Monitoring - Evaluate patient condition for at least 72 hours post fall."</p> <p>Resident #11's Incident and Accident Report documented the following:</p> <p>* 6/17/18 at 11:15 AM: Resident #11 experienced an unwitnessed fall from bed. Resident #11 had no injuries from fall. The investigation documented a nurse administered an IM injection prior to the fall, and resisted assistance with adjusting her clothing following the injection. Resident #11 was found kneeling on the floor within 5 minutes after the nurse left her room.</p> <p>Neurological assessments following Resident #11's unwitnessed fall were not found in her clinical record.</p> <p>A nurse's progress note, dated 6/17/18 at 1:15 PM, stated, "Resident had slid from her belly off the bed in a kneeling position beside her bed with forehead resting on bed. No injuries noted."</p> <p>On 6/29/18 at 9:59 AM, the DNS stated neurological assessments should have been completed every shift for 3 days following Resident #11's 6/17/18 unwitnessed fall.</p> <p>4. Resident #2 was admitted to the facility on 8/5/16 with multiple diagnoses, including Alzheimer's disease, dementia, dysphagia (difficulty swallowing), and as of 1/8/18 began receiving hospice services.</p> <p>Resident #2's quarterly MDS assessment, dated</p>	F 684			

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F 684	<p>Continued From page 41 2/21/18, and significant change MDS assessment, dated 3/8/18, documented she was not cognitively intact and required oxygen therapy.</p> <p>Resident #2's physician order, dated 8/2/16, documented staff were to implement an oxygen protocol to maintain her oxygen saturation levels at or above 90%. Resident #2's physician order dated 8/4/18, documented staff were to continue the oxygen protocol.</p> <p>Resident #2's care plan, dated 1/2/18, documented staff were to check her oxygen saturation levels as ordered by the physician and notify the physician of any abnormal levels.</p> <p>From 6/25/18 - 6/29/18, Resident #2 was observed receiving 2 liters of oxygen via nasal cannula.</p> <p>Resident #2's MAR, dated June 2018, documented she was to receive oxygen at 2-3 liters per minute via nasal cannula to maintain comfort. An order with a start date of 2/23/18, stated staff were to check Resident #2's oxygen saturation level every shift.</p> <p>Resident #2's MAR for 6/1/18 - 6/30/18, did not include documentation of the specific liters per minute of oxygen she was receiving. Additionally, Resident #2's oxygen saturation levels were not documented as assessed on the following shifts:</p> <p>6/1/18 - Evening and night shifts 6/2/18 - Evening and night shifts 6/4/18 - Night shift 6/7/18 - Night shift</p>	F 684			

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F 684	Continued From page 42 6/8/18 - Day and night shifts 6/11/18 - Night shift 6/15/18 - Evening and night shifts 6/16/18 - Evening shift 6/22/18 - Night shift 6/23/18 - Evening shift	F 684			
F 686 SS=G	On 6/27/18 at 3:50 PM, the DNS stated her expectations were the nurses document every shift and there should not be blanks on the MAR. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and review of facility policies, it was determined the facility failed to prevent the development and worsening of pressure ulcers. This was true for 3 of 4 residents (#10, #52, and #162) reviewed for pressure ulcers. This deficient practice caused harm to Resident #10, #52, and #162 when:	F 686	Resident #10 and #162 are no longer at the facility. The clinical management team reviewed resident #52, the pressure ulcer was reviewed with the wound Nurse Practitioner. An assessment was done and proper treatments and interventions were put into place to prevent the worsening of the pressure ulcer.	8/22/18	

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F 686	<p>Continued From page 43</p> <ul style="list-style-type: none"> * Resident #10 developed an unstageable pressure ulcer on his coccyx. * Resident #52 developed a bruise on his right lower leg that deteriorated and became an unstageable pressure ulcer, and he developed unstageable pressure ulcers on the left ankle and right ankle. * Resident #162 developed an unstageable pressure ulcer on her right heel. Findings include: <p>The facility's policy and procedure for Prevention and Treatment of Pressure Ulcers and Other Skin Alterations, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> * A risk assessment would be performed on admission and at designated times throughout the resident's stay. * The Braden Scale would be used to identify residents at risk for pressure ulcers. * "Based upon the assessment and the resident's clinical condition, choices, and identified needs, basic or routine care could include, but is not limited to, interventions to: <ul style="list-style-type: none"> - Redistribute pressure (such as repositioning, protecting, and/or offloading heels, etc.) - Minimize exposure to moisture and keep skin clean, especially of fecal contamination. - Provide appropriate, pressure-redistributing, support surfaces. - Provide non-irritating surfaces. - Maintain or improve nutrition and hydration status, where feasible..." * Treatment of new or already-present pressure 	F 686	<p>The clinical management team reviewed other residents for risk of development of worsening of pressure ulcers. Adjustments have been made as indicated. External wound care company has been contracted with to provide clinical expertise.</p> <p>Nursing staff are educated on prevention and management of pressure ulcers. Re-education was provided by Director of Nursing and/or designee to include but not limited to, accurate assessment of skin alterations, ability to stage a wound, treatment implementation, physician/practitioner updates with deterioration or lack of healing, timely implementation of preventative devices, management of non-compliance, and documentation of care provided. The system is amended to include review of residents with changes of condition in clinical meeting to implement preventative measure. In addition, the external wound company will conference with nursing leadership weekly on changes to current wounds.</p> <p>The Director of Nursing and/or designee will audit 2 residents for risk of pressure ulcers and residents with alteration in skin integrity weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks,</p>		

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F 686	<p>Continued From page 44 and non-pressure wounds would be "initiated following the principles of wound healing."</p> <p>1. Resident #10 was admitted to the facility on 1/30/17 with multiple diagnoses, including unspecified dementia with behavioral disturbance, contracture of muscle, multiple sites, and edema (swelling). Resident #10 was transferred to another facility on 5/8/18.</p> <p>Resident #10's annual MDS assessment, dated 2/7/18, documented the following:</p> <ul style="list-style-type: none"> * Severe cognitive impairment * Not at risk for pressure ulcers. * No unhealed pressure ulcers. * Moisture associated skin damage. * Pressure reducing device for chair. * Pressure reducing device for bed. <p>Resident #10's quarterly MDS assessment, dated 3/16/18, documented the following:</p> <ul style="list-style-type: none"> * Short term and long term memory problems. * Severe cognitive impairment in daily decision making. * At risk for pressure ulcers. * No unhealed pressure ulcers. * A skin tear was present. * Moisture associated skin damage. * Pressure reducing device for chair. * Pressure reducing device for bed. * Application of nonsurgical dressings. <p>Resident #10's care plan documented: Potential impairment to skin integrity related to incontinence was initiated on 2/10/17. A pressure relieving/reducing chair cushion, pressure</p>	F 686	<p>as it deems appropriate.</p> <p>Date of compliance will be 8/22/2018.</p>		

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F 686	<p>Continued From page 45 relieving/reducing mattress, and weekly skin assessments by the licensed nurse were initiated on 2/10/17 and revised on 9/21/17.</p> <p>A Progress Note, dated 3/6/18 at 5:39 AM, documented blisters developed above Resident #10's coccyx that were fluid-filled and intact.</p> <p>A Weekly Skin Check, dated 3/12/18 at 1:02 AM, documented Resident #10 had no skin conditions or changes, ulcers, or injuries, and "Skin is intact. Has slightly abraded area on buttock responding rapidly to treatment."</p> <p>A Progress Note, dated 3/16/18 at 8:23 PM, documented Resident #10 had a weight loss of 15.8 pounds over the past 30 days. Resident #10 was recently fitted for a new wheelchair. There was a skin tear on the coccyx and treatment was in place.</p> <p>A Progress Note, dated 3/17/18 at 11:35 PM, documented there was a large wound on Resident #10's coccyx that was draining and had white eschar (dead tissue) at the base. The wound was covered with a dressing and was unstageable. The assessing nurse would call the morning nurse the next day and measurements would be done in the morning.</p> <p>A Weekly Pressure Ulcer/BWAT Report, dated 3/18/18 at 1:46 PM, documented a new onset pressure ulcer on Resident #10's coccyx measuring 7.0 cm (length) by 4.0 cm (width) by 0.2 cm (depth) and was unstageable. The date of initial observation was 3/18/18. The wound was treated with Silvasorb and a sacral dressing.</p>	F 686			

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F 686	<p>Continued From page 46</p> <p>A Progress Note, dated 3/18/18 at 1:57 PM, documented Resident #10 developed an open wound on the coccyx measuring 7 cm by 4 cm by 0.2 cm. The wound was cleansed and a temporary dressing was applied. Staff were to turn Resident #10 side to side, and he was to be the last person to get up and first person to bed at mealtimes.</p> <p>A Progress Note, dated 3/19/18 at 10:36 AM, documented a pressure ulcer on Resident #10's coccyx that measured 1 by 1 on 3/15/18, then 7 cm by 4 cm by 0.2 cm on 3/18/18. The wound care nurse was to assess the wound on that day and discuss it with the physician. Occupational therapy (OT) had recently changed the wheelchair to a cube chair, and it was to be evaluated to determine whether the wheelchair caused pressure to the coccyx. Staff members were educated to turn the resident side to side and not onto his back.</p> <p>A Progress Note, dated 3/19/18 at 11:00 AM, documented Resident #10's wound was evaluated by the Assistant Director of Nursing (ADON) and the floor nurse. The wound was between Stage 2 and Stage 3. Treatment orders were requested from the physician for Silver Triact (brand name "Restore," a type of wound dressing) to the base of the wound covered by Optifoam basic and a Mepilex dressing. OT was consulted regarding placing a Roho (pressure relief) cushion in the resident's chair.</p> <p>A Weekly Skin Check, dated 3/19/18 at 12:40 PM, documented a linear or elongated pressure ulcer on Resident #10's coccyx (tailbone area) and new suspected ulcer/deep tissue injury.</p>	F 686			

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F 686	<p>Continued From page 47</p> <p>Wound care orders were as follows: Cleanse the wound with wound cleaner, apply silver with a soft pad and a sacral dressing.</p> <p>A Progress Note, dated 3/19/18 at 2:46 PM, documented Resident #10's weight loss was discussed with a family member. The facility was going to obtain an air bed, turn him side to side, try to encourage nutritional intake, and limit time out of bed.</p> <p>Resident #10's physician orders documented wound care to the sacral wound started on 3/20/18 as follows: clean with wound cleanser and 4 by 4 dressing, apply Triact Silver to the wound bed, Optifoam Basic and cover with a Mepilex dressing every other day.</p> <p>Resident #10's Weekly Pressure Ulcer/BWAT Reports documented the following:</p> <p>* On 3/25/18 at 1:46 AM: The pressure ulcer on the coccyx measured 6 cm by 6.5 cm by 0.1 cm and was Stage 2. There was significant improvement, there was no sign of infection, and the wound width increased due to "irregular shape and spreading his buttocks for treatment."</p> <p>* On 4/1/18 at 1:46 AM: The pressure ulcer on the coccyx measured 6 cm by 4.5 cm by 0.1 cm and was Stage 2. The area was significantly improved. There was no sign of infection. The wound center remained red and surrounding tissue was a pink scar.</p> <p>* On 4/8/18 at 1:46 AM: The pressure ulcer on the coccyx measured 3.5 cm by 4 cm by 0.1 cm and was Stage 2. Treatment was to continue a few more days. The wound was "essentially healed, skin is intact, pink scar is very fragile and</p>	F 686			

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F 686	<p>Continued From page 48</p> <p>fresh."</p> <p>* On 4/14/18 at 1:46 AM: The pressure ulcer on the coccyx measured 1.5 cm by 1 cm by 0.1 cm and was Stage 2. The wound was almost healed and had a small open area in the center of fresh pink scar tissue. The surrounding skin was very fragile. The resident was incontinent, on an air bed, had contractures, and required routine turning as he could not reposition himself.</p> <p>* On 4/21/18 at 10:10 AM: The pressure ulcer on the coccyx measured 1.4 cm by 1 cm by 0 cm and was Stage 2. The area was almost healed and had a fresh pink scar. The skin remained fragile. The resident was incontinent of bowel and bladder. Staff continued the air bed and every two hour turning, and contractures limited his mobility.</p> <p>* On 4/28/18 at 9:56 AM: The pressure ulcer on the coccyx measured 1.0 cm by 1 cm by 0 cm and was Stage 2. The area was almost healed. The resident continued to have fragile skin, incontinence, and contractures. Staff continued every two hour turning.</p> <p>On 6/29/18 at 9:23 AM, the Unit Manager said Resident #10 had a skin tear on his coccyx on 3/15/18 and she did not recall how it happened. The Unit Manager said the wound was 1 cm x 1 cm x 0.1 cm, and it progressed and was determined to be a pressure sore on on 3/18/18. The Unit Manager said the wound had improved on 3/22/18, and slough (layer of dead tissue separated from surrounding living tissue) made it impossible to measure the depth. The Unit Manager said the pressure ulcer showed significant improvement with visible depth on 3/25/18.</p>	F 686			

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F 686	<p>Continued From page 49</p> <p>On 6/29/18 at 9:35 AM, the Unit Manager said Resident #10 was on an air mattress, although she did not know when it was applied.</p> <p>2. Resident #52 was readmitted to the facility on 2/5/18 with multiple diagnoses, including heart failure, acute and chronic respiratory failure, muscle weakness, and dementia.</p> <p>Resident #52's Braden Scale for Predicting Pressure Sore Risk, dated 2/5/18, 2/12/18, 2/19/18, 2/26/18, and 3/5/18, documented he was at risk for pressure sores.</p> <p>Resident #52's quarterly MDS assessment, dated 2/18/18, documented the following:</p> <ul style="list-style-type: none"> * Moderate cognitive impairment. * Total dependence on the physical assistance of two people for bed mobility and transfers. * At risk for pressure ulcers. * No unhealed pressure ulcers. * Skin and ulcer treatments, including a pressure reducing device for the chair and bed. <p>Resident #52's quarterly MDS assessment, dated 5/18/18, documented the following:</p> <ul style="list-style-type: none"> * Severe cognitive impairment. * Total dependence on two person physical assistance with bed mobility and transfers. * At risk for pressure ulcers. * One unstageable pressure ulcer with suspected deep tissue injury. * Skin and ulcer treatments, including a pressure reducing device for the chair and bed, nutrition or hydration intervention, pressure ulcer care, application of non-surgical dressings. 	F 686			

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F 686	<p>Continued From page 50</p> <p>Resident #52's physician orders directed staff to float the heels at all times starting on 2/27/18.</p> <p>Resident #52's current care plan documented the following:</p> <ul style="list-style-type: none"> * Initiated and last revised on 3/28/18: A wound on the left gluteal fold. The care plan directed staff to float heels at all times, check that the head of the bed was not higher than 30 degrees, administer wound care as ordered by the physician, and turn side to side every two hours when in bed. *Initiated and last revised on 3/28/18: Impaired circulation and edema (swelling) related to congestive heart failure, and directed staff to elevate legs when resting, ensure proper-fitting footwear, inspect feet frequently for areas of injury, and inspect foot/ankle/calf frequently for changes. <p>Resident #52's Weekly Skin Checks, dated 4/3/18 and 4/10/18, documented there were no skin conditions, changes, ulcers, or injuries.</p> <p>A Progress Note, dated 4/19/18 at 12:35 PM, documented the physician examined an "unusual spot" on Resident #52's right calf and determined it was a bruise. Staff were directed to apply Betadine (an antiseptic) and cover it with a foam dressing daily until resolved.</p> <p>A physician's note, dated 4/19/18, documented the physician saw Resident #52 at the request of nursing staff. A dark purple spot was noted on the left lateral leg two days prior. An "oval area of</p>	F 686			

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F 686	<p>Continued From page 51</p> <p>purple discoloration with some mild erythema (redness) right around the edge." The area measured approximately 2.5 cm by 1.5 cm, and the central area was "going to slough." The area was diagnosed as a superficial bruise on the right lateral leg. The physician ordered swabbing the wound with Betadine and applying a foam dressing. The physician said the resident "has advanced age, poor circulation, nutrition and is a risk for a wound..."</p> <p>A physician's order, started on 4/19/18, documented staff were to clean the bruise on Resident #52's right calf with Betadine and cover with a foam dressing once a day until resolved, and notify physician if worse or not improving.</p> <p>A Weekly Skin Check, dated 4/24/18 at 2:49 AM, documented there was a dressing to the bruise on Resident #52's right calf.</p> <p>A Progress Note, dated 5/8/18 at 9:42 PM documented the physician examined Resident #52 on that day, wanted to continue treatment to a "sloughing bruise" on the leg, and the resident was to wear Prevalon boots when in bed.</p> <p>A physician's note, dated 5/8/18, documented the physician examined Resident #52 and documented the area on the right lateral leg was a superficial bruise with thickening and slough. There were no signs of infection. The wound was slow to heal. There were no signs of infection, and the resident was to wear Prevalon boots.</p> <p>A Progress Note, dated 5/15/18 at 7:25 PM documented an antibiotic was ordered four times a day for 7 days for Resident #52's wound with</p>	F 686			

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F 686	<p>Continued From page 52 dressing changes.</p> <p>A Progress Note, dated 5/15/18 at 10:37 PM documented the physician examined Resident #52, new wound care orders were received for the RLE, Prevalon boots were to be on at all times, and Keflex (antibiotic) four times a day for 7 days for "mild RLE infection."</p> <p>Resident #52's physician's order, starting on 5/15/18, documented he was to wear Prevalon boots on at all times, and RLE wound: dry completely, apply Bacitracin (antibiotic) ointment and cover with an island dressing. Change every other day, and Cephalexin capsule (antibiotic) 500 mg four times a day for RLE wound infection.</p> <p>A Weekly Skin Check, dated 5/15/18 at 2:49 AM, documented there was a sloughing bruise and Resident #52 was on an antibiotic.</p> <p>A physician note, dated 5/15/18, documented the physician examined Resident #52 and said the bruise had some thickening of the eschar (dark, crusty dead tissue). The wound was not getting worse but was not improving. Staff had been applying Betadine and an island dressing. There was also an abrasion to the ankle area at that time. The resident had multiple illnesses and was "declining fairly rapidly since he came here." There was some tenderness to the wound on the right lateral leg and some swelling behind it. The assessment included a bruise to the right lateral lower extremity that was slow to resolve and had possible "very early onset wound infection," and there was an abrasion to the right ankle area. The wounds were to be cleaned, dried thoroughly, Bacitracin ointment applied, and</p>	F 686			

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F 686	<p>Continued From page 53</p> <p>covered with an island dressing every other day. Betadine was discontinued. Prevalon boots were to be on at all times, and Cephalexin was started four times a day for 7 days. Resident #52 was at high risk for skin breakdown related to his poor nutritional status, weight loss, and protein calorie malnutrition, and was at risk for poor wound healing due to his overall condition.</p> <p>A physician's note, dated 5/17/18, documented Resident #52's condition was poor and he continued to decline.</p> <p>A Progress Note, dated 5/18/18 at 2:36 PM, documented Keflex was continued for Resident #52's RLE wound.</p> <p>Resident #52's Progress Note, dated 5/19/18 at 9:21 AM documented "RLE wound: dry thoroughly, apply [B]acitracin ointment and cover with island dressing/change every other day..."</p> <p>A Progress Note, dated 5/20/18 at 10:06 PM, documented Keflex was continued for Resident #52's RLE wound.</p> <p>A Progress Note, dated 5/21/18 at 5:41 PM, documented Resident #52's wound started as a small bruise, and it had increased in size and severity. The ADON assessed the wound and it measured 1.5 cm by 0.5 cm by 0.1 cm. The wound was oblong-shaped and had a yellow wound bed. The skin at the outer perimeter of the wound was very red and the resident complained of soreness at the outer edges of the wound. There was minimal drainage which was serosanguinous (bloody) in color. A new dressing was placed, and the nurse would notify the</p>	F 686			

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F 686	<p>Continued From page 54 physician at the next visit.</p> <p>A Progress Note, dated 5/22/18 at 3:43 PM, documented the physician examined Resident #52. The wound ointment was changed to Santyl and the dressing was to be changed daily.</p> <p>A physician note, dated 5/22/18, documented Resident #52's right lower leg had a linear wound measuring 1 cm wide by 2.5 cm long. The base had 100% yellow slough. The assessment was an ulceration of the right lateral lower extremity and the antibiotic ointment was discontinued. Santyl was ordered to the wound base and cover with an island dressing daily.</p> <p>A Progress Note, dated 5/23/18 at 10:00 PM, documented Resident #52 had completed the course of antibiotics, and the "Wound changes between a white mealy wound bed and a dark brown pliable crust. There is no drainage. Now being treated with daily Santyl."</p> <p>A wound healing note, dated 5/25/18 documented pressure ulcers on Resident #52's right lateral calf, right ankle, right second toe, and left ankle. It was ordered to encourage repositioning every 2 to 3 hours, encourage offloading of heels and bony prominences, provide a supportive cushion in the wheelchair, and reposition the resident every 2 to 3 hours when up in wheelchair.</p> <p>A Progress Note, dated 5/31/18 at 4:30 AM, documented a new dressing was applied to Resident #52's wounds on the lower right leg.</p> <p>A Weekly Skin Check, dated 6/8/18 at 2:44 AM</p>	F 686			

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F 686	<p>Continued From page 55</p> <p>documented there were open wounds on Resident #52's right lower leg (rear), right ankle (outer) and left ankle (outer).</p> <p>A Progress Note, dated 6/8/18 at 12:28 PM, documented the Interdisciplinary Team met and discussed Resident #52's weight loss and wound status. A low air loss mattress was started on the previous day at the recommendation of the wound nurse practitioner for wounds to legs.</p> <p>A Progress Note, dated 6/10/18 at 2:28 PM, documented Resident #52's Pressure Ulcer BWAT report was completed. The right lower leg (rear) pressure wound measured 4.0 cm (length) by 2.1 cm (width), undetermined depth and unstageable. The wound was initially observed on 5/23/18. The right ankle (outer) pressure wound measured 1.8 cm by 1.0 cm and depth was undetermined and unstageable. The wound was initially observed on 5/23/18.</p> <p>A Progress Note, dated 6/10/18 at 9:37 PM, documented Resident #52's Pressure Ulcer BWAT report was completed. The left ankle (outer) pressure wound measured 0.5 cm by 0.5 cm, and depth was undetermined and unstageable. The wound was initially observed on 5/23/18.</p> <p>A Progress Note, dated 6/15/18 at 9:48 AM, documented Resident #52's Pressure Ulcer BWAT report was completed. The right lateral calf pressure wound measured 3.7 cm by 2.7 cm, depth was zero and unstageable. The wound was initially observed on 4/19/18. The eschar was separating from the wound edges "leaving a narrow pink-red ring around it. This could</p>	F 686			

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F 686	<p>Continued From page 56</p> <p>account for the slightly larger size of the wound this week. Will consider cornstarch next Friday."</p> <p>A Progress Note, dated 6/15/18 at 10:11 AM, documented Resident #52's Pressure Ulcer BWAT report was completed. The left ankle (outer) pressure wound measured 0.6 cm by 0.4 cm, and depth was zero and unstageable. The wound was initially observed on 5/25/18. The wound was improved and slightly smaller with no signs of infection.</p> <p>A Progress Note, dated 6/15/18 at 9:37 PM, documented Resident #52's Pressure Ulcer BWAT report was completed. The right ankle (outer) pressure wound measured 1.8 cm by 1.7 cm, and depth was zero and unstageable. The wound was initially observed on 5/25/18. The wound was slightly smaller than the previous week, and still had slough on the wound bed.</p> <p>A Progress Note, dated 6/18/18 at 11:03 AM, documented the wounds to Resident #52's left ankle and right second toe were improved and had smaller measurements. The wound on the right lateral calf and right ankle were "slightly larger." There were no signs of infection.</p> <p>A Progress Note, dated 6/19/18 at 10:57 AM documented the physician ordered Juven (a nutrition powder) twice a day for 14 days per the dietician's recommendations to promote wound healing for Resident #52.</p> <p>A Progress Note, dated 6/22/18 at 10:27 AM, documented Resident #52's Pressure Ulcer BWAT report was completed. The right ankle (outer) pressure wound measured 1.9 cm by 1.4,</p>	F 686			

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F 686	<p>Continued From page 57</p> <p>cm depth was "0" and "suspected deep tissue injury. The wound was initially observed on 5/25/18. There was no change in treatment.</p> <p>A Progress Note, dated 6/22/18 at 1:55 PM, documented Resident #52's Pressure Ulcer BWAT report was completed. The right lateral calf pressure wound measured 4 cm by 2.5 cm, and depth was zero and unstageable. The wound was initially observed on 4/19/18. The eschar was separating from the wound edges and the base of the wound was covered with soft black eschar. The resident winced when the area was touched.</p> <p>A Progress Note, dated 6/22/18 at 2:03 PM, documented Resident #52's Pressure Ulcer BWAT report was completed. The left ankle (outer) pressure wound measured 0.6 cm by 0.4 cm, and depth was zero and unstageable. The wound was initially observed on 5/25/18. Current treatment was continued and "make effort to offload."</p> <p>Resident #52's wound healing notes documented the following: On 6/1/18, 6/8/18, 6/15/18, and 6/22/18: Pressure ulcers on the right lateral calf, right ankle, right second toe, and left ankle. Wound orders included the following:</p> <ul style="list-style-type: none"> *To the right calf: cleanse with normal saline or wound spray. * Protect around the wound with skin protectant. * Apply Iodosorb (a common wound treatment) * Cover the wound with bordered foam. * Change the dressing daily or as needed. <p>* To the right ankle: cleanse with normal saline or</p>	F 686			

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F 686	<p>Continued From page 58</p> <p>wound spray.</p> <ul style="list-style-type: none"> * Protect around the wound with skin protectant. * Cover the wound with bordered foam. * Change the dressing daily or as needed. <p>* To the right second toe: cleanse with normal saline or wound spray.</p> <ul style="list-style-type: none"> * Protect around the wound with skin protectant. * To the left ankle: cleanse with normal saline or wound spray. * Protect around the wound with skin protectant. * Cover the wound with bordered foam. * Change the dressing daily or as needed. <p>Additional orders included painting the wound with Betadine, encourage repositioning every 2 to 3 hours, a total air loss mattress per the primary physician's orders, encourage repositioning every 2 to 3 hours, encourage offloading of heels and bony prominences, provide a supportive cushion in the wheelchair, and reposition the resident every 2 to 3 hours when up in wheelchair.</p> <p>Resident #52's TAR documented the following: "Turn side to side every two hours when in the bed." It was not documented the every 2 hour turns were completed on the following dates/times:</p> <ul style="list-style-type: none"> * Day shift on 4/4/18, 1/14/18, 4/19/18, 4/22/18, 4/23/18, 5/2/18, 5/23/18, 5/26/18, 5/31/18, 6/2/18, 6/4/18, 6/8/18, 6/9/18, 6/15/18, and 6/18/18. * Evening shift on 4/2/18, 4/6/18, 4/13/18, 4/17/18, 4/22/18, 5/8/18, 5/9/18, 5/19/18, 5/26/18, 6/2/18, 6/3/18, 6/11/18, and 6/14/18. * Night shift on 5/3/18, 5/10/18, 5/11/18, 5/18/18, 5/21/18, 5/25/18, 5/28/18, 5/30/18, 6/2/18, 	F 686			

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F 686	<p>Continued From page 59 6/13/18, 6/15/18, 6/18/18, 6/24/18, and 6/25/18.</p> <p>On 6/26/18 at 9:47 AM, LPN #1 was observed performing wound care to Resident #52's right ankle, left ankle, and right lateral leg. The wound on the right lateral leg appeared mildly reddened around the edges. The wound on the right ankle and left ankle appeared as ulcerations on the bony prominences of the outer ankles. At that time, LPN #1 stated the wounds were measured on Fridays, there was a physician's assistant following the resident for the wounds, the wounds were from pressure, and she believed the wounds developed in the facility.</p> <p>On 6/27/18 at 9:32 AM, CNA #3 said staff repositioned Resident #52 every 2 hours, he had boots, and staff were to keep his feet up. CNA #3 said she did not know where to document it but staff did turn him every 2 hours.</p> <p>On 6/27/18 at 9:35 AM, LPN #1 said there were no wounds on Resident #52's buttock area at that time. LPN #1 said the wound on his outer calf came first, it started as a small open area, he was treated with an antibiotic then it got hard eschar. LPN #1 said there was a different treatment on it at that time, and there was a red area on it. LPN #1 said the wound on Resident #52's calf was caused from him not getting up and from his disease process, then the right ankle wound came next from pressure. LPN #1 said she thought the left ankle wound was fairly recent and it was just from positioning. LPN #1 said pillows were placed underneath Resident #52's legs and a wedge was placed under his legs after the first ulcer developed. LPN #1 said Resident #52 had always been on an air</p>	F 686			

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F 686	Continued From page 60 mattress and turned every 2 hours. On 6/27/18 at 9:45 AM, the Unit Manager said the CNAs would report signs of a pressure ulcer and the resident would be put on alert charting. The Unit Manager said the physician saw an unusual bruise on Resident #52's leg on 4/19/18, and it was treated it with Betadine and a foam dressing. The Unit Manager said the physician indicated on 5/8/18 that it was not from pressure and it was a sloughing bruise. The Unit Manager said Resident #52's leg was protected with Prevalon boots and he was put on Keflex. The Unit Manager said it was determined the Prevalon boot was causing pressure on Resident #52's leg. The Unit Manager said the wound care nurse practitioner started seeing Resident #52 and he did not wear the Prevalon boot anymore. The Unit Manager said the CNA noticed the area on Resident #52's leg and reported it to the nurse on approximately 5/20/18. The physician evaluated the wound 1 to 2 days later and ordered the wound to be covered and protected. The Unit Manager said the wound team evaluated Resident #52's wound and said the wound was pressure related on 5/23/18. The Unit Manager said Resident #52 was turned often, had an air mattress, had his heels floated, and staff did not elevate his head more than 30 degrees for comfort if he was sleeping. The Unit Manager said the right ankle wound came next, that it was on a bony prominence and had to be from pressure. The Unit Manager said floating the heels was done shortly after the Prevalon boot was removed and there was a protective dressing over it. The Unit Manager said the left ankle was the same thing, and staff were putting skin prep around it and applying a protective	F 686			

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F 686	<p>Continued From page 61 dressing.</p> <p>On 6/27/18 at 10:23 AM, the Unit Manager said Resident #52 received an air mattress on 6/7/18.</p> <p>On 6/27/18 at 10:30 AM, the DNS said Resident #52 was being followed by a wound care nurse practitioner for multiple wounds on his legs. The DNS said it started on 4/19/18 as an unusual bruise, it was observed by the physician and was treated with Betadine. The DNS said the Prevalon boot might have contributed to the pressure ulcer, so the boot was removed and a wedge and air mattress were put in place. The DNS said Resident #52 did not like to be turned, and the wound nurse did not think the wounds would heal due his medical state. The DNS said when the first wound came up, the physician looked at it and prescribed an order, and the physician did not feel it was pressure related. The physician described it as a sloughing bruise. The DNS said staff added Prevalon boots and floating his heels to relieve pressure. The DNS said wound care started in May, and the wound care team thought it was from pressure from the Prevalon boot so an air mattress and a wedge were added. The DNS said the physician saw the right lower leg wound again on 5/15/18 and wrote an order for Keflex. On 5/21/18 it looked worse and the physician was notified. The physician saw the wound again on 5/22/18 and changed treatment to a Santyl dressing. The DNS said the wound care nurse practitioner saw the wound for the first time on 5/18/18, and no orders were made until the first official wound team visit on 5/25/18. The DNS said the low loss air mattress was put in place on 6/7/18. The DNS said staff should check the skin integrity on the resident's</p>	F 686			

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F 686	<p>Continued From page 62</p> <p>leg whenever the Prevalon boot is removed and before placing it back on the leg. The DNS said the staff were monitoring the skin under Resident #52's Prevalon boot and the weekly skin checks would document status of his skin. The DNS said Resident #52 was at risk for pressure ulcers.</p> <p>On 6/29/18 at 9:45 AM, the DNS said repositioning was considered a standard of care and it was not necessarily documented. The DNS said Resident #52 was resistant to turning.</p> <p>3. Resident #162 was readmitted to the facility on 8/10/10 with multiple diagnoses, including Type 2 diabetes mellitus and hereditary and idiopathic neuropathy (nerve damage). Resident #162 passed away in the facility on 4/5/18.</p> <p>Resident #162's quarterly MDS assessment, dated 1/8/18, documented severe cognitive impairment, not at risk for developing pressure ulcers, and no unhealed pressure ulcers.</p> <p>Resident #162's Significant change MDS assessment, dated 3/8/18, documented severe cognitive impairment, extensive assistance of two persons with bed mobility and transfers, at risk for pressure ulcers, one unhealed pressure ulcer that was unstageable, presence of and pressure reducing device for the chair and bed, pressure ulcer care, and application of dressings to feet.</p> <p>Resident #162's care plan documented the following:</p> <p>* A potential for skin integrity issues related to incontinence and decreased mobility was initiated on 12/23/14. Staff interventions included</p>	F 686			

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F 686	<p>Continued From page 63</p> <p>the following: A pressure reduction mattress was initiated on 12/23/14. Float heels with pillows while in bed and Prevalon boots in place when in wheelchair was initiated on 2/1/18. Encourage turning and repositioning every 2 hours or assist if she unable to reposition independently was initiated on 9/27/15.</p> <p>* Resident #162 had a deep tissue injury to her right heel was initiated on 1/30/18 and revised on 4/6/18. Staff interventions included the following: One to one staff supervision while awake due to the resident attempting to remove the boots was initiated on 2/27/18. Apply Betadine and heel cup every shift was initiated on 1/30/18 and revised on 3/1/18. A Keene wedge to the bed for "absolute pressure relief" was initiated on 1/30/18 and revised on 3/1/18. Encourage a high protein diet and protein-rich snacks was initiated on 3/26/18. Prevalon boots on at all times was initiated on 1/30/18. Wound care as prescribed by the physician was initiated on 3/12/18.</p> <p>Resident #162's February 2018 physician orders documented the following:</p> <p>* Started on 1/30/18: Right heel deep tissue injury: Apply Betadine and cover with a protective heel cup every shift, and Prevalon boot on at all times.</p> <p>* Started on 2/14/18: Complete the pressure ulcer report weekly, document findings in the nurse's notes and on the appropriate evaluation every Wednesday,</p> <p>A Weekly Pressure Ulcer BWAT Report, dated 1/30/18 at 5:25 PM, documented a pressure ulcer on Resident #162's right heel that</p>	F 686			

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F 686	<p>Continued From page 64</p> <p>measured 3.0 cm by 3.5 cm and was unstageable. Deep tissue injury was suspected. The wound was first observed on that date. Betadine was to be applied every shift per physician's order, as well as Prevalon boots at all times and a heel cup.</p> <p>A Progress Note, dated 1/21/18 at 9:49 PM, documented a CNA reported to the nurse there was discoloration to Resident #162's feet. The nurse assessed the feet and noted "bluish discoloration" to the left second, third, and fourth toes and a red area on the right fifth toe. The skin was intact, and the resident was to be added to the podiatrist's schedule that week.</p> <p>A Progress Note, dated 1/30/18 at 5:25 PM, documented Resident #162's Pressure Ulcer BWAT Report was completed for a right heel wound measuring 3.0 cm by 3.5 cm and was unstageable. There was a suspected deep tissue injury initially observed on 1/30/18. Staff were to apply Betadine every shift, Prevalon boots at all times, and a heel cup for protection.</p> <p>A Progress Note, dated 1/30/18 at 6:05 PM, documented a deep tissue injury was noted to Resident #162's inner right heel measuring 3.0 cm by 3.5 cm and was "light purplish/dark color." The skin was intact, "loosely adhered and has palpable fluid under skin." A Keene wedge was placed on the bed to float heels and assure pressure relief.</p> <p>A Progress Note, dated 2/2/18 at 2:26 AM, documented a large fluid-filled blister was present on Resident #162's right heel. The area was purple and round around the perimeter of</p>	F 686			

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F 686	<p>Continued From page 65</p> <p>the blister. The area was cleansed with Betadine and covered with a heel cup. Prevalon boots were in place.</p> <p>A Progress Note, dated 2/3/18 at 5:52 AM, documented the blister on Resident #162's right heel was unchanged. Resident #52 "made several attempts to remove her Prevalon boots."</p> <p>Resident #162's Weekly Skin Check, dated 2/4/18 at 3:09 AM, documented a deep tissue injury with a "small amount of breakdown/peeling skin..." to the right heel.</p> <p>A Progress Note, dated 2/5/18 at 4:49 PM, documented there was further skin breakdown on Resident #162's right heel over the deep tissue injury. The heel cups and Betadine were discontinued and the Prevalon boots were to be on at all times. The resident attempted to remove the boots when up in her wheelchair. Staff "will redirect and remind [resident] the boots must stay on..."</p> <p>A Progress Note, dated 2/6/18 at 4:00 PM, documented Resident #162's right heel remained fragile with minimal skin breakdown over the deep tissue injury. The Prevalon boots were in place at all times. Staff were to turn her every two hours while in bed.</p> <p>A Progress Note, dated 2/11/18 at 9:15 AM, documented there were small red areas on Resident #162's second and fifth toes on the left foot and second toe and bunion on the right foot. The right heel wound was purple with no open skin and measured 4 cm by 4 cm. Prevalon boots were in place.</p>	F 686			

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F 686	<p>Continued From page 66</p> <p>A Progress Note, dated 2/19/18 at 10:27 PM, documented Resident #162's right heel wound measured 3.8 cm by 4.7 cm by 0.1cm. There was eschar with no drainage, the area was cleansed with wound cleanser, Bacitracin was applied and a gauze dressing was applied.</p> <p>Resident #162's Weekly Skin Checks documented the following:</p> <p>* On 2/22/18 at 4:57 PM: Deep tissue injury to the right heel with skin breakdown and black tissue in areas.</p> <p>* On 2/25/18 at 11:08 AM: "Deep tissue breakdown on [the] right heel with black necrotic (dead tissue) area." Prevalon boots were in place and the charge nurse was notified of the heel condition.</p> <p>* On 3/4/18 at 11:20 PM, A round wound on the right heel with a 4.5 cm by 4.5 cm black necrotic area, dry skin and a red area. The area was dry with no drainage, and Prevalon boots were in place. There was a trace of edema (swelling) to the feet.</p> <p>* On 3/11/18 at 1:00 AM: A 3.5 cm by 3.5 cm round black wound to the right heel with some redness and skin peeling around the outside of the wound. There was no drainage. There was a trace of edema to the feet.</p> <p>* On 3/18/18 at 2:05 AM: A 3.5 cm by 3 cm black area to the right heel and the skin was peeling around the outside of the wound. There was a trace of edema to the heels.</p>	F 686			

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F 686	<p>Continued From page 67</p> <p>* On 3/25/18 at 2:05 AM: A deep tissue injury to the right heel and treatment was in place. There was a dark, necrotic cap to the right heel.</p> <p>A physician's note, dated 4/1/18 at 7:30 PM, documented Resident #162 was on hospice, was unable to ambulate, and could transfer with assistance. One on one care was required due to the resident's impulsivity and need for assistance. Protective footwear was in place and there was a 4 cm by 4 cm pressure injury to the right heel. The wound was covered with gauze and a Tegaderm dressing. A note from the wound clinic was reviewed. Previous wound care orders were discontinued and the wound clinic's recommendations were to be followed, which included the following: Cleanse the wound with normal saline, apply Betadine, apply barrier film to surrounding skin, apply a foam dressing to the wound bed and cover with a foam dressing "or similar for protection." Assess the wound and apply Betadine daily, change the cover dressing three times a week and more often if needed, apply off-loading boots and avoid pressure to the affected area.</p> <p>On 6/29/18 at 9:16 AM, the Unit Manager said Resident #162 had a heel blister with suspected deep tissue injury that was documented on 1/30/18. The Unit Manager said up until then Resident #162 was fairly active, but she declined and went on hospice. The Unit Manager said there were orders on 1/30/18 to apply Betadine and Prevalon boots and place a wedge on the bed. The Unit Manager said Resident #162 would kick off and remove the Prevalon boots. The Unit Manager said the wound on Resident</p>	F 686			

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F 686	Continued From page 68 #162's heel deteriorated and she was declining, she was not moving as much, and that was the reason for the Keene Wedge (to float the heels). On 6/29/18 at 9:38 AM the Unit Manager said she was sure Resident #162 was on an air mattress but was unsure of the date when the air mattress was applied.	F 686			
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review, and record review, it was determined the facility failed to ensure residents received proper treatment and care to maintain good foot health. This was true for 1 of 1 resident (#52) reviewed for foot care. This failed practice created the potential for harm should residents experience complications from their medical condition related to the lack of proper foot care. Findings include: The facility's policy and procedure for ADLs (Activities of Daily Living)- AM Cares, dated	F 687	The clinical management team reviewed resident #52. Podiatrist appointment was completed for treatment. The clinical management team reviewed other residents for proper treatment and care to maintain good foot health. Adjustments have been made as indicated. Nurses are educated to evaluate resident's feet to ensure proper treatment and care to maintain good foot health.	8/22/18	

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F 687	<p>Continued From page 69</p> <p>10/31/17, and ADLs- PM/HS (bedtime) cares, dated 11/14/17 documented the following: Nail care to be performed with showers and "intermittently as indicated." A licensed nurse was to provide care to diabetic and/or high risk residents.</p> <p>Resident #52 was readmitted to the facility on 2/5/18 with multiple diagnoses, including heart failure, acute and chronic respiratory failure, muscle weakness, and dementia.</p> <p>Resident #52's quarterly MDS assessment, dated 5/18/18, documented the following:</p> <ul style="list-style-type: none"> * Severe cognitive impairment. * Total dependence on two person physical assistance with bathing and personal hygiene. <p>Resident #52's current care plan documented the following:</p> <ul style="list-style-type: none"> * Initiated on 3/1/18: Requires 1 staff participation with personal hygiene. * Initiated on 3/28/18: Impaired circulation and edema (swelling) related to congestive heart failure. * Initiated on 3/28/18: Staff were directed to elevate legs when resting, ensure proper fitting footwear was in place, inspect for areas of rubbing or injury, inspect the foot/ankle/calf for skin changes, and monitor pedal pulses (pulse on the foot). <p>On 6/26/18 at 9:47 AM, Resident #52's feet were observed to have small scabs on top of the second toe on the right and left foot. The toenails were long and thick.</p>	F 687	<p>Re-education was provided by Director of Nursing and/or designee to include but not limited to, process to validate that the podiatrist provides foot care in a timely manner. The system is amended to include documentation by the licensed nurses when communicating with Social Service department for podiatry referrals. Additional podiatry visits will be provided as indicated</p> <p>The Director of Nursing and/or designee will audit 4 residents for proper treatment and care to maintain good foot health weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>Date of compliance will be 8/22/2018.</p>		

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F 687	<p>Continued From page 70</p> <p>On 6/27/18, CNA #2 said any CNA could cut nails for a resident if they were not diabetic. CNA #2 said she did not know when Resident #52's nails were last trimmed.</p> <p>On 6/27/18 at 2:19 PM, the Unit Manager said staff were unable to cut Resident #52's toenails because they were too thick, and she had attempted to cut his nails one time after he returned to the facility because she noticed they were too thick. The Unit Manager said a podiatrist came to the facility about every 3 months, and she put Resident #52 on the podiatrist list either before or shortly after he returned to the facility (in February 2018), and the podiatrist would not be back until August. The Unit Manager said Resident #52's nails had not changed and staff looked at them with weekly skin checks or when he got a bath. The Unit Manager said social services referred residents to the podiatrist, and there had been some changes in social services. The Unit Manager said she told social services to add Resident #52 to the podiatrist list in June, but it got missed and he was not seen.</p> <p>On 6/27/18 at 2:30 PM, Social Worker #1 said he helped coordinate podiatry services and he was not aware of Resident #52 needing podiatry services.</p> <p>On 6/27/18 at 2:45 PM, Social Worker #2 said she was not aware of Resident #52 needing podiatry services. Social Worker #2 said there was previously another social worker, and she did not know if that social worker had the information to refer Resident #52 for podiatry</p>	F 687			

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F 687	Continued From page 71 services. On 6/29/18 at 9:45 PM, the DNS said foot care/nail care was put on the schedule and the CNAs could perform nail care except for residents who were not diabetic. The DNS said if toenails were too thick the resident would be placed on the podiatrist list, and if the nail was curling or causing a problem the resident would be taken out to see a podiatrist. The DNS said if the condition could wait they would put them on the podiatrist list, and the podiatrist would come to the facility about every 3 months.	F 687			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, policy review, resident interview and staff interview, it was determined the facility failed to ensure residents were provided the necessary respiratory care and services. This was true for 3 of 3 (#2, #27, #40) residents sampled for review of respiratory care and services. This failure increased the risk for residents to experience respiratory complications and physical decline. Findings include:	F 695	The clinical management team reviewed resident #2, #27, and #40. The oxygen orders were updated to document the liter flow and oxygen saturation levels as indicated. The clinical management team reviewed other resident's oxygen orders and they were clarified to include monitoring saturation levels and liter flow. Adjustments have been made as	8/22/18	

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F 695	<p>Continued From page 72</p> <p>The American Association for Respiratory Care Clinical Practice Guideline -Oxygen Therapy in the Home or Alternate Site Health Care Facility -2007 Revision & Update P1063-1067- found at http://www.rcjournal.com/cpgs/pdf/08.07.1063.pdf, states the following:</p> <p>"For a resident receiving oxygen therapy, the resident's record must reflect ongoing assessment of the resident's respiratory status, response to oxygen therapy and include, at a minimum, the attending practitioner's orders and indication for use. In addition, the record should include the type of respiratory equipment to use, baseline SpO2 levels and to initiate and/or discontinue oxygen therapy."</p> <p>The facility's Respiratory Care policy and procedure, dated 11/28/17, stated, "The resident is provided the necessary medical and nursing care and treatment services consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences." The care plan identifies interventions and the resident's record should reflect ongoing assessment for oxygen therapy, such as the attending practitioner's orders, type of oxygen delivery system, when to administer, equipment settings for the prescribed flow rates, and monitoring of SpO2 (blood oxygen saturation) levels and/or vital signs.</p> <p>The above practices and policy were not followed. Examples include:</p> <p>1. Resident #2 was admitted to the facility on 8/5/16 with multiple diagnoses, including</p>	F 695	<p>indicated.</p> <p>Nurses are educated to clarify oxygen orders to include necessary parameters and documentation. Re-education was provided by Director of Nursing and/or designee to include but not limited to, clarifying oxygen orders to include liter flow, saturation levels, and accurate setting on the oxygen concentrators'. The system is amended to include clinical management team to review oxygen orders in clinical meeting.</p> <p>The Director of Nursing and/or designee will audit 4 residents for oxygen orders that include necessary parameters and documentation weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>Date of compliance will be 8/22/2018.</p>		

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F 695	<p>Continued From page 73</p> <p>Alzheimer's disease, dementia, dysphagia (difficulty swallowing), and as of 1/8/18 began receiving hospice services.</p> <p>Resident #2's quarterly MDS assessment, dated 2/21/18, and significant change MDS, dated 3/8/18, documented she was not cognitively intact and required oxygen therapy.</p> <p>Resident #2's physician orders dated 8/2/16, documented she staff were to implement an oxygen protocol to maintain her oxygen saturation levels at or above 90%. Resident #2's physician orders dated 8/4/18, documented staff were to continue the oxygen protocol.</p> <p>Resident #2's care plan, dated 1/2/18, documented staff were to check her oxygen saturation levels as ordered by the physician and notify the physician of any abnormal levels.</p> <p>From 6/25/18 - 6/29/18, Resident #2 was observed receiving 2 liters of oxygen via nasal cannula.</p> <p>Resident #2's MAR, dated June 2018, documented she was to receive oxygen at 2-3 liters per minute via nasal cannula to maintain comfort. An order with a start date of 2/23/18, stated staff were to check Resident #2's oxygen saturation level every shift.</p> <p>Resident #2's MAR for 6/1/18 - 6/30/18, did not include documentation of the specific liters per minute of oxygen she was receiving. Additionally, Resident #2's oxygen saturation levels were not documented as completed on the following shifts:</p>	F 695			

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F 695	<p>Continued From page 74</p> <p>6/1/18 - Evening and night shifts 6/2/18 - Evening and night shifts 6/4/18 - Night shift 6/7/18 - Night shift 6/8/18 - Day and night shifts 6/11/18 - Night shift 6/15/18 - Evening and night shifts 6/16/18 - Evening shift 6/22/18 - Night shift 6/23/18 - Evening shift</p> <p>Resident #2's weights and vitals summary record for June 2018, did not include the oxygen specific liters per minute flow rates.</p> <p>On 6/27/18 at 3:50 PM, the DNS stated her expectations were the nurses document every shift and there should not be blanks on the MAR.</p> <p>2. Resident #40 was admitted to the facility on 2/5/18 with multiple diagnoses, including COPD, anxiety, and muscle weakness.</p> <p>The quarterly MDS assessment, dated 5/15/18, documented Resident #40 was cognitively intact and independent with bed mobility.</p> <p>Resident #40's physician order, dated 2/28/18, documented she was to receive oxygen at 2 liters per minute via nasal cannula and staff were to attempt to wean her off the oxygen while maintaining her oxygen blood saturation levels at greater than 90% throughout day. Oxygen was to continue throughout the "night every shift."</p> <p>Resident #40's Weights and Vitals Summary Record for June 2018 documented oxygen saturations between 92% and 98% via nasal</p>	F 695			

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F 695	<p>Continued From page 75</p> <p>cannula. The documentation did not include the liter flow rate.</p> <p>Resident #40's June 2018 MAR documented oxygen saturation levels three times a day. The MAR did not include what liter flow Resident #40 was receiving to maintain saturation levels above 90%.</p> <p>On 6/25/18 at 2:23 PM, Resident #40 was in her room wearing oxygen at 2 liters via nasal cannula and stated she used to be on 3 liters prior to admission.</p> <p>A care plan, revision date 5/30/18, documented, Resident #40 had COPD. The care plan interventions were documented as follows:</p> <p>* "Give oxygen therapy as ordered by the physician. [Resident #40] is on 2 L via nasal cannula."</p> <p>On 6/27/18 at 3:50 PM, the DNS stated Resident #40's oxygen liter flow was to be weaned down to keep oxygen saturations above 90% during the day and evening. At night, Resident #40 was to wear oxygen at 2 liters via nasal cannula continuously. The DNS stated the June MAR and the Vitals Summary Record did not document the liter flow rate for Resident #40.</p> <p>3. Resident #27 was readmitted to the facility on 5/13/18 with multiple diagnoses, including acute respiratory failure, COPD, acute lower respiratory tract infection, and heart failure.</p> <p>Resident #27's physician orders documented the following: Check oxygen saturation level (the</p>	F 695			

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F 695	<p>Continued From page 76</p> <p>percentage of oxygen in the body) every shift and as needed to maintain saturation above 90%.</p> <p>Resident #27's current care plan directed staff to administer oxygen as ordered by the physician, and was initiated on 4/10/15 and revised on 9/1/17.</p> <p>Resident #27's May 2018 and June 2018 TARs documented the following:</p> <p>* Oxygen at 1-5 liters to keep saturation above 90%, adjust as needed to keep saturation above 90%, starting on 3/16/17. The oxygen liter flow rate was not documented on the TAR.</p> <p>Resident #27's Weight and Vitals Summary did not document the oxygen liter flow rate in May or June 2018.</p> <p>On 6/25/18 at 1:58 PM, Resident #7 was sitting in her room in her wheelchair. The oxygen tubing was not in place in her nostrils. The oxygen concentrator was operating and was set at 2.5 liters per minute.</p> <p>On 6/26/18 at 12:57 PM, Resident #7 was asleep in her bed with oxygen tubing in place in her nostrils. The oxygen concentrator was operating and was set at 2 liters per minute.</p> <p>On 6/29/18 at 10:14 AM, the DNS said staff should determine how much oxygen to deliver to Resident #7 by checking the oxygen saturation and adjusting. The DNS said if the oxygen saturation was 92% on 2 liters of oxygen, then it was fine and keep it there. The DNS said if the oxygen saturation was 89% then she would turn</p>	F 695			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
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F 695	Continued From page 77 up the oxygen flow to 3 liters. The DNS said she would consider it a standard of practice for nursing to monitor the oxygen saturation, and the order should be on the MAR or TAR. The DNS said the TAR did not document the liter flow of oxygen being administered to Resident #7.	F 695			
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 725		8/22/18	

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F 725	<p>Continued From page 78</p> <p>Based on staff interview, record review, and facility policy and procedure review, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of residents. This failed practice had a direct negative impact on the level of supervision and/or services provided to 2 of 16 (#49 and #53) sampled residents and 3 of 9 residents who attended resident council who resided in the facility and placed the health and safety of all 59 residents in the facility, at risk of serious harm should the staffing shortage result in the failure to deliver care as physician ordered, as included in their care plans, or otherwise needed. Findings include:</p> <p>The facility's 1:1 staffing Policy and Procedure documented the expectations of the CNA's while sitting with their one to ones as follows:</p> <ul style="list-style-type: none"> * "You are expected to be within an arm's reach at all times. * If you need to be relieved for any reason you must have the person taking over sign that they are taking responsibility for your one to one. * We have to continue to document on all behaviors, each monitor is tailored to each resident so please let Medical Records know if we need to add any behaviors. * You will be expected to provide activities to your one on one while you are with them. Reference the Kardex that is in each 1:1 binder for a list of activities that resident enjoys. * If you have any additional questions go to your 	F 725	<p>The clinical management team reviewed resident #49 and 53 to validate that their plan of care and needs are met. No adjustments were indicated.</p> <p>The clinical management team reviewed other residents for staff availability to meet their needs. Staffing patterns indicate that there is staff scheduled and available to meet the needs of the resident's current conditions.</p> <p>The Director of Nursing, licensed nurses, and staffing coordinator are educated to adequate staffing requirements. Re-education was provided by the Administrator to include but not limited to, communication regarding staff attendance, resident change of conditions, and alternative plans for meeting staffing needs. The system is amended to document alternate processes attempted to meet resident needs and final plan implemented. In addition, staffing needs will be reviewed in resident council for perceived resident changes.</p> <p>The Administrator and/or designee will audit staffing schedules prior to use and post implementation each morning for 4 weeks to validate resident needs are met with adequate staffing. In addition, review of resident response to staffing needs will be monitored through monthly resident council meetings. Starting the week of August 13th, the review will be documented on the audit tool. Any</p>		

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F 725	<p>Continued From page 79 unit manager."</p> <p>An Incident and Accident Report, dated 6/7/18 at 7:45 PM, documented Resident #49 had an unwitnessed fall in his room. The witness statements stated Resident #49's roommate alerted staff that Resident #49 was on the floor. The immediate interventions taken to protect the resident after the unwitnessed fall was "15 minutes checks and 1:1 when in hall or out of bed."</p> <p>A evaluation summary progress note, dated 6/7/18 at 7:51 PM, documented Resident #49 was last seen sleeping in bed two minutes before the fall.</p> <p>A physician's verbal order, dated 6/4/18, Resident was assigned to have 1:1 staffing.</p> <p>Resident #49's care plan, dated 6/4/18, documented, "[Resident #49] has a need for 1:1 staffing PRN."</p> <p>On 6/29/18 at 3:28 PM, the DNS stated Resident #49 was assigned to have 1:1 staffing and Resident #53 was attempting to elope, so the 1:1 staff was reassigned to Resident #53 and then Resident #49 woke up and fell in his room. The DNS stated there was not enough staff to assign an additional 1:1 to Resident #53.</p> <p>b. The facility's Dining Standards policy and procedure, dated 11/28/17, documented the following:</p> <p>* "Adequate staff would be provided for assisting residents during mealtimes.</p>	F 725	<p>concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>The date of compliance will be 8/22/18.</p>		

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F 725	<p>Continued From page 80</p> <ul style="list-style-type: none"> * Meals would be served to residents who required assistance with feeding "when a staff member is available to assist them." * Residents who were sitting together would be served in consecutive order, one table at a time. * Staff would be available to assist and supervise residents as needed." <p>Resident #2 was admitted to the facility on 8/5/16 with multiple diagnoses, including dysphagia (a swallowing disorder) and Alzheimer's disease.</p> <p>Resident #2's significant change MDS, dated 3/8/18, documented short term and long term memory problems, moderate cognitive impairment with daily decision making, and she was totally dependent on the physical assistance of one staff for eating.</p> <p>Resident #2's current care plan documented she was at risk for nutritional decline related to Alzheimer's disease, dementia, significant weight loss, variable intake, history of refusing meals, and hospice care. The care plan directed staff to provide 1:1 staff to assist Resident #2 to eat.</p> <p>On 6/25/18 at 12:30 PM, Resident #2 was sitting in her wheelchair at the dining table, and her plate of food was placed in front of her uncovered. Twenty-one minutes later, at 12:51 PM, CNA #5 began assisting Resident #2 to eat.</p> <p>On 6/26/18 at 12:39 PM, Resident #2 was sitting in her wheelchair at the dining table, and her plate of food was placed in front of her</p>	F 725			

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F 725	<p>Continued From page 81</p> <p>uncovered. CNA #2 was sitting between Resident #2 and another resident and began assisting the other resident with his/her meal. Resident #2 sat in her wheelchair with her uncovered plate in front of her and was unassisted with her meal until 12:54 PM, 19 minutes later.</p> <p>On 6/26/18 at 12:59 PM, CNA #4 stated the facility's policy was staff were to assist one resident at a time with meals. CNA #4 stated she was going to sit down and assist Resident #2, but then was called away to assist a resident in the resident's room.</p> <p>On 6/26/18 at 1:06 PM, the Unit Manager stated the expectation was the residents who required assistance with meals, their plate would be served last, then the CNA would sit down and assist with the meal right away. The Unit Manager stated Resident #2 should have been assisted with her meal in a timely manner.</p> <p>On 6/26/18 at 11:01 AM, Resident Council minutes documented resident concerns for staffing. Nine residents were in attendance.</p> <p>Residents #15 and #30 stated that there was not enough staff and has had to wait from 30 minutes up to an hour to get help during the day, but particularly in the evening.</p> <p>Resident #46 stated the staff were always short on Sundays. She stated that a couple of days ago the staff was pulled away and she was unable to have a walking activity.</p> <p>On 6/27/18 at 8:42 AM, CNA #5 stated that the facility needed more staffing, especially at night</p>	F 725			

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F 725	Continued From page 82 time. On 6/27/18 8:44 AM, CNA #4 said it would always be better to have more staff. On 6/27/18 at 10:15 AM, Resident #39 was observed with cares of showering, dressing, grooming and transfer by CNA #8 and CNA #4. CNA #8 stated it would be better to have 3 CNAs for staffing to help with cares during the day and they used to have 3 and now they have 2. CNA #8 said it was difficult to get all the cares completed with 2 CNAs.	F 725			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §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; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		8/22/18	

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F 758	<p>Continued From page 83</p> <p>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure there was behavior monitoring for a resident receiving an anti-anxiety medication. This was true for 1 of 6 residents (#18) reviewed for psychotropic medications. This failed practice created the potential for harm should residents experience adverse reactions and behaviors from psychotropic medications. Findings include:</p> <p>The facility's policy and procedure for Unnecessary Medications and Psychotropic</p>	F 758	<p>The clinical management team reviewed resident #18 and behavior monitoring was added for the antianxiety medication.</p> <p>The clinical management team reviewed other residents for behavior monitors who are receiving anti-anxiety medication. Adjustments have been made as indicated.</p> <p>Nurses and Social Services staff are educated behavior monitoring of</p>		

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F 758	<p>Continued From page 84</p> <p>Drugs/Antipsychotic Medication, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> * "A resident's medication regimen is free of any medication used in excessive dose (including duplicative therapy), excessive duration, without adequate monitoring, without adequate indications for its use..." * Documentation of signs of distress, delirium, or other changes in status. * Medications are monitored for to follow progress towards goals and to detect any adverse effects. <p>Resident #18 was admitted to the facility on 12/10/15 with multiple diagnoses, including generalized anxiety disorder.</p> <p>Resident #18's quarterly MDS assessment, dated 4/10/18, documented the following:</p> <ul style="list-style-type: none"> * Short term and long term memory problems. * Some difficulty in new situations with making decisions regarding daily tasks of life-modified independence. * Anxiety disorder. * Anti-anxiety medication received on 7 of the last 7 days. <p>Resident #18's physician orders documented Xanax tablet (anti-anxiety medication) 0.25 mg 1 tablet once a day for generalized anxiety disorder was started on 11/28/17.</p> <p>Resident #18's current care plan documented the following:</p> <ul style="list-style-type: none"> * Resident #18 had anxiety. 	F 758	<p>psychotropic medication. Re-education was provided by Director of Nursing and/or designee to include but not limited to, review post resident admission and with physician order change for related behavioral monitor. The system is amended to include review for behavioral monitor post admission and with physician order change in clinical meeting.</p> <p>The Director of Nursing and/or designee will audit 4 residents with psychotropic medication orders for behavior monitors weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>Date of compliance will be 8/22/2018.</p>		

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F 758	Continued From page 85 * Allow him to make decisions about treatment. * When he is anxious, offer a walk, visiting, calling his spouse, and reassurance. * Encourage participation and interaction as much as possible during cares. * Provide activities that focus on life history and present strengths. Resident #18's May 2018 and June 2018 MARs documented the Xanax was administered each day except for 5/19/18. Documentation of the monitoring of resident specific behaviors related to Resident #18's anxiety, was not completed prior to 6/28/18, the day prior to the survey exit conference on 6/29/18. On 6/28/18 at 3:49 PM, the Unit Manager said the behavior monitoring was not completed for Resident #18's Xanax and it should be. On 6/29/18 at 9:45 AM, the DNS said if a resident was on Xanax, the nurse should get an order and sign off on behavior monitoring and side effects.	F 758			
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering	F 773		8/22/18	

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F 773	<p>Continued From page 86</p> <p>physician's orders.</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 promptly notify the resident's physician of an abnormal PT/INR lab value. This was true for 1 of 1 (#5) sampled residents for anticoagulation medications. This failure created the potential for harm if complications arose related to the use of anticoagulation medications without monitoring or treatment. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 7/20/17 with multiple diagnoses, including atrial fibrillation (irregular heartbeat).</p> <p>The quarterly MDS assessment, dated 6/11/18, documented Resident #5 was severely cognitively impaired, required extensive assistance with transfers and bed mobility, and received anticoagulants 7 days a week.</p> <p>A Physician's Order, dated 6/5/18 at 2:44 PM, documented PT/INR labs were to be completed in two weeks, 6/19/18.</p> <p>A nurse's progress note, dated 6/5/18 at 2:43 PM, documented, "[Physician's name] ordered Coumadin 7.5 mg on Mon-Wed-Fri and 5 mg the other four days a week. Will do PT/INR on 6/19."</p> <p>On 6/28/18 at 5:45 PM, the DNS provided the PT/INR results, dated 6/20/18. Resident #5 had blood drawn on 6/19/18 at 4:51 PM and the laboratory reported the lab results on 6/20/18 at 10:20 AM. The PT results were 47.60, flagged as "high". The normal range for PT was 9.40-12.50.</p>	F 773	<p>The clinical management team reviewed resident #5. The resident's physician was notified with new orders noted.</p> <p>The clinical management team reviewed other residents with anticoagulation medications for appropriate laboratory monitoring and physician notification. Adjustments have been made as indicated.</p> <p>Nurses are educated to notify the resident's physician of lab results. Re-education was provided by Director of Nursing and/or designee to include but not limited to, timely notification of abnormal PT/INR lab values. The system is amended to include clinical management team review of PT/INR lab results during clinical meeting.</p> <p>The Director of Nursing and/or designee will audit 4 residents for prompt notification of the resident's physician of abnormal lab results weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>The date of compliance will be 8/22/2018.</p>		

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F 773	Continued From page 87 The INR results were 4.37, flagged "high". The normal range was 2.0-3.0. The DNS stated the laboratory was interfaced with their electronic system and also faxed a copy of the lab results to the facility. There was no documentation when, or if, the physician was notified regarding the abnormal lab value. The DNS stated the physician was not notified of the abnormal PT/INR lab value until 6/28/18.	F 773			
F 838 SS=E	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 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: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (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; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;	F 838		8/22/18	

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F 838	<p>Continued From page 88</p> <p>(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and</p> <p>(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.</p> <p>§483.70(e)(2) The facility's resources, including but not limited to,</p> <p>(i) All buildings and/or other physical structures and vehicles;</p> <p>(ii) Equipment (medical and non- medical);</p> <p>(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;</p> <p>(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their 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 its Facility Assessment identified the resources and equipment needed to provide person centered</p>	F 838	<p>The clinical management team reviewed residents #2, #11, #15, #28, #31, #39, #40, #53, #56, #59, and #62. These residents were assessed to determine if</p>		

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F 838	Continued From page 89 care and services required by the resident population. The failure had the potential to affect 11 of 15 sampled residents (#2, #11, #15, #28, #31, #39, #40, #53, #56, #59, and #62) whose beds were positioned against the wall and were not individually assessed to determine if the bed against the wall was a potential restraint. This deficient practice created the potential for residents to experience physical injury or psychological decline due to restricted movement. Findings include: The Facility Assessment, dated September 30, 2016 - September 30, 2017, did not address the facility's practice of routinely placing beds against the wall to increase the functional space in residents rooms. The assessment did not address the need to assess each individual resident to determine if the resident's bed positioned against the wall may be a restraint. On 6/27/18 at 1:00 PM, the facility President stated the Facility Assessment did not address beds against the wall in resident rooms as a potential restraint. Also, refer to F604 as it relates to the failure of the facility to ensure residents were free of physical restraints.	F 838	the bed against the wall was a potential restraint. No assessment indicated that the resident was restrained. The Facility Assessment was updated to identify the space issues and inherent risk of a restraint with beds positioned against the wall. Other residents with beds against the wall have the issue of potential restraint addressed in the updated Facility Assessment. The Administrator, Director of Nursing, and the Interdisciplinary Team are educated to update the Facility Assessment. Re-education was provided by the Director of Operation to include but not limited to, identification of resident issues that may result in a restraint to include beds against the wall being addressed on the Facility Assessment. The system is amended to include review of other physical plant items that were not addressed in the Facility Assessment. The Administrator and Director of Operation will review and update the Facility Assessment and bring to QAPI committee. The QAPI committee will review to validate accuracy for physical plant issues that should be addressed in the Facility Assessment. The date of compliance will be 8/22/2018.		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		8/22/18	

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F 880	<p>Continued From page 90</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a</p>	F 880			

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F 880	<p>Continued From page 91</p> <p>resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 of 1 sampled resident (#52) observed during a dressing change when staff failed to perform hand hygiene following a dressing change and resident cares, and failed to follow universal precautions with a bottle of wound cleanser.</p>	F 880	<p>The clinical management team reviewed resident #52. No negative outcomes resulted from care.</p> <p>The clinical management team reviewed other residents for possible cross contamination. Shared wound care supplies were disposed of and new products were assigned for each resident.</p>		

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F 880	<p>Continued From page 92</p> <p>These failures created the potential for harm from cross contamination. Findings include:</p> <p>The facility's policy and procedure for Hand Hygiene/Handwashing, dated 11/28/17, documented the following:</p> <p>* Hand hygiene is to be performed at the following times: After touching blood, body fluids, secretions, excretions, and contaminated items, between tasks and procedures on the same resident when there is contamination with body fluids, when moving from a contaminated body area to a clean body area, after removing gloves, intermittently after removing gloves, between contact with residents, and when "otherwise indicated to avoid transfer of microorganisms to other patients or environments," and after contacting a resident's intact skin.</p> <p>The facility's policy and procedure for Infection Prevention and Control Program, dated 10/31/17, documented the following:</p> <p>* "Establishing facility wide engineering and work practice to reduce risk of exposure to and transmission of healthcare associated infections."</p> <p>Resident #52 was readmitted to the facility on 2/5/18 with multiple diagnoses, including heart failure, acute and chronic respiratory failure, muscle weakness, and dementia.</p> <p>Resident #52's quarterly MDS assessment, dated 5/18/18, documented the following:</p> <p>* Severe cognitive impairment. * Total dependence on two person physical</p>	F 880	<p>Nurses are educated to infection control practices. Re-education was provided by the Director of Nursing and/or designee to include but not limited to, hand hygiene, universal precautions when touching items, clean dressing techniques, use of wound products for individual residents. The system is amended to include random wound care audits by Unit Managers and/or designees and use of wound products for individual residents.</p> <p>The Director of Nursing and/or designee will audit 2 residents for infection control prevention and control during wound care weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.</p> <p>The date of compliance will be 8/22/2018.</p>		

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F 880	<p>Continued From page 93</p> <p>assistance with bed mobility and transfers.</p> <ul style="list-style-type: none"> * At risk for pressure ulcers. * One unstageable pressure ulcer with suspected deep tissue injury. * Skin and ulcer treatments, including a pressure reducing device for the chair and bed, nutrition or hydration intervention, pressure ulcer care, application of non-surgical dressings. <p>Resident #52's physician orders documented the following:</p> <ul style="list-style-type: none"> * Starting on 4/19/18: Once a day, clean bruise on right calf with Betadine (an antiseptic) and cover with a foam dressing daily until resolved, and notify physician if worse or not improving. * Starting on 5/15/18: RLE wound: dry completely, apply Bacitracin (antibiotic) ointment and cover with an island dressing. Change every other day. * Starting on 5/15/18: Cephalexin capsule (antibiotic) 500 mg four times a day for RLE wound infection. <p>Resident #52's current care plan documented the following:</p> <ul style="list-style-type: none"> * Initiated and last revised on 3/28/18: A wound on the left gluteal fold, and directed staff to float heels at all times, check that the head of the bed was not higher than 30 degrees, administer wound care as ordered by the physician, and turn side to side every two hours when in bed. <p>On 6/26/18 at 9:55 AM, LPN #1 completed wound care and dressings changes to Resident</p>	F 880			

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F 880	<p>Continued From page 94</p> <p>#52's right lower leg, right ankle, and left ankle. A bottle of SeaCleans (wound cleanser) was on Resident #52's bed and was near the resident and the wound care supplies. After she completed wound care, LPN #1 picked up the used, soiled dressings with her gloved hands, held the used, soiled dressings in one hand and removed one glove. LPN #1 did not perform hand hygiene, then picked up a cup from Resident #52's bedside table and assisted him to drink while she held the used, soiled dressings in her other hand. LPN #1 then removed her gloves, picked up the bottle of SeaCleans from Resident #52's bed and left the room without performing hand hygiene. LPN #1 then went to the medication cart, opened the bottom drawer of the cart and placed the bottle of SeaCleans in the drawer. LPN #1 said the bottle of SeaCleans was a universal bottle and it was used on other residents. LPN #1 said she did not perform hand hygiene after performing wound care.</p> <p>On 6/26/18 at 10:00 AM, the Unit Manager said the nurse should have cleaned her hands after she took her gloves off, before assisting Resident #52 to drink, and the bottle of SeaCleans should not have been on the resident's bed and returned to the medication cart.</p> <p>On 6/29/18 at 9:50 AM, the DNS said staff should sanitize their hands anytime they are soiled, anytime going in and out of the resident's room, and with providing cares to residents. The DNS said the bottle of SeaCleans should have been cleaned off before returning it to the cart.</p>	F 880			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		8/22/18	

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F 883	Continued From page 95 §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 refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883			

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F 883	<p>Continued From page 96</p> <p>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 record review, policy review, and staff interviews, the facility failed to ensure that residents received the pneumonia vaccine per the Center for Disease Control (CDC) recommendations and per the resident's request. This was true for 1 of 5 residents (#7) reviewed for immunizations when the resident received the first pneumonia vaccine in 2013 and requested the Prevnar 13 vaccine but did not receive it. This failure created the potential for harm should residents contract Pneumococcal pneumonia and experience illness from pneumonia. Findings include:</p> <p>The CDC website, accessed 7/5/18, documented recommendations for Pneumococcal vaccination (PCV13 or Prevnar 13®, and PPSV23 or Pneumovax 23®) for all adults 65 years or older as follows:</p> <p>* Adults 65 years or older who have not</p>	F 883	<p>The clinical management team reviewed resident #7. Prevnar 13 was given to Resident #7.</p> <p>The clinical management team updated the pneumococcal vaccination log for other residents regarding needed immunizations. Eligible residents, who gave consent, have been provided pneumococcal immunization as indicated.</p> <p>Nurses are educated to pneumococcal vaccination as per CDC guidelines. Re-education was provided by the Director of Nursing and/or designee to include but not limited to, updating the pneumococcal vaccination log, screening and administering pneumococcal immunization to eligible/consenting residents. The system is amended to include a tracking system to monitor</p>		

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F 883	<p>Continued From page 97</p> <p>previously received PCV13 should receive a dose of PCV13 first, followed at least one 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 the most recent dose of PPSV23.</p> <p>The facility's policy and procedure for the Pneumococcal Program, dated 10/31/17, documented the following:</p> <p>* Residents are offered and given the Pneumococcal vaccine according to physician orders unless medically contraindicated, they have already received the vaccine, or the vaccine is refused.</p> <p>* PCV13 or Prevnar 13 and PPSV23 or Pneumovax23 are available and recommended for adults over the age of 65.</p> <p>* On new admission and new requests for the vaccine, education would be provided about the vaccine and a copy of the VIS (Vaccine Information Statement) would be provided.</p> <p>* Residents would be screened to determine history of anaphylactic (allergic) reaction to the vaccine and their status in the vaccine series.</p> <p>* The vaccine would be offered to the resident or resident's representative.</p> <p>* If not previously given, provide the PCV13 upon admission then follow up with the PPSV23 in at least 8 weeks for those at high risk, or in at least one year for other residents.</p>	F 883	<p>residents post admission and at the quarterly care conference for re-offer if refused and/or administration as indicated.</p> <p>The Director of Nursing and/or designee will audit new admission and resident with quarterly care conferences for pneumococcal vaccination weekly for 4 weeks. Starting the week of August 13th, the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4weeks, as it deems appropriate.</p> <p>The date of compliance will be 8/22/2018.</p>		

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F 883	<p>Continued From page 98</p> <p>Resident #7 was admitted to the facility on 10/4/16 with multiple diagnoses, including Alzheimer's disease and generalized anxiety disorder.</p> <p>Resident #7's annual MDS assessment, dated 9/26/17, and quarterly MDS assessment, dated 3/16/18, documented the following:</p> <ul style="list-style-type: none"> * Short and long term memory problems, and moderate impairment in cognitive skills. * The Pneumococcal vaccine was not up to date. * The Pneumococcal vaccine was offered and declined. <p>Resident #7's physician orders documented "May have Pneumovax vaccine if no history of vaccine" ordered on 10/4/16.</p> <p>Resident #7's Pneumococcal PPSV23 Immunization Record, dated 10/31/16, documented the vaccine was refused, and she received the vaccine 3 years prior but would like to have the Prevnar 13.</p> <p>The facility did not provide documentation that Resident #7 received the Prevnar 13 vaccine.</p> <p>On 6/28/18 at 1:06 PM, the Infection Control Nurse said Resident #7's family member agreed to the pneumonia vaccine and there was no documentation she received it. The Infection Control Nurse said a couple of the residents had received the Prevnar 13 vaccine but the facility had not routinely offered it.</p> <p>On 6/28/18 at 1:47 PM, the DNS said she did not</p>	F 883			

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F 883	Continued From page 99 believe any residents received the Prevnar 13 vaccine and the facility was in the process of obtaining the vaccine. The DNS said if a resident received the PPSV23 vaccine in 2016, the facility should offer the Prevnar 13 vaccine and it was available from the pharmacy. On 6/28/18 at 1:53 PM, the Unit Manager said if a resident wanted to receive the pneumonia vaccine she would verify their vaccination status, obtain an order, and obtain the vaccine from the pharmacy.	F 883			
F 912 SS=E	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, it was determined the facility failed to ensure rooms with multiple residents had at least 80 square feet of living space per resident. This was true for 3 of 32 resident rooms (rooms 111, 112, and 114) which did not meet the minimum requirement of 80 square feet per resident. This was true for 2 of 2 sample residents who resided in the rooms and the other 4 residents whose rooms did not have 80 square feet of living space. The failure created the potential for residents experienced a loss of well-being due to a lack of living space. Findings include: * 2 residents were in room 111, which had 78.6 square feet per resident. * 2 residents were in room 112, which had 79	F 912	The facility is requesting to renew the room size requirement waiver, according to 483.90(e)(1)(ii).	7/23/18	

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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	
F 912	<p>Continued From page 100 square feet per resident. * 2 residents were in room 114, which had 79.5 square feet per resident.</p> <p>From 6/25/18 to 6/29/18, the residents in rooms 111, 112, and 114 stated they liked their rooms, including Resident's #15 and #40. The furniture in the rooms were arranged in a manner that provided for ease of access to the beds and closets.</p> <p>The facility had a room size requirement waiver for rooms 111, 112 and 114 which was granted on 1/11/17 and was in effect until the next on-site survey.</p> <p>On 6/29/18 at 10:30 AM, the facility President stated the facility wanted to renew its room size requirement waiver.</p>	F 912			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/29/2018
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NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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C 422	<p>02.120.05,p,vii Capacity Requirments for Toilets/Bath Areas</p> <p>vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to maintain the minimum number of tubs or showers for licensed beds. This affected 18 of 18 (#2, #5, #7, #11, #15, #18, #27, #28, #31, #39, #40, #49, #52, #53, #56, #59, #60, and #62) sampled residents residing in the facility, and had the potential to affect all residents who resided in the facility. Findings include:</p> <p>The facility was licensed for 71 beds and had 59 residents who lived in the facility.</p> <p>IDAPA 16.03.02.120.05.p.vii requires, in part, "...there shall be at least one (1) tub or shower for every twelve (12) licensed beds..." Seventy-one licensed bed divided by 12 licensed beds equaled 5.916 or 6 tubs or showers.</p> <p>Three bathing areas were identified during the "General Observations of the Facility" on 6/29/18 at 10:45 AM with LPN #2. They were: the East tub room with 1 tub, the Spa room with 1 shower, and the West Bath with 1 shower.</p> <p>On 6/29/18 at 11:00 AM, the President said the</p>	C 422	The facility is requesting to renew the waiver for the tub and shower requirement, IDAPA 16.03.02.120.05.p.vii.	7/23/18
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 07/30/18
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001100	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/29/2018
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NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 422	Continued From page 1 facility wanted to renew their waiver for the tub and shower requirement	C 422		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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August 1, 2019

Bryan McNeil, Administrator
Caldwell Care of Cascadia
210 Cleveland Boulevard
Caldwell, ID 83605-3622

Provider #: 135014

Dear Mr. McNeil:

On **June 25, 2019** through **June 29, 2018**, an unannounced on-site complaint survey was conducted at Caldwell Care of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007770

ALLEGATION #1:

Residents are fearful of other residents in the facility.

FINDINGS #1:

During the survey, fifteen resident records were reviewed, observations were conducted, facility incident and accident reports were reviewed, and staff were interviewed.

Observations were conducted during the week of survey for quality of care, residents' interactions with other residents, and staffing services.

Four residents were interviewed for safety of being in the facility with other residents. Four residents stated they were not fearful of other residents. One resident stated she was in a private room because she does tend to become upset and does not want to hurt another resident.

Two resident records were reviewed for resident to resident interaction. One resident, admitted January 2018, was physically and verbally abusive towards staff. An incident report documented the resident was very upset and barricaded herself in her room.

Bryan McNeil, Administrator
August 1, 2019
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The report documented the resident was verbally abusive towards staff and the staff were attempting to help her and she would not allow the staff to come in her room. The resident was in a room without any other residents in the room. The report also documented, after a few attempts from the staff to assist the resident in the room, the resident allowed a staff member to come into the room to assist her. The resident was sent to the hospital for an evaluation and was readmitted to the facility after the resident was stable.

The Director of Nursing stated when a resident became physically and/or verbally abusive, the staff provided safety measures for the resident and other residents to protect the residents from harm.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility needs more staff to provide care to the residents.

FINDINGS #2:

Two residents were observed who required 1:1 supervision by staff. The first resident observed wandered and attempted to leave the facility. The 1:1 staff member provided redirection to the resident. The second resident was observed at meals and required 1:1 assistance with eating. The resident's plate of food was uncovered in front of the resident getting cold and the resident did not receive assistance with the meal from a staff member.

Two residents records were reviewed. An incident and accident report documented the first resident had a fall from the bed because the staff assigned to provide 1:1 supervision was not in the room to keep the resident from falling. The report documented the staff member assigned to the first resident was reassigned to the second resident, who attempted to leave the facility and wandered in and out of other resident rooms, leaving the first resident without supervision.

In interviews, two CNAs stated it was difficult to provide efficient care to meet the needs of the residents. The CNAs stated they also provided showers to the residents, and with only two CNAs were assigned to the hall it was difficult to complete all the tasks to assure the residents needs were met.

Based on the investigative findings, the allegation was substantiated, and deficiencies were cited at F725, as they related to the failure of the facility to provide adequate staff for the residents' care needs.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

Bryan McNeil, Administrator
August 1, 2019
Page 3 of 3

The facility delayed implementing infection control precautions for residents.

FINDINGS #3:

Three residents' records were reviewed for infection control precautions. Two of the three residents required universal precautions (the practice in medicine of avoiding contact with patients' bodily fluids, by wearing nonporous articles such as medical gloves, goggles, face shields and disposable gowns). The resident records documented the facility was providing the correct protocol for the universal precautions.

One resident's record documented a rash had developed on the resident's side and the physician was notified and a cream was prescribed. After receiving the cream for less than 24 hours, the resident's rash spread throughout the resident's body. The resident was sent to the ER for evaluation and returned the same day with oral antibiotics and a cream was prescribed for staff to apply to the resident's skin twice a day. The ER cultured the rash and when the results of the culture were received positive for a contagious condition, new orders were prescribed and isolation precautions were initiated.

CNAs and nurses were interviewed and stated the facility provided the isolation precautions in a timely manner. The CNAs and nurses stated they did not contract the contagious condition. The infection control nurse stated the resident was transferred into a private room and staff provided isolation precautions per protocol of the facility. The infection control nurse stated no other resident or staff members were diagnosed with the contagious condition.

Based on the investigative findings, the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj