



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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July 13, 2018

CORRECTED LETTER 07/18/18

Mindy Shepard, Administrator
Royal Plaza Health & Rehabilitation
2870 Juniper Drive,
Lewiston, ID 83501-4720

Provider #: 135116

Dear Ms. Shepard:

On **June 29, 2018**, a survey was conducted at Royal Plaza Health & Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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 23, 2018**. Failure to submit an acceptable PoC by **July 23, 2018**, may result in the imposition of civil monetary penalties by **August 15, 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*.

Your facility's noncompliance with the following:

F883 42 CFR §483.80(d) Influenza and pneumococcal immunizations

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

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

Residents #1, #15, #36, #37, and #91 as identified on the enclosed Resident Identifier List.

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

Civil money 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

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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 23, 2018**. If your request for informal dispute resolution is received after **July 23, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

dr/
Enclosures

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

PRINTED: 09/07/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135116	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/29/2018
NAME OF PROVIDER OR SUPPLIER ROYAL PLAZA HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2870 JUNIPER DRIVE LEWISTON, ID 83501		
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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from June 25, 2018 through June 29, 2018. The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Presie Billington, RN Teri Hobson, RN Survey Abbreviations: ADL - Activities of Daily Living CDM - Certified Dietary Manager CNA - Certified Nursing Assistant COPD - Chronic Obstructive Pulmonary Disease DON - Director of Nursing DS - Dietary Staff LPN - Licensed Practical Nurse MDS - Minimum Data Set mg - milligram SW - Social Worker	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		7/31/18	

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

TITLE

(X6) DATE

Electronically Signed

07/24/2018

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 550	<p>Continued From page 1</p> <p>promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to maintain or enhance residents' dignity during dining when residents seated at the same table were served their meals at different times. This was true for 2 of 12 residents (#16 and #24) observed dining in the facility. This failure had the potential to cause</p>	F 550	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents #16 and #24 were provided an evening meal on 06/27/18.</p>		

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F 550	<p>Continued From page 2</p> <p>a decrease in residents' sense of self-worth and psycho-social well-being. Findings include:</p> <p>On 6/27/18 at 5:42 PM, Resident #16 and Resident #24 were seated across from each other at a table in the main dining room with another female resident and a male resident.</p> <p>On 6/27/18 at 5:50 PM, the first meal tray was served to the assisted area of the main dining room.</p> <p>On 6/27/18 at 6:00 PM, two meal trays were brought to Resident #16 and Resident #24's table. The trays were for the female and male resident. Resident #16 and Resident #24 did not receive their meal. Resident #16 and Resident #24 were quiet and looking at each other as the female and male resident started eating their meals.</p> <p>On 6/27/18 at 6:15 PM, the male resident was observed looking occasionally at Resident #16 and Resident #24 while he was eating. He asked Resident #16 and Resident #24 when they were going to eat. Resident #16 did not answer. The male resident then offered his half-eaten burger to Resident #16. Resident #16 just smiled at the male resident.</p> <p>On 6/27/18 at 6:18 PM, both the male and the female residents finished their main meals and were now eating their desserts. Resident #16 and Resident #24 still had not received their meal. The male resident waved his hand to get the attention of one of the staff. A CNA came over and Resident #24 stated every one else had gotten their food but he and Resident #16 had</p>	F 550	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions(s) will be taken?</p> <p>Residents were audited to ensure that no other resident(s) were omitted from being served their evening meal.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>The IDT was in-serviced on the facility policy on serving all residents at the same table their meals at the same time. The IDT (including the dietary staff) were in-serviced on the facility double checking procedure to ensure that all residents have meal tray tickets available for each meal.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.</p> <p>Dining room Monitor to assess that residents at the same table are being serviced their meals at the same time and that all residents receive their meal. DNS and/or their designee will monitor via weekly audits X 4 weeks, monthly audits X 2 months and PRN thereafter.</p> <p>The ED and DNS and/or their designee</p>		

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F 550	Continued From page 3 not received their meal. On 6/27/18 at 6:23 PM, Resident #16 and Resident #24's meal trays arrived at the table. On 6/27/18 at 6:34 PM. CNA #1 said they usually served meals to all residents at a table at the same time so they could all eat together. CNA #1 said Resident #16 and Resident #24's meal tickets might have been stacked with other meal tickets or misplaced. On 6/28/18 at 9:49 AM, LPN #1 said the first tray should be served beginning with residents in the assisted area if there were staff to assist them, followed by residents who needed to be reminded or cued to eat, and then other residents to follow. LPN #1 said she usually checked if the residents sitting together have their food delivered but she did not check yesterday. She said because there were so many staff members in the dining room other staff should have noticed Resident #16 and Resident #24 did not receive their tray. She said residents sitting together at a table should be served at the same time.	F 550	will review the Dining Room Monitor reports during the monthly QAPI meeting.		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		7/31/18	

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F 600	<p>Continued From page 4</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident and staff interview, policy review, and record review, it was determined the facility failed to provide the services needed to prevent harm and injury of a resident. This was true for 1 of 1 resident (#36) reviewed for accidents. Resident #36 sustained an injury when a staff member failed to follow the care plan when attempting to transfer her during toileting. This failure created harm when the resident suffered a broken femur. Findings include:</p> <p>Resident #36 was readmitted to the facility on 3/26/18, with diagnoses which included right knee replacement and right hip replacement.</p> <p>Resident #36's record included a care plan with identified deficits related to urinary incontinence and ADLs. The care plan stated Resident #36 required extensive assistance when transferring. The interventions in her care plan included having 2 staff members to assist with transfers and using a gait belt.</p> <p>Resident #36's Care Directive Form, dated 5/11/17, documented she required extensive assistance with 2 staff members for toileting.</p> <p>A facility policy Gait Belt, updated September 2008, stated gait belts were to be used when transferring resident from a chair to a commode</p>	F 600	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #36's care plan and care directives were reviewed and updated.</p> <p>How the facility will identify other resident shaving the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p> <p>Residents care plans and care directives were reviewed and updated as appropriate.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>The CNA involved was provided disciplinary action and individual in-service on following the residents care plan. Nursing staff were in-serviced on care plans, care directives, proper transfers according to residents care plan. Nursing staff were provided competencies on following the resident care plan/care directive.</p>		

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F 600	<p>Continued From page 5</p> <p>or toilet. The policy also stated the use of a gait belt was mandatory for transfers.</p> <p>An Occurrence Report, dated 4/22/18, documented Resident #36 fell in her bathroom during a transfer. The report stated after toileting, Resident #36 was attempting to transfer from the toilet to her wheelchair and she was unable to support her weight. In the report Resident #36 stated her knees were feeling weak and she could not "hold on anymore."</p> <p>CNA #2 stated in the report Resident #36 was standing after toileting and was holding onto the grab bar and she was standing behind Resident #36 attempting to pull up her adult incontinence brief. CNA #2 stated she observed Resident #36's right leg turning inward and she began to lower. CNA #2 stated she then attempted to help Resident #36 into her wheelchair, by placing her arms underneath Resident #36's arms and slowly lower her into the wheelchair. She stated Resident #36 was partially seated her in wheelchair and screaming her leg hurt. CNA #2 stated she then " ...kicked her chair out of the way to lay her down."</p> <p>A Nursing Home to Hospital Transfer form, dated 4/22/18, documented Resident #36 was transferred to an acute care hospital with pain to her right lower extremity after a fall.</p> <p>An Emergency Department Note, dated 4/22/18, documented Resident #36 presented for evaluation of her right clavicle, right hip, and right knee due to pain after a fall. The note stated Resident #36 was being transferred from the toilet to her wheelchair when she fell and she</p>	F 600	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?</p> <p>SDC and/or designee will complete visual observation audits of staff 1 time per week X 4 weeks, 1 X per month X 2 months, PRN and upon annual evaluation.</p> <p>The ED and DNS and/or their designee will review the audits during the monthly QAPI meeting.</p>		

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F 600	Continued From page 6 landed on her right side. The note documented Resident #36 had swelling to the center or her right clavicle, mild pain in the right hip, and severe pain to her right knee. The note stated x-rays of Resident #36's right knee showed a fracture of the right distal femur (thigh bone). On 6/26/18 at 11:21 AM, Resident #36 stated she broke her leg during a transfer in the restroom. She stated she twisted her knee and fell. She stated its almost healed. She stated she was not wearing the brace any longer. She denied pain. On 6/26/18 at 4:59 PM, the DON stated CNA #2 transferred the resident without a second staff member and she did not use a gait belt. She stated CNA #2 received additional training and education following the incident.	F 600			
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 645		7/31/18	

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F 645	<p>Continued From page 7</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services; or</p> <p>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.</p> <p>§483.20(k)(2) Exceptions. For purposes of this section-</p> <p>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.</p> <p>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-</p> <p>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,</p> <p>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and</p> <p>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.</p>	F 645			

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F 645	<p>Continued From page 8</p> <p>§483.20(k)(3) Definition. For purposes of this section-</p> <p>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).</p> <p>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.</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 Pre-Admission Screening and Resident Reviews (PASRR) were complete and accurate for 1 of 1 resident (#13) reviewed for a PASRR. The deficient practice had the potential to cause more than minimal harm if residents required, but did not receive, specialized services for mental health while residing in the facility. Findings include:</p> <p>Resident #13 was admitted to the facility on 1/30/17, with multiple diagnoses which included bipolar disorder (mental disorder).</p> <p>Resident #13's admission MDS assessment, dated 2/6/17, documented she had no behaviors and there was no level II PASRR.</p> <p>Resident #13's PASRR, dated 1/30/17, documented she was currently taking bupropion 75 mg for depression, clonazepam 0.5 mg for anxiety, and venlafaxine 37.5 mg for anxiety. The MDS also documented the attending physician certified prior to admission Resident #13 would require less than 30 calendar days of services in</p>	F 645	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #3 has had a new PASRR completed and it was faxed to the Bureau of Long Term Care (BLTC) for a Level II review.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken.</p> <p>Resident's charts were audited for complete and accurate PASRRs. Any resident who was identified to require an update PASRR has one completed and sent to the BLTC for a Level II screening as appropriate.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p>		

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F 645	Continued From page 9 a nursing facility and her symptoms were stable, therefore she was exempt from a level II PASRR. Resident #13's PASRR, dated 3/23/17, documented she had depressive disorder and was taking bupropion 0.5 mg and venlafaxine 37.5 mg for Major Depressive Disorder, and klonopin 0.5 mg for anxiety. There was no documentation in Resident #13's clinical record a level II PASRR screening was completed or whether or not she required specialized services for her mental issues. On 6/27/18 at 10:00 AM, the Administrator said the Social Worker who was responsible for completing the PASRR form was no longer in the facility. She said Resident #13 should have had a level II PASRR completed.	F 645	The facility SSD completed a PASRR training. The IDT was in-serviced on current PASRR regulations. The facility PASRR monitoring policy was reviewed and updated. The Admissions Director will verify a completed PASRR prior to facility admission. The SSD will review PASRR at the time of admission, at the 72-hour care conference and will the resident's quarterly assessment for completion and accuracy. The SSD will maintain a PASRR "tickler file" for all PASRR indicating short term placement and will facilitate the update of the PASRR accordingly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. DNS and/or their designee will complete audit 1 X per week X 4 weeks, 1 X per month X 2 months and PRN thereafter. ED and DNS and/or designee will provide QAPI oversight during the daily clinical meeting and monthly Social Service PASRR reports.		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		7/31/18	

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F 656	Continued From page 10 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656			

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F 656	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans related to the use of psychotropic medications and resident preference to use a recliner for sleep for 2 of 12 residents (#13 and #17) whose care plans were reviewed. The residents' care plans did not address the identification of resident specific behaviors to monitor, behavioral goals, or resident-specific interventions to address behaviors exhibited, or the resident's preference to sleep in her recliner. This failure created the potential for harm if residents experienced continued anxiety, depression, or a deterioration in their physical and mental health status. Findings include:</p> <p>1. Resident care plans did not identify or address monitoring or interventions related to behavioral symptoms and ordered medications.</p> <p>a. Resident #17 was admitted to the facility on 5/11/17, with multiple diagnoses which included major depression.</p> <p>A Care Plan dated 6/5/17, documented Resident #17 had a diagnosis of chronic depression and received psychotropic medications to control these symptoms. The care plan did not include resident-specific behaviors the staff were to monitor or resident-specific interventions staff were to implement when she exhibited target behavioral symptoms.</p> <p>An annual MDS assessment dated 4/30/18,</p>	F 656	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #13 care plan and behavior monitor form was reviewed and updated as appropriate.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions(s) will be taken?</p> <p>Residents care plans and behavior monitors were reviewed and updated as appropriate.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>The IDT was in-serviced on the regulations and facility policy regarding care planning specifically, psychotropic medications, behavior interventions and resident preferences.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.</p> <p>The IDT will review during the Clinical meeting to identify an residents with</p>		

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F 656	<p>Continued From page 12</p> <p>documented Resident #17 was cognitively impaired, received antidepressant medications daily, and had no signs of depression.</p> <p>Behavior Monthly Flow Sheets, included the following:</p> <ul style="list-style-type: none"> - March 2018 - Resident #17 was monitored for agitation, anxiety, and depressed withdrawn. - April 2018 - Resident #17 was monitored for fear and/or panic, agitation, and anxiety. - May 2018 - Resident #17 was monitored for exhibiting poor eye contact, wandering, and depressed withdrawn. <p>A Psychoactive Drug and Behavior Medication Review Form, dated 5/3/18, documented a recent increase in behaviors which included exit-seeking and wandering. The Psychoactive Drug and Behavior Medication Review Form did not reflect documentation for the changes in the Behavior Monthly Flowsheets for the months of March 2018 and April 2018.</p> <p>The most recent mental health visit, dated 5/24/18, documented Resident #17 exhibited difficulty sleeping, exit-seeking behavior, and stayed in her room and rarely left her bed.</p> <p>On 6/27/18 at 4:15 PM, the DON stated she was not able to find documentation of resident-specific target behaviors or interventions to address behavioral symptoms on Resident #17's care plan.</p> <p>2. Resident #13 was admitted to the facility on</p>	F 656	<p>psychoactive medications that were new admissions, changes in current residents and newly initiated psychoactive medications and ensure that care plans were initiated and/or updated as appropriate.</p> <p>DNS and/or designee will monitor via 1 X per week audits X 4 weeks, 1 time per month X 2 months and PRN thereafter. SSD to provide a monthly QAPI report of residents on behavior monitors, psychoactive medications and care plan updates for the prior month.</p> <p>The ED and DNS and/or their designee will review during the monthly QAPI meeting.</p>		

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F 656	<p>Continued From page 13</p> <p>1/30/17, with multiple diagnoses which included bipolar disorder (mental disorder) and dementia.</p> <p>Resident #13's Annual MDS assessment, dated 1/27/18, documented she was cognitively intact, had no behaviors, no signs of depression, and received anti-depressant and anti-anxiety medications daily.</p> <p>Resident #13's Quarterly MDS assessment, dated 4/23/18, documented she was moderately cognitively impaired and had a feeling of being tired or having little energy several days of the week.</p> <p>Resident #13's recapitulated Physician's Order for April 2018, May 2018 and June 2018, documented she was to receive bupropion hcl (hydrochloride) 75 mg for Major Depressive Disorder and klonopin 0.25 mg for Somatization Disorder (mental illness which causes pain).</p> <p>Resident #13's care plan, documented she had anxiety and depression triggered by changes in daily routine and health status. The goal, with a goal date of 7/31/18, was for Resident #13's symptoms of anxiety and depression to be controlled with minimal side effects over the next quarter. Interventions included in the care plan were "Engage Resident #13 in group/individual activities that reduce periods of anxiety. Monitor for side effects of medication (drowsiness, loss of coordination, fatigue, mental slowness...). Provide quiet atmosphere with one-on-one support during periods of increased anxiety...Record behavior on Behavior Tracking Form." The care plan did not indicate Resident #13's specific type behaviors or how she</p>	F 656			

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F 656	<p>Continued From page 14 manifested her anxiety or depression.</p> <p>Behavior Monthly Flow Sheets for Resident #13 included the following:</p> <ul style="list-style-type: none"> - January 2018 - Resident #13 was monitored for anxiety and being depressed withdrawn. - February 2018 - Resident #13 was monitored for agitation, anxiety, and continuous crying. - March 2018 - Resident #13 was monitored for anxiety, being depressed, withdrawn and mood changes. - April 2018 - Resident #13 was monitored for being agitated and depressed, withdrawn, and angry. - May 2018 - Resident #13 was monitored for anxiety, being agitated and continuous crying. <p>The Behavior Monthly Flow Sheet, documented Resident #13 had not demonstrated any behaviors.</p> <p>Resident #13's Psychoactive Drug and Behavior Medication Review Form documented on 1/16/18, there was a failed Gradual Dose Reduction (GDR) of klonopin since restart and there were no new behaviors or outbursts. Resident #13's plan of care was to be continued. On 5/2/18, Resident #13's plan of care was to be continued.</p> <p>Resident #13's Nursing Notes, dated 1/31/18 through 6/3/18, documented she had no behaviors.</p>	F 656			

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F 656	Continued From page 15 On 6/26/18 at 9:00 AM, Resident #13 was observed with other residents in the Day Room participating in the Restorative Program. At 11:34 AM, Resident #13 was observed sitting in her recliner in her room reading a Reader's Digest book with her room door open. On 6/27/18 at 10:47 AM, the DON said Resident #13's care plan did not document her specific target behaviors and she did not know the reason why Resident #13 was monitored for different behaviors monthly.	F 656			
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure physicians wrote, signed, and dated progress notes for each resident. This was true for 1 of 12	F 711	What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	7/31/18	

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F 711	<p>Continued From page 16 residents (#17) whose records were reviewed. This had the potential for lack of care and services needed by residents in the facility and created the potential for harm to residents who may not have received ordered care and services. Findings include:</p> <p>Resident #17 was admitted to the facility on 5/11/17, with multiple diagnoses which included major depression.</p> <p>Resident #17 was transported to the physician's office by the facility staff for appointments. Resident #17's medical record did not reflect physician visits.</p> <p>On 6/27/18 at 3:45 PM, the DON provided 2 faxed forms that documented the facility requested the physician's office to provide a signed copy of the office note for the visits Resident #17 had on 1/10/18 and on 3/29/18. Communication Result Reports, dated 2/2/18 and 4/19/18, requested the progress notes for the physician visits which occurred on the above listed dates. The DON stated the physician's office did not provide the documentation requested.</p>	F 711	<p>Resident #17 physician progress not able to be obtained as a result of provider and facility discrepancy. The situation was reviewed with the facility Medical Director.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions(s) will be taken?</p> <p>Resident physician visit schedule was reviewed and charts were audited for corresponding progress notes.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>The facility policy on physician visits and documentation was reviewed and updated. The IDT was in-serviced on the facility policy and procedures for documenting physician visits and obtaining corresponding notes.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.</p> <p>The IDT will review during the daily Clinical meeting to identify any residents who had a physician visit and the location of the corresponding progress note. DNS and/or their designee will audit</p>		

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F 711	Continued From page 17	F 711	physician visits and documentation 1 X per week X 4 weeks, 1 time per month X 2 months, PRN thereafter and during the employees annual evaluation. The ED and DNS and/or their designee will review during the monthly QAPI meeting.		
F 757 SS=D	<p>Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)</p> <p>§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents receiving a psychoactive medication had resident-specific target behaviors identified</p>	F 757	What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	7/31/18	

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F 757	<p>Continued From page 18</p> <p>and monitored, and had an appropriate indication for use for these medications. This was true for 2 of 5 (#13 and #17) sampled residents who received psychoactive medications. This deficient practice created the potential for harm if residents received medications that may result in negative outcomes without clear indication of need. Findings include:</p> <p>1. Resident #17 was admitted to the facility on 5/11/17, with multiple diagnoses which included major depression.</p> <p>A Care Plan dated 6/5/17, documented Resident #17 had a diagnosis of chronic depression and received psychotropic medications to control these symptoms. The care plan did not include resident-specific behaviors the staff were to monitor or interventions staff were to implement when she exhibited target behavioral symptoms.</p> <p>An annual MDS assessment dated 4/30/18, documented Resident #17 was cognitively impaired, received antidepressant medications daily, and had no signs of depression.</p> <p>A facility Psychoactive Drug and Behavior Medication Review Form, dated 5/3/18, documented Resident #17 had a recent increase in behaviors which included exit-seeking and wandering.</p> <p>The most recent mental health visit, dated 5/24/18, documented staff reported Resident #17 exhibited periods of difficulty sleeping, exit-seeking behavior, and stays in her room and rarely leaves her bed. The visit note documented Resident #17 had good eye contact and stated</p>	F 757	<p>Resident #13 and #17 care plans and behavior monitors were reviewed and updated as appropriate.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions(s) will be taken?</p> <p>Residents who received psychotropic medications care plans and behavior monitors were reviewed and updated accordingly.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>The IDT was in-serviced on the facility policy for care planning psychoactive medications and behavior monitoring. Residents psychoactive Drug and Behavior Medication Review assessment and care plans will be reviewed and updated accordingly Q 3 months.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.</p> <p>The IDT will review during the daily Clinical Meeting to identify any Residents with psychoactive medications that were new admissions, changes in current residents and newly initiated psychoactive</p>		

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F 757	<p>Continued From page 19 she prefers to usually stay alone in her room.</p> <p>Resident #17's physician orders for June 2018, included bupropion ER (antidepressant) 150 mg, 2 tablets by mouth for major depressive disorder, mirtazapine (antidepressant) 15 mg by mouth at bedtime for major depressive disorder, and Depakote (mood stabilizer) 125 mg, 2 capsules two times daily.</p> <p>The facility Behavior Monthly Flowsheets provided staff 38 standardized choices of exhibited behaviors and 12 standardized choices for interventions to select. The flowsheet did not document resident-specific behavior related to anxiety and depression. Each of the target behaviors were monitored each shift during the day, evening, and night. The form directed staff to enter the number of times the behavior occurred, the intervention/drug used, and the outcome.</p> <p>A Behavior Monthly Flowsheet, dated March 2018, directed the staff to monitor for and document the number of episodes of Resident #17 being agitated, exhibiting anxiety, being depressed and withdrawn. The Behavior Monthly Flowsheet documented 13 days that reflected Resident #17 of being depressed and withdrawn on day and evening shift in the month of April 2018.</p> <p>A Behavior Monthly Flowsheet, dated April 2018, directed the staff to monitor for and document the number of episodes of Resident #17 being afraid, panicked, agitated, or anxious. The Behavior Monthly Flowsheet reflected 6 episodes of agitation on evening shift in the month of April</p>	F 757	<p>medications and ensure that care plans and behavior monitors were initiated and/or updated as appropriate.</p> <p>The IDT will review residents according to their quarterly MDS schedule and PRN during the weekly Psychotropic and Behavior Management Meeting.</p> <p>DNS and/or their designee will monitor via weekly audits X 4 weeks, monthly audits X 2 months and PRN thereafter.</p> <p>The ED and DNS and/or their designee will review during the monthly QAPI meeting.</p>		

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F 757	<p>Continued From page 20 2018.</p> <p>A Behavior Monthly Flowsheet, dated May 2018, directed the staff to monitor for and document the number of episodes of Resident #17 being depressed or withdrawn, having poor eye contact, and wandering. The Behavior Monthly Flowsheet documented 2 episodes of wandering on night shift in the month of May 2018.</p> <p>On 6/27/18, the DON stated she was not able to determine why the behaviors monitored changed monthly.</p> <p>The facility failed to ensure resident-specific target behaviors and interventions were in place for the staff to monitor to have a positive outcome for Resident #17.</p> <p>2. Resident #13 was admitted to the facility on 1/30/17, with multiple diagnoses which included bipolar disorder (mental disorder) and dementia.</p> <p>Resident #13's Annual MDS assessment, dated 1/27/18, documented she was cognitively intact, had no behaviors, no signs of depression, and received anti-depressant and anti-anxiety medications daily.</p> <p>Resident #13's Quarterly MDS assessment, dated 4/23/18, documented she was moderately cognitively impaired and had a feeling of being tired or having little energy several days of the week.</p> <p>Resident #13's recapitulated Physician's Order for April 2018, May 2018 and June 2018, documented she was to receive bupropion hcl</p>	F 757			

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F 757	<p>Continued From page 21 (hydrochloride) 75 mg for Major Depressive Disorder and klonopin 0.25 mg for Somatization Disorder (mental illness which causes pain).</p> <p>Resident #13's care plan, documented she had anxiety and depression triggered by changes in daily routine and health status. The goal, with a goal date of 7/31/18, were for Resident #13's symptoms of anxiety and depression to be controlled with minimal side effects over the next quarter. Interventions included in the care plan were "Engage Resident #13 in group/individual activities that reduce periods of anxiety. Monitor for side effects of medication (drowsiness, loss of coordination, fatigue, mental slowness...). Provide quiet atmosphere with one-on-one support during periods of increased anxiety...Record behavior on Behavior Tracking Form." The care plan did not indicate Resident #13's specific type behaviors or how she manifested her anxiety or depression.</p> <p>Behavior Monthly Flow Sheets for Resident #13 included the following:</p> <ul style="list-style-type: none"> - January 2018 - Resident #13 was monitored for anxiety and being depressed, withdrawn. - February 2018 - Resident #13 was monitored for agitation, anxiety, and continuous crying. - March 2018 - Resident #13 was monitored for anxiety, being depressed, withdrawn, and mood changes. - April 2018 - Resident #13 was monitored for being agitated and depressed, withdrawn, and angry. 	F 757			

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F 757	<p>Continued From page 22</p> <p>- May 2018 - Resident #13 was monitored for anxiety, being agitated, and continuous crying.</p> <p>The Behavior Monthly Flow Sheet, documented Resident #13 had not demonstrated any behaviors.</p> <p>Resident #13's Psychoactive Drug and Behavior Medication Review Form documented on 1/16/18, there was a failed Gradual Dose Reduction (GDR) of klonopin since restart and there were no new behaviors or outbursts. Resident #13's plan of care was to be continued. On 5/2/18, the form stated there were 2 failed attempts of bupropion and klonopin and Resident #13 did not exhibit new behaviors. Resident #13's plan of care was to be continued.</p> <p>Resident #13's Nursing Notes, dated 1/31/18 through 6/3/18, documented she had no behaviors.</p> <p>On 6/26/18 at 9:00 AM, Resident #13 was observed with other residents in the Day Room participating in Restorative Program. At 11:34 AM, Resident #13 was observed sitting in her recliner in her room reading a Reader's Digest book with her room door open.</p> <p>On 6/27/18 at 10:47 AM, the DON said Resident #13's care plan did not document her specific target behaviors and she did not know the reason why Resident #13 was monitored for different behaviors monthly.</p> <p>The facility failed to ensure resident specific behaviors were documented and monitored</p>	F 757			

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F 757	Continued From page 23	F 757			
F 812 SS=F	<p>adequately to determine the ongoing necessity of psychotropic medications.</p> <p>Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen. This affected 12 of 12 (#1, #8, #13, #15, #16, #17, #22, #24, #36, #37, #40, and #91) sample residents who resided in the facility and the 32 other residents who dined in the facility. This failure created the potential for harm if residents contracted foodborne illnesses. Findings include:</p>	F 812	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>There was no specific resident identified and there was no negative outcome to the residents.</p> <p>How the facility will identify other residents having the potential to be</p>	7/31/18	

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F 812	Continued From page 24 On 6/27/18 at 4:50 PM, DS #1 was observed wearing an apron during the dish washing process. DS #1 removed clean dishes from the dishwasher and stacked them on a 3-tier cart. DS #1 placed a dirty dish tub in the dishwasher and removed it when the cleaning process was completed. DS #1 then placed multiple dirty baking sheets, one at a time, in the dishwasher and removed them when the cleaning process was completed. DS #1 did not change his apron after handling dirty dishes and kitchen supplies prior to handling clean dishes and kitchen supplies, or when moving between the dirty and clean areas of the kitchen. DS #1 stated he did not know about changing his apron between the clean and dirty sections. He stated he would change his apron after the work was done or if the apron he was wearing became messy. On 6/28/18 at 4:30 PM, the CDM stated DS #1 was trained to change his apron between the dirty to clean areas in the kitchen.	F 812	affected by the same deficient practice and what corrective actions(s) will be taken? There was no specific resident identified and there was no negative outcome to the residents. Measures the facility will take or the systems it will alter to ensure that the problem does not recur. Kitchen staff in-serviced on the facility policy on changing of aprons in the dish room. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The Food and Nutrition Services Director and/or their designee will provide visual audits on the staff in the dish room 1 X per week X 4 weeks, 1 X per month for 2 months and PRN thereafter. The ED and DNS and/or their designee will review the audits during the monthly QAPI meeting.		
F 883 SS=F	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative	F 883		7/31/18	

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F 883	<p>Continued From page 25</p> <p>receives education regarding the benefits and potential side effects of the immunization;</p> <p>(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;</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 influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p>	F 883			

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F 883	<p>Continued From page 26</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and record review, it was determined the facility failed to initiate, update, and implement a tracking process to minimize the risk of residents acquiring, transmitting, or experiencing complications from the pneumococcal (bacterial) pneumonia. this was true for 5 of 5 residents (#1, #15, #36, #37, #91) reviewed for pneumococcal vaccines and the other 41 residents who resided in the facility. These failed practices represented a systemic failure which increased residents' risk for contracting pneumonia with its associated complications of infection of the blood and covering of the brain and spinal cord which could cause death or brain damage. Findings include:</p> <p>On 6/27/18 at 1:08 PM, the DON stated the facility's immunizations were not being tracked until after the facility standards state call regarding immunizations. She was observed calling a pharmacy and requesting a list of the immunizations which were sent to the facility. The DON was unable to provide a tracking system that showed who received the vaccines, which vaccine was received, when the next vaccination was due, and who refused and the reason why it was refused.</p>	F 883	<p>Requesting the INFORMAL DISPUTE RESOLUTION (IDR) Process What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Residents charts were audited, records requested from MD office and consents were signed.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions(s) will be taken?</p> <p>Residents charts were audited, records requested from MD and consents signed.</p> <p>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</p> <p>Pneumococcal consents placed in new admission nursing packets. Admitting nurses were in-serviced on the need for obtaining vaccination records.</p>		

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F 883	<p>Continued From page 27</p> <p>A Pneumococcal Vaccination policy, updated October 2015, stated a log was maintained documenting the number of residents who received each version of the vaccine (PCV 13, PPSV 23) and those residents who refused or did not receive the vaccine. Residents who received a vaccine were to have it documented in their immunization record. The policy further stated pneumococcal vaccination occurred at the facility per the CDC guidelines.</p> <p>The Centers for Disease Control and Prevention (CDC) website, accessed 7/11/18, included recommendations for Pneumococcal vaccination (PCV 13 and PPSV 23) for all adults 65 years or older. The recommendations stated adults who were 65 years or older, who had not previously received PCV 13, should receive a dose of PCV 13 first. A dose of PPSV 23 should occur 1 year later. The recommendations stated if a resident already received 1 or more doses of PPSV 23, the dose of PCV 13 should be given at least 1 year after they received the most recent dose of PPSV 23.</p> <p>The facility policy was not followed. Examples include:</p> <p>a. Resident #1 was admitted to the facility on 9/21/16, with diagnoses which included hypothyroidism, vitamin D deficiency, deficiency of other nutrient elements, and muscle weakness.</p> <p>A Pneumococcal Vaccine consent, dated 6/14/18, documented verbal consent from a family member of Resident #1 for a pneumococcal vaccine to be given. There was no</p>	F 883	<p>Consents or declines will be obtained for existing residents no later than July 2, 2018.</p> <p>Vaccinations will be ordered and placed on the July MARS for administration. New admissions will be reviewed during the morning clinical meeting for vaccination information and consents. Residents vaccination records will be reviewed during their scheduled assessment period. (Quarterly)</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.</p> <p>Infection control nurse will maintain a tickler system to monitor vaccination status of the residents. Infection control nurse will report to the DNS and the QAPI team Q month. ED and DNS and/or their designee will monitor the immunization program during the monthly Infection Control/QAPI meeting.</p>		

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F 883	<p>Continued From page 28</p> <p>documentation which vaccine (PCV13 or PPSV23) was consented to.</p> <p>Resident #1's Immunization record did not include documentation of a pneumococcal vaccination.</p> <p>b. Resident #15 was admitted to the facility on 2/6/17, with diagnoses which included muscle weakness, legally blind, and polyosteoarthritis.</p> <p>A Pneumococcal Vaccine consent, dated 6/14/18, was signed by the resident. There was no documentation which vaccine (PCV13 or PPSV23) was consented to.</p> <p>Resident #15's Immunization record did not include documentation of a pneumococcal vaccination.</p> <p>c. Resident #36 was admitted to the facility on 3/26/18, with diagnoses which included COPD, nutritional deficiency, vitamin deficiency, muscle weakness, cerebral infarct (stroke), and shortness of breath.</p> <p>A Pneumococcal Vaccine consent, dated 6/14/18, was signed by the resident. There was no documentation which vaccine (PCV13 or PPSV23) was consented to.</p> <p>Resident #36's Immunization record did not include documentation of a pneumococcal vaccination.</p> <p>d. Resident #37 was admitted to the facility on 5/21/18, with diagnoses which included displaced fracture of the left femur, weakness, and diabetes</p>	F 883			

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F 883	Continued From page 29 type II. A Pneumococcal Vaccine consent, dated 6/21/18, documented Resident #37 refused the pneumococcal vaccine because she already had it. There was no documentation which vaccine she received or the date it was given. There was no documentation which vaccine (PCV13 or PPSV23) was refused. e. Resident #91 was readmitted to the facility on 6/25/18, with diagnoses which included vitamin deficiency, nutritional deficiency, heart failure, COPD, muscle weakness, and pulmonary embolism. A Pneumococcal Vaccine consent, dated 6/25/18, documented Resident #91 consented to receive a pneumococcal vaccine. There was no documentation which vaccine (PCV13 or PPSV23) was consented to.	F 883			



IDAHO DEPARTMENT OF
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April 10, 2019

Mindy Shepard, Administrator
Royal Plaza Health & Rehabilitation
2870 Juniper Drive,
Lewiston, ID 83501-4720

Provider #: 135116

Dear Ms. Shepard:

On **June 25, 2019** through **June 29, 2018**, an unannounced on-site complaint survey was conducted at Royal Plaza Health & Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007789

ALLEGATION #1:

A resident's physical therapy was discontinued and it was not explained to the family member.

FINDINGS#1:

During the investigation resident records were reviewed including the Physical Therapy and Occupational Therapy notes for Quality of Care issues. The facility's Grievance Files were also reviewed. The Physical Therapist (PT) and Occupational Therapist (OT) were interviewed regarding their programs. The Business Office Manager was interviewed regarding their notification of residents of Notice of Medicare Non-Coverage.

One resident's PT and OT notes including her progress notes, treatment encounter notes and discharge notes were reviewed. The frequency of treatments was 6 times per week for a duration of 4 weeks. It was documented the identified resident was discharged from her PT and OT skilled services program due to the resident's limited progress with the program related to her refusals and lack of motivation to participate.

Mindy Shepard, Administrator
April 10, 2019
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The resident's record included a Notice of Medicare Non-Coverage form documented the entire content of the form including why Medicare services had ended and that this was explained to the family member over the phone. The telephone number of the Quality Improvement Organization (QIO) which was the independent reviewer authorized by Medicare to review decision to end these services was also provided to the family member. The form was signed by the family member.

A nursing notes documented the resident's appeal to continue Medicare services was denied, and a second appeal was in process. A subsequent nursing note documented the resident's second appeal for Medicare services was denied and the independent reviewer agreed to end Medicare services.

Based on the investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj