



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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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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August 11, 2018

Breanna McKay, Administrator
Lewiston Of Cascadia
3315 8th Street,
Lewiston, ID 83501-4966

Provider #: 135021

Dear Ms. McKay:

On **July 27, 2018**, a survey was conducted at Lewiston 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.

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 **August 21, 2018**. Failure to submit an acceptable PoC by **August 21, 2018**, may result in the imposition of civil monetary penalties by **September 13, 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*.

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 Monetary Penalty

Denial of payment for new admissions effective October 27, 2018

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 27, 2019**, 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.

Breanna McKay, Administrator
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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:

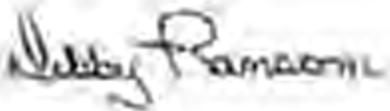
- BFS Letters (06/30/11)

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

This request must be received by **August 21, 2018**. If your request for informal dispute resolution is received after **August 21, 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

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August 11, 2018
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/27/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2018
NAME OF PROVIDER OR SUPPLIER LEWISTON OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted July 23, 2018 to July 27, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Linda Kelly, RN Presie Billington, RN</p> <p>ABBREVIATIONS:</p> <p>ADL = Activities of Daily Living BM = bowel movement cm = centimeters CNA = Certified Nursing Assistant cont = continue DC = Discontinued DNS = Director of Nursing d/t = due to ER = Emergency Room fib = fibula (the smaller of the two bones in the lower leg) fx = fracture LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MD = physician or doctor MDS = Minimum Data Set mg = milligrams prn = as needed qd = every day RCM = Resident Care Manager RLE = Right lower extremity RN = Registered Nurse SDTI = Suspected Deep Tissue Injury</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

08/21/2018

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 000	Continued From page 1 TAR = Treatment Administration Record tib = Tibia (the larger of the two bones in the lower leg) TX or tx = treatment x = by	F 000			
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs.	F 553		9/10/18	

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F 553	<p>Continued From page 2</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff and resident interview and record review, it was determined the facility failed to ensure residents or their representatives were included in the care conference meeting. This was true for 1 of 18 residents (#37) whose care plans were reviewed. The deficient practice created the potential for harm if care was provided in a way inconsistent with the resident's needs and preferences. Findings include:</p> <p>Resident #37 was admitted to the facility on 5/26/18 with multiple diagnoses, including major depressive disorder.</p> <p>Resident #37's admission MDS assessment, dated 6/2/18, documented she was cognitively intact, had moderate depression, with symptoms of little interest or pleasure in doing things and feeling down, depressed or hopeless several days of the week, feeling tired or having little energy almost every day, and received anti-depressant and anti-anxiety medications daily.</p> <p>On 7/24/18 at 1:53 PM, Resident #37 said she could not remember if she had a care conference with the facility.</p> <p>Resident #37's Licensed Social Worker (LSW) Notes documented:</p> <p>* 5/31/18- LSW spoke to the resident and care conference was scheduled on June 5, 2018 at 3:00 PM.</p>	F 553	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Transitional Care of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F553: Right to Participate in Planning Care</p> <p>Resident Specific:</p> <p>The clinical management team has reviewed resident #37 and a care conference has been completed with the resident participating in her planning of care.</p> <p>Other residents:</p> <p>The clinical management team reviewed other residents for missing care conferences and participation in the planning of their care. Adjustments have been made as indicated.</p>		

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F 553	Continued From page 3 * 6/5/18- Resident had an unexpected doctor's appointment "will have to reschedule care conference that was set for today." * 6/19/18 - LSW spoke to different agencies to see if they could help move resident belongings from her trailer to a new apartment... * 6/26/18- LSW spoke to [name of company] help move resident's belongings from her trailer to her new apartment... On 7/25/18 at 3:33 PM, the LSW reviewed Resident #37's clinical record and said she could not find the care conference documentation. The LSW said Resident #37's care conference was scheduled on June 5, 2018, but the resident had an unexpected doctor's appointment. The LSW said the care conference was to be rescheduled, however, she did not set a date. The LSW said she would talk to Resident #37 and schedule a care conference.	F 553	Facility systems: Social service is responsible for coordinating care conferences and validating that they are completed in the required time. Education has been provided by the Executive Director and/or designee to include but not limited to; completion of 48-hour care conference regulation and plans to address resident's inability/refusal to participate. This system is amended to include oversight by the Executive Director with review in clinical meeting for upcoming and completed care conferences. Monitor: Executive Director and/or designee will audit completion of 48-hour care conferences for all new admissions weekly for 4 weeks, and then 2 new admissions weekly for 8 weeks. Starting the week of September 10th, 2018. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance: September 10th, 2018.		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice	F 585		9/10/18	

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F 585	<p>Continued From page 4</p> <p>grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:</p> <p>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of</p>	F 585			

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F 585	Continued From page 5 independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;	F 585			

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F 585	<p>Continued From page 6</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident and staff interviews, review of facility grievances, and record review, it was determined the facility failed to identify and handle a resident's verbal grievance of missing money and a coffee mug. This was true for 1 of 1 (#2) sampled resident who verbalized a grievance. This created a potential for psychosocial harm if a resident had a grievance and could not get someone to look into it.</p> <p>Findings include:</p> <p>Resident #2 was admitted to the facility on 1/9/17 with multiple diagnoses, including paraplegia (paralysis of the legs and lower body).</p> <p>A quarterly MDS assessment, dated 7/12/18, documented Resident #2 was cognitively intact.</p> <p>On 7/24/18 at 2:45 PM, Resident #2 stated he was missing two \$50 bills and a Seahawks coffee mug about a year ago. Resident #2 stated he notified the LSW and the facility did not replace his money or coffee mug.</p>	F 585	<p>F 585: Grievances</p> <p>Resident Specific:</p> <p>The clinical management team has reviewed Resident #2. Executive Director has identified the resident's grievance and completed an investigation. The facility has reimbursed resident #2 for his missing Seahawks cup and money.</p> <p>Other Residents</p> <p>The clinical management team interviewed residents who are able to communicate for unresolved grievances. Adjustments have been made as indicated.</p> <p>Facility Systems:</p> <p>Nursing staff, activity staff, therapy staff, and ID team have been educated on the reporting of grievances. Re-education</p>		

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F 585	<p>Continued From page 7</p> <p>The facility's grievance file from June 2017 through July 2018 was reviewed. There were no grievances completed for Resident #2.</p> <p>On 7/25/18 at 11:38 AM, the Administrator stated she was unaware of the missing money for Resident #2. The Administrator was unable to find a grievance filed for Resident #2. The Administrator stated she remembered Resident #2 was missing his Seahawks coffee mug, but it was found in the kitchen later in the day and returned to Resident #2.</p> <p>On 7/25/18 at 2:37 PM, the Administrator stated she did not fill out a grievance for the coffee mug, because she thought it was found. The Administrator stated she would talk with Resident #2, file a grievance for both the missing money and the Seahawks coffee mug, and would complete an investigation.</p> <p>On 7/25/18 at 2:50 PM, the LSW stated she recalled Resident #2 reporting to her he was missing money in an envelope quite awhile ago. The LSW stated she did not know how much he was missing, but remembered reporting the missing money in the morning meeting with the managers. The LSW stated she did not remember who the Administrator was at that time, but remembered when she stated Resident #2 was missing money, it seemed like the managers in the meeting were already aware of the missing money. The LSW did not fill out a grievance and after she verbally reported the missing money in the morning meeting, she did not follow up with Resident #2 or the facility staff. The LSW stated she thought the Seahawks coffee mug was found and did not follow up with</p>	F 585	<p>was provided by Director of Nursing and/or designee to include but not limited to reporting a grievance by completing a tool, follow up to the grievance for a plan, and IDT review of the grievance for resolution. This system has been amended to include oversight by the Executive Director and/or designee with validation of resident resolution in operations meeting.</p> <p>Monitor:</p> <p>Executive Director and/or designee will interview 5 residents weekly for 4 weeks for unresolved grievances, then 2 residents weekly for 8 weeks. Starting the week of September 10th, 2018. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of compliance:</p> <p>September 10th, 2018.</p>		

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F 585	Continued From page 8 Resident #2.	F 585			
F 641 SS=D	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, it was determined the facility failed to ensure residents' assessments reflected hospice services. This was true for 1 of 1 (#26) resident reviewed who received hospice services. This failure had the potential for harm if Resident #26's care plan was inaccurate and her specific needs related to her end of life care were not met. Findings include:</p> <p>Resident #26 was admitted to the facility on 9/5/17 with multiple diagnoses, including hospice care for lung cancer.</p> <p>The admission physician orders, dated 8/31/17, documented Resident #26 had hospice services.</p> <p>The admission MDS assessment, dated 9/12/17, documented Resident #26 did not receive hospice care.</p> <p>The quarterly MDS assessment, dated 12/13/17, documented Resident #26 did not receive hospice care.</p> <p>The quarterly MDS assessment, dated 3/12/18, documented Resident #26 did not receive hospice care.</p>	F 641	<p>F 641- Accuracy of Assessment:</p> <p>Resident Specific:</p> <p>Resident # 26 MDS was reviewed and modified to reflect Hospice services being provided.</p> <p>Other Residents:</p> <p>The Clinical management team reviewed all residents MDSs that are receiving Hospice services for accuracy. No additional adjustments were indicated.</p> <p>Facility systems:</p> <p>The MDS coordinator is responsible for validating the accuracy of the MDS coding per the RAI manual. Education was provided by the Director of Nursing and/or designee to include but not limited to; coding hospice services on the MDS per the RAI manual, and care plan accuracy. The system is amended to include oversight by the Director of Nursing with review for resident specific support services prior to submission.</p>	9/10/18	

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F 641	Continued From page 9 The quarterly MDS assessment, dated 6/7/18, documented Resident #26 did not receive hospice care. Resident #26's care plan, target date 9/20/18, documented Resident #26 was receiving hospice services, initiated 9/6/17. On 7/24/18 at 9:48 AM, Resident #26 stated she was admitted to the facility with hospice services due to a diagnosis of lung cancer. On 7/26/18 at 11:24 AM, the MDS Coordinator stated Resident #26 was admitted with hospice services. The MDS coordinator stated Resident #26's MDS assessments should have documented she was receiving hospice care.	F 641	Monitor: Director of Nursing and/or designee will audit all residents with new orders to receive hospice services for MDS/care plan accuracy, weekly for 4 weeks, and other residents currently on hospice with quarterly care conference starting the week of September 10th, 2018. Any concerns will be addressed immediately and will be reviewed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance: September 10th, 2018		
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 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	F 656		9/10/18	

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F 656	<p>Continued From page 10</p> <p>provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(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.</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, family, resident, and staff interview, and record review, it was determined the facility failed to ensure person-centered comprehensive care plans were developed and implemented to address residents' preferences. This was true for 2 of 18 sample residents (#2 and #30) reviewed for care plans. Resident #2's care plan did not address his preference to smoke in the facility's designated area and Resident #30's care plan did not address the resident's preference to have his bed positioned against a wall. The failure placed residents at risk of not having their preferences honored. Findings</p>	F 656	<p>F 656: Develop/ Implement Comprehensive Care Plan</p> <p>Resident Specific:</p> <p>The clinical team reviewed resident # 30s care plan. Resident #30s care plan was updated to reflect resident's preference for his bed to be positioned against a wall.</p> <p>The clinical team reviewed resident # 2 care plan. Resident #2 care plan has been updated to reflect his preference to</p>		

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F 656	<p>Continued From page 11 include:</p> <p>1. Resident #30 was originally admitted to the facility in 2015 and readmitted on 11/14/16 with multiple diagnoses including Huntington's disease (an inherited disorder that results in death of brain cells), chronic post-traumatic stress disorder, anxiety disorder, major depressive disorder, urinary retention, and constipation.</p> <p>A 7/11/18 significant change MDS assessment documented Resident #30 had moderately impaired cognition; and required extensive assistance with most ADLs, including bed mobility and transfers.</p> <p>Resident #30's bed was observed against the wall on the resident's right side on 7/24/18 at 10:30 AM, 10:37 AM, and 10:53 AM; on 7/25/18 at 8:22 AM; and, on 7/26/18 at 1:40 PM. On 7/24/18 at 8:19 PM, the resident's spouse said Resident #30 wanted his bed to be against the wall.</p> <p>Resident #30's care plan documented he was at high risk for falls with interventions for a wide mattress, revised 9/30/17; and to assist him to lay in the middle of the mattress, revised 10/5/17. The care plan also documented Resident #30's physical mobility was impaired and included interventions for extensive assistance with bed mobility and verbal cues, such as, "Move your feet off the edge of the bed" and "Push up with your right arm."</p> <p>The bed against the wall was not addressed in Resident #30's care plan.</p>	F 656	<p>smoke in the facility's designated area.</p> <p>Other Residents:</p> <p>The Clinical management team reviewed other residents for missing preferences reflected on the care plans. Adjustments have been made as indicated.</p> <p>Facility Systems:</p> <p>Nursing staff and MDS coordinator have been educated on completion of person-centered comprehensive care plans. Education was provided by Director of nursing and/or designee to include but not limited too; person-centered care plan completion/accuracy for position of beds against the wall and ability to smoke. This system is amended to include oversight by the Resident Care Managers nurse with review in the clinical meeting for new admissions and changes.</p> <p>Monitor:</p> <p>Resident care manager and/or designee will audit for accuracy of care plan completion to include resident's preferences. 5 residents will be reviewed weekly for 4 weeks and then 2 residents weekly for 8 weeks. Starting the week of September 10th, 2018. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12</p>		

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F 656	Continued From page 12 On 7/26/18 at 5:44 PM, the MDS Coordinator said Resident #30's care plan did not address his bed against the wall. 2. Resident #2 was admitted to the facility on 1/9/17 with multiple diagnoses, including paraplegia (paralysis of the legs and lower body). A quarterly MDS assessment, dated 7/12/18, documented Resident #2 was cognitively intact. On 7/24/18 at 2:51 PM, Resident #2 stated he smoked cigars independently at the facility's designated area when his puppy came to the facility for a visit. Resident #2 stated the person caring for his puppy had not been in, and would not be in until next week, for a visit. Resident #2 was not observed smoking a cigar during the survey. A smoking assessment, dated 1/10/17, documented Resident #2 was safe to smoke independently. A smoking assessment, dated 1/13/17, documented Resident #2 was safe to smoke independently when he was more mobile. Resident #2's care plan did not include Resident #2 wished to smoke at the facility. On 7/25/18 at 4:05 PM, the DNS stated Resident #2's care plan did not include his wishes to smoke at the facility.	F 656	weeks, as it deems appropriate. Date of Compliance: September 10th, 2018.		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		9/10/18	

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F 684	<p>Continued From page 13</p> <p>§ 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 record review, staff interview, review of post-fall investigations, and policy review, it was determined the facility failed to ensure professional standards of practice related to neurological checks were followed for 1 of 18 sample residents (#49) reviewed for standards of practice. The failure created the potential for harm if changes in Resident #49's neurological status went undetected and untreated after two falls, one of which resulted in a laceration to the left eyebrow. Findings include: The facility's Neurological Evaluation policy and procedure, dated 11/27/17, documented, "Neurological vital signs supplements the routine measurement of temperature, pulse rate, and respirations when a resident is suspected to have hit their head...has hit their head...The physician's order dictates the frequency of neurological evaluations." The neurological evaluation consisted of assessing the resident's level of consciousness, pupils and eye movement, and motor function response. The policy instructed staff to complete neurological evaluations every 15 minutes for an hour, then; every 30 minutes for an hour, then; every hour</p>	F 684	<p>F 684: Quality of care:</p> <p>Resident Specific:</p> <p>Resident #49 neurological status was assessed for a change. No change has been identified.</p> <p>Other Residents:</p> <p>The Clinical management team assessed other residents who have had unwitnessed falls or falls with impact to their head in the last 14 days for a change in their neurological status. No additional changes were identified.</p> <p>Facility Systems:</p> <p>Nursing staff are educated to post-fall neurological assessment protocol. Re-education was provided by Director of Nursing and/or designee to include but not limited to; post-fall neurological assessment completion for each of the identified times, incident report</p>		

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F 684	<p>Continued From page 14 for 2 hours, then; every 4 hours until the physician stated it was no longer necessary or in 72 hours if the resident's condition is stable and showing no signs and symptoms of neurological injury.</p> <p>Resident #49 was admitted to the facility on 2/2/18 with multiple diagnoses including hypertension and heart failure. She was readmitted on 2/14/18 with aphasia and dysphagia (loss of ability to understand or express speech) following a cerebral infarction (stroke).</p> <p>Post Fall Investigations documented Resident #49 had two unwitnessed falls, one on 5/13/18 at 6:00 PM and another on 5/22/18 at 9:45 PM, and neurological evaluations were initiated both times.</p> <p>Post Fall Investigation records documented there was no injury related to Resident #49's fall on 5/13/18 and that she sustained a laceration to the left eyebrow, swelling at the site, and no pain "except to site when touched" related to the fall on 5/22/18.</p> <p>Neurological Records documented Resident #49's neurological status was not consistently evaluated after the unwitnessed falls on 5/13/18 and 5/22/18. Regarding the fall on 5/13/18, the evaluations were not completed on 5/14/18 at 2:00 PM, 5/15/18 at 10:00 AM, 2:00 PM, 10:00 PM, and on 5/16/18 at 2:00 AM, and the evaluation on 5/15/18 at 6:00 AM did not include Resident #49's pupil size and reaction. Regarding the fall on 5/22/18, the evaluations were not completed on 5/23/18 at 9:00 PM or on</p>	F 684	<p>investigation protocol, and the process to validate each shift is aware of ongoing neurological monitoring required. The system is amended to include clinical management team review on rounds for completion of neurological assessments daily for at least 72 hours for unwitnessed falls or falls that with impact to the residents' head. Completed reports will be brought to clinical meeting for validation of completed neurological assessment.</p> <p>Monitor:</p> <p>The Director of Nursing and/or designee will audit residents with unwitnessed falls or falls that impact the residents' head for completion of post-fall neurological assessment each week for twelve weeks. Starting the week of September 10th, 2018. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance:</p> <p>September 10th, 2018</p>		

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F 684	Continued From page 15 5/25/18 at 9:30 AM and 1:30 PM. On 7/26/18 at 2:10 PM, DNS said she expected nurses to follow the neurological evaluation protocol. The DNS reviewed Resident #49's neurological evaluations related to falls on 5/13/18 and 5/22/18 and said the documentation was missing in some of the neurological assessments.	F 684			
F 686 SS=G	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, staff interview, policy review, record review, and review of Incident and Accident Reports, it was determined the facility failed to prevent the development of avoidable pressure ulcers. This was true for 2 of 4 (#30 and #106) residents reviewed for pressure ulcers. Resident #106 was harmed when daily assessments were not completed, physician orders were not clarified, and she developed 6 suspected deep tissue injuries that worsened to	F 686	F-686: Treatment/ Svcs to Prevent/ Heal Pressure Ulcer Resident Specific: Resident #106 is no longer in the facility Resident #30 pressure area is resolved Other residents:	9/10/18	

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F 686	<p>Continued From page 16</p> <p>unstageable pressure ulcers. The pressure ulcers were related to a brace placed on Resident #106's right lower leg following a fracture. Resident #30 harmed when the facility failed to ensure the catheter tubing positioned to his leg was properly placed and free of kinks and he developed a stage II pressure ulcer. Findings include:</p> <p>The facility's Prevention and Treatment of Pressure Ulcers and Other Skin Alterations policy, dated 11/21/17, documented, "The facility has a system in place to promote skin integrity, prevent pressure ulcer development/other skin alterations, promote healing of existing wounds consistent with professional standards of practice and prevent further development of additional skin alterations unless the individual's clinical condition demonstrates they are unavoidable... Avoidable means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate."</p> <p>1. Resident #106 was admitted to the facility on 4/2/12 with multiple diagnoses, including osteomyelitis (bone infection), history of pressure ulcers, and diabetes mellitus.</p> <p>Resident #106's annual MDS assessment, dated 9/20/17, documented Resident #106 was moderately cognitively impaired and required two person assistance with ADL's and transfers. The</p>	F 686	<p>Clinical management nursing staff assessed current residents with DME and internal/ external catheters for appropriate monitors/assessments and current skin impairment. Adjustments have been made as indicated.</p> <p>Facility systems:</p> <p>Nursing staff, therapy staff, management staff, activity staff, and clinical management team are educated to pressure ulcer prevention protocol. Re-education was provided by the Director of Nursing and/or designee to include but not limited to; identification of the DME and or internal/ external catheter which may create a potential skin impairment, clarification of MD orders as needed for assessment with frequency of removal or skin checks under device, and documentation on monitors to validate nursing completion. The system is amended to include review of new DME or catheter orders to validate monitoring is established Q shift for skin integrity and that it is documented as completed by the nurse as indicated on the TAR in clinical meeting.</p> <p>Monitors:</p> <p>The Director of Nursing and/or designee will review 5 residents with DME/catheters/pressure ulcers for skin breakdown, appropriate physician orders, and documentation of appropriate</p>		

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F 686	<p>Continued From page 17</p> <p>MDS assessment documented Resident #106 was at risk for pressure ulcers and had no unhealed pressure ulcers.</p> <p>An Incident and Accident Report, dated 11/2/17 at 4:30 PM, documented Resident #106 fell from the salon chair to the floor, landed on her left side, sustained a small abrasion to her nose, had range of motion to all extremities, and denied pain. After Resident #106 was assessed, two staff members transferred Resident #106 with a Hoyer lift to the wheelchair.</p> <p>A Weekly Skin Alteration Report, dated 11/2/17 at 9:30 PM, documented Resident #106 had an edematous (swollen) area with bruising to the right ankle and it extended in a proximal direction. The edematous area measured 11.5 x 6.5 cm and the bruised area measured 6.5 x 5.0 cm. The color was described as light purple and light green. Resident #106 had periodic pain that was relieved by pain medication.</p> <p>A Nurse's Progress Note, dated 11/3/17 at 3:02 PM, documented Resident #106 complained of severe right leg pain with increased swelling and bruising to the right leg up to the right knee. Resident #106 was sent to the ER for further evaluation per physician's order.</p> <p>An X-ray Report from the hospital, dated 11/3/17 at 5:54 PM, documented the impression of the right ankle for Resident #106 as follows:</p> <p>* "Mild comminuted (break or splinter of the bone into more than two fragments) spiral fracture of the distal tibial metadiaphysis (lower part of the shin bone) with mild displacement</p>	F 686	<p>assessment monitors for four weeks, then 2 residents weekly for eight weeks. Starting the week of September 10th, 2018. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance: September 10th, 2018</p>		

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F 686	<p>Continued From page 18</p> <p>* Spiral fracture of the distal fibula diaphysis (broken ankle) with minimal displacement</p> <p>* Severe osteoporosis"</p> <p>A Nurse's Progress Note, dated 11/3/17 at 9:14 PM, documented Resident #106 returned from the ER.</p> <p>An ER physician's order, dated 11/3/17, documented, "Keep boot on at all times, check skin periodically, non-weight bearing, elevate, follow up with [Orthopedic] Tuesday."</p> <p>The care plan area addressing Resident #106's skin integrity bruise on the right medial lower leg, dated 11/3/17, documented, "monitor daily, until resolved...Notify physician, for any adverse changes to affected area."</p> <p>A Nurse's Progress Note, dated 11/4/17 at 10:22 PM, documented, "Resident with slight increase in pain with movement to right LL (lower leg). Walking boot in place along with wrap. Toes are warm and blanchable. Resident with no sensation to bottom of foot."</p> <p>The November 2017 TAR, dated 11/4/17 and discontinued on 11/30/17, documented for licensed staff to "monitor bruise to the right medial lower leg, every day, until resolved. Update physician, for any adverse changes." The TAR was left blank from 11/4/17 to 11/26/17 and 11/29/17, indicating the monitoring did not occur.</p> <p>A physician's order from the Orthopedic physician, dated 11/7/17, documented Resident</p>	F 686			

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F 686	<p>Continued From page 19</p> <p>#106 had a "Tib/Fib Fx (fracture) treat with Tall Walking Boot; May open Front of boot and adjust air bladders 1 and 2 as needed; May remove ACE Bandage prn (as needed)."</p> <p>There was no documentation from 11/7/17 to 11/11/17 the facility requested clarification from the Orthopedic physician regarding when or why to remove the ACE bandage and how often the licensed staff should assess under the walking boot and ACE bandage on Resident #106's right lower leg.</p> <p>Resident #106's November 2017 TAR included the above orders by the Orthopedic physician and all the spaces for documentation were blank.</p> <p>Resident #106's November 2017 TAR and Nurse's Progress Notes from 11/7/17 to 11/11/17 did not contain documentation of the removal of the ACE bandage or opening the front of the walking boot to adjust the air bladders.</p> <p>A primary Physician's Progress Note, dated 11/10/17, documented, "Resident #106 did not like wearing the boot, but will wear it" and an Orthopedic physician was following her for her fractured right ankle.</p> <p>A Nurse's Progress Note, dated 11/12/17 at 8:14 PM, documented RN #2 removed the walking boot, ACE wrap, and webril (cotton pad) from Resident #106. RN #2 documented Resident #106 had "6 SDTI's (Suspected Deep Tissue Injuries) on RLE. Heel was 3.1 x 4 x 0 cm; lateral ankle was 1.6 x 3.4 x 0 cm; posterior foot and nearbase of 5th toe was 3 x 4 x 0 cm; anterior leg was 7.6 x 3.6 x 0 cm; anterior foot was 2.8 x 1.8 x</p>	F 686			

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F 686	<p>Continued From page 20</p> <p>0 cm, and near 1st metatarsal head was 0.8 x 1.2 x 0 cm. All areas are dark purple, not open."</p> <p>The care plan area addressing Resident #2's skin integrity, pressure ulcer, use of boot to RLE, dated 11/12/17, documented staff were to, "encourage/assist with frequent position changes; follow physician orders for skin care and treatment (Utilize Best Practice Guidelines); monitor for signs and symptoms of infection and report to physician for care and treatment or debride."</p> <p>On 11/12/17 at 8:20 PM, RN #2 requested clarification orders from Resident #106's primary physician to "check skin periodically."</p> <p>A physician' order by the primary physician, dated 11/13/17 at 4:03 PM, documented, "please call [Orthopedic physician's name] as she [Resident #106] may need a second x-ray to be sure the fx remains in place."</p> <p>Resident #106 was seen by the Orthopedic physician on 11/14/17. No new orders were received.</p> <p>An Orthopedic physician's order, dated 11/16/17, documented to remove Resident #106's boot on her right lower leg every day, apply a border foam dressing to the SDTIs, and to wrap her leg with an ACE wrap and then reapply the boot to her right lower leg.</p> <p>Resident #106's November 2017 TAR, dated 11/16/17, documented the above orders by the Orthopedic physician. The TAR was left blank on 11/17/17 and 11/18/17. The TAR was</p>	F 686			

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F 686	<p>Continued From page 21</p> <p>documented as "refused" on 11/16/17 and 11/19/17 with no explanation on the back of the TAR or in the Nurse's Progress Notes as to why Resident #106 "refused" the dressing changes.</p> <p>The Nurses' Progress Notes did not contain documentation of removing Resident #106's boot and ACE wrap to assess the SDTIs to her RLE from 11/13/17 to 11/19/17.</p> <p>A Weekly Pressure Ulcer Report, dated 11/20/17, documented, "this right heel wound has deteriorated from SDTI to an unstable wound. The right heel wound is now unstageable d/t (due to) necrotic (dead) tissue at site." The right heel measurement was 4.6 x 5.2 x 0 cm.</p> <p>A Weekly Pressure Ulcer Report, dated 11/20/17, documented the right ankle SDTI and the right anterior SDTI had merged to create one large wound. "Currently presents as a dark, fluid filled blister, bordered foam has a tacky covering, which could cause blister to open."</p> <p>A Skin/Wound Progress Note, dated 11/20/17 at 5:11 PM, documented, "SDTI's to right lower extremity are deteriorating. Right heel wound is now unstageable d/t necrotic tissue at site. Anterior leg wound is a blister, with very fragile skin covering blister. Current tx is bordered foam over SDTI's. Bordered foam has sticky convening (sic), putting fragile skin over blisters at risk of tearing...."</p> <p>Resident #2's care plan area addressing her skin integrity, pressure ulcer, use of boot to RLE, updated 11/20/17, documented, "TX/order."</p>	F 686			

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F 686	<p>Continued From page 22</p> <p>A physician's order, dated 11/20/17, documented, "DC Bordered foam to SDTI on RLE cont[inue] to remove RLE boot qd (every day). Apply nonadherent dressings to SDTI's. Wrap with ace wrap and reapply boot. Use two people for tx, one to support leg. Santyl (debridement treatment) to right heel qd. Apply nonadherent dressing."</p> <p>Resident #106's November 2017 TAR, dated 11/21/17, documented the above orders by the primary physician. The TAR was documented as "refused" on 11/21/17 and 11/26/17 with no explanation on the back of the TAR or in the nurses' progress notes on why Resident #106 "refused" the dressing treatment.</p> <p>A Nurse's Progress Note, dated 11/23/17 at 10:28 PM, documented Resident #106 dressings were changed on her RLE. The progress note documented, "Slight drainage noted to middle of shin area with skin peeling. Areas remain very dark brown." There was no documentation the physician was notified of the change.</p> <p>A Weekly Pressure Ulcer Report, dated 11/27/17, documented Resident #106's right unstageable heel ulcer measurement was 7 x 18 x 0 cm. RN #2 documented, "Heel wound has merged with other wounds, creating larger wound. Necrotic tissue remains on heel portion of wound. Will continue current tx, continue to monitor."</p> <p>A Weekly Pressure Ulcer Report, dated 11/27/17, documented Resident #106's right anterior foot ulcer measured 4.6 x 3.4 x 0 cm and had slightly decreased in size. The right lateral leg ulcer measured 2.5 x 2.2 x 0 cm. RN #2 documented,</p>	F 686			

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F 686	<p>Continued From page 23</p> <p>"This SDTI to right lateral leg is open, with dark covering to wound. Covering appears to be dried drainage rather than eschar (dark, leathery or hard dead tissue). Periwound area is without redness or edema. Will notify MD with request for tx change." The right posterior foot ulcer measured 4 x 6 x 0 cm, was stable, and the wound appeared to be fading. The right great toe ulcer measured 1.6 x 2.2 x 0 cm and was stable.</p> <p>The physician was not notified of the change of measurements to the right heel ulcer and that the right lateral leg was an open wound.</p> <p>A Nurse's Progress Note, dated 11/29/17 at 9:22 AM, documented Resident #106 was sent to the ER, "due to change in mental status, post tib-fib fx and resulting pressure related injuries to the Rt lower leg."</p> <p>An ER physician's order, dated 11/29/17, documented, "Change hard boot for heel protector on the right lower extremity to reduce pressure on the Mepilex dressings."</p> <p>A Nurse's Progress Note, dated 11/29/17 at 3:40 PM, Resident #106 returned from the ER with new orders to change hard boot for soft heel protectors and dressing changes to a Mepilex dressing every other day to right lower leg.</p> <p>Resident #106's December 2017 TAR, dated 11/30/17, documented, "Mepilex dressing change every other day for pressure ulcer treatment until resolved." The TAR was left blank on 12/2/17 and 12/4/17, indicating the dressing changes did not occur on those dates.</p>	F 686			

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F 686	<p>Continued From page 24</p> <p>A Weekly Pressure Ulcer Report, dated 12/4/17, documented Resident #106's unstageable pressure ulcer to right heel, measured 10 x 10 x 0 cm with black eschar in place. The right lateral leg measured 2.5 x 2.2 x 0 cm unstageable pressure ulcer with black eschar in place. The right ankle measured 8.2 x 11 x 0.1 cm unstageable pressure ulcer. RN #2 documented, "This right lateral ankle/anterior leg wound has deteriorated. Wound bed is irregularly shaped and is a mix of eschar and skin exposed by open blister." The physician was notified.</p> <p>A physician's order, dated 12/6/17, documented to discontinue Mepilex dressing and apply Silvasorb and cover the open areas with a nonadherent dressing, wrap loosely with kerlix, and replace rook boot (pressure relief) every day.</p> <p>Resident #106's December 2017 TAR, dated 12/8/17, documented the above orders for the Silvasorb. The TAR was left blank for 12/8/17 and 12/9/17, indicating the orders were not carried out on those dates.</p> <p>A Nurse's Progress Note, dated 12/9/17 at 10:45 AM, documented Resident #106 was sent to the ER for evaluation due to complaints of generalized unwell feeling and increased confusion.</p> <p>A Nurse's Progress Note, dated 12/9/17 at 5:32 PM, documented Resident #106 was admitted to the hospital for "treatment and cardiac observation."</p> <p>A hospital discharge summary, dated 12/11/17, documented Resident #106's X-rays show the</p>	F 686			

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

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F 686	<p>Continued From page 25</p> <p>fractures were not healing. The summary documented, "She has severe necrotic wounds, lower extremity, and it is clear she probably has some vascular compromise with superficial vessels from the fractures... The patient was seen by [Physician's name] who reiterates that patient needs more than just a debridement, that it likely needs amputation, but the patient would not tolerate that, and it was for the patient to go back to the facility with hospice."</p> <p>A Nurse's Progress Note, dated 12/11/17 at 9:51 PM, Resident #106 was readmitted to the facility and to continue with palliative care. Resident #106 passed away 12/12/17.</p> <p>On 7/27/18 at 9:00 AM, the DNS was unable to provide additional information that Resident #106's RLE was assessed daily from 11/4/17 to 11/12/17. The DNS stated the nurses should have documented daily assessments and notified the physician of changes to Resident #106's RLE. The DNS stated if the TAR was left blank that meant the treatment was not done.</p> <p>On 7/27/17 at 12:15 PM, RN #2 stated Resident #106's physician's orders on 11/4/17 should have been clarified that day as to what "skin checks periodically" meant and if the staff could have removed the boot to assess the RLE. RN #2 stated the Orthopedic physician would not respond when the facility faxed and called with clarification of orders. RN #2 stated Resident #106's primary physician kept referring clarification orders to the Orthopedic physician. RN #2 stated the brace to Resident #106's RLE caused pressure to her RLE.</p>	F 686			

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F 686	<p>Continued From page 26</p> <p>On 7/27/17 at 12:20 PM, the DNS and RN #2 stated the facility called the Orthopedic physician's office frequently to receive the dictation from the office visits on 11/7/17 and 11/14/17. The DNS stated the facility's Medical Director had several calls to the Orthopedic physician to receive dictation for the office visits. The facility received the dictation on 12/7/17.</p> <p>2. Resident #30 was originally admitted to the facility in 2015 and readmitted on 11/14/16 with multiple diagnoses including benign prostatic hyperplasia, urinary retention, and history of urinary tract infection.</p> <p>A 7/11/18 significant change MDS assessment documented Resident #30 had moderately impaired cognition; required extensive assistance for transfers, dressing, and toileting; used an external (condom) urinary catheter; and, a stage II pressure ulcer developed on 7/9/18.</p> <p>A 7/9/18 Skin Alteration Investigation for Resident #30 documented a blister to the left upper leg was found when his condom catheter tubing was "in improper position." The investigation included a statement by a CNA which documented, "Resident found on rounds with condom cath[eter] with penis positioned upward with kink in catheter - tube put pressure on leg causing water blister." It also contained a statement by an LPN which documented, "...upper leg near groin - water blister 3 cm x [by] 1 cm noted where cath[eter] tubing was resting on leg with pants on - skin was indented where penis & cath had been resting - that part now resolved." An attached Skin Alteration Incident Investigation Directive was dated 7/9/18 at 10:00 PM.</p>	F 686			

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F 686	Continued From page 27 Resident #30's care plan area addressing urinary incontinence, revised 12/28/16, documented he wore a condom catheter during the day. Interventions revised on 7/10/18 documented the staff were to keep the catheter tubing free from kinks, place the tubing over the leg, and secure the tubing with tape or a leg strap. Resident #30's care plan area addressing his actual alteration in skin integrity, revised 7/10/18, documented a "water blister to upper left leg" with interventions for the staff to monitor the placement of the catheter to prevent skin issues and maintain proper placement. Resident #30's care plan addressing his actual alteration in skin integrity related to a stage 2 pressure ulcer on his left upper thigh, initiated 7/17/18, included interventions for the staff to follow physician orders for care and treatment and to monitor for and report signs and symptoms of infection. Resident #30's active physician orders included a 4/13/16 order for a nurse to place the condom catheter one time a day and change the drainage bag daily with the condom catheter application. The active orders also included an order, starting on 7/12/18 and to be in place until the left thigh pressure ulcer resolved, for wound wash/skin prep to the "unbroken blister" and a foam border dressing every 3 days, and as needed for a missing or soiled dressing. On 7/24/18 at 10:37 AM, a clean, dry, and intact, approximately 4 inch by 4 inch padded bandage, dated 7/21/18, was observed on Resident #30's	F 686			

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F 686	<p>Continued From page 28</p> <p>left upper thigh as RN #4 applied his condom catheter. The RN also applied a leg strap above the resident's left knee and attached the catheter tubing to the strap. RN #4 said the bandage covered a blister that was "caused" by the catheter tubing.</p> <p>A 7/17/18 weekly pressure ulcer report documented the left thigh pressure ulcer size increased to 3.1 cm by 3.1 cm, it was a "bright red" reabsorbed blister, and the skin was fragile. A 7/24/18 weekly pressure ulcer report documented the pressure ulcer size decreased to 2.5 cm by 2.5 cm, the intensity of the color decreased, and the skin remained intact.</p> <p>On 7/25/18 at 3:10 PM, the DNS said Resident #30's left thigh blister was caused by pressure from the catheter tubing laying on his skin and that the catheter was not secured then. The DNS said the catheter tubing was being secured now. The DNS provided the facility's External Catheter policy and said the policy did not address securing the catheter. The DNS said the facility followed the Lippincott Manual of Nursing Practice, 10th edition, guidelines for standard of practice regarding securing urinary catheters. The DNS provided a copy of page 781 from the Lippincott Manual regarding securing the catheter and tubing placement.</p> <p>The Lippincott Manual documented urinary catheters should be secured to the patient's thigh using tape, strap, adhesive anchor, or other securement device, and to allow some slack of the tubing to accommodate the patient's movement. The rationale was that properly securing the catheter prevents catheter</p>	F 686			

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F 686	Continued From page 29 movement and traction on the urethra. The Manual also documented to keep the tubing over the patient's leg and that this tubing position helps prevent kinking or forming loops of stagnant urine.	F 686			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, and clinical record and policy review, it was determined the facility failed to ensure residents who smoked tobacco products were assessed at least quarterly per the facility's policy and a care plan was in place regarding the smoking. This was true for 1 of 4 sample residents (#2) reviewed for smoking. The failure created the potential for harm if Resident #2's smoking ability/needs/supervision changed since his last assessment on 1/13/17. Findings include: The facility's Smoking policy, dated 10/31/17, documented, "The Interdisciplinary Team (IDT) evaluates patients desiring to smoke for their ability to smoke independently or dependently upon admission, quarterly, with a significant change or as deemed necessary." Resident #2 was admitted to the facility on 1/9/17	F 689	F 689: Free of Accident Hazards/ Supervision/ Devices Resident specific: The clinical management team reviewed resident #2. Resident #2 has an updated smoking assessment that reviewed his ability/needs/supervision. No changes noted since last smoking assessment. Care plan has been updated to reflect resident's use of tobacco products and assessment findings. Other residents: The clinical management team reviewed other residents who smoke tobacco products for missing quarterly smoking assessments and corresponding care	9/10/18	

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F 689	<p>Continued From page 30 with multiple diagnoses, including paraplegia.</p> <p>A quarterly MDS assessment, dated 7/12/18, documented Resident #2 was cognitively intact.</p> <p>On 7/24/18 at 2:51 PM, Resident #2 stated he smoked cigars independently at the facility's designated area when his puppy came to the facility for a visit. Resident #2 stated the person caring for his puppy had not been in, and would not be in, until next week for a visit.</p> <p>Resident #2 was not observed smoking a cigar during the survey.</p> <p>A smoking assessment, dated 1/10/17, documented Resident #2 was safe to smoke independently.</p> <p>A smoking assessment, dated 1/13/17, documented Resident #2 was safe to smoke independently when he was more mobile.</p> <p>Resident #2's clinical record did not contain smoking assessments after 1/13/17.</p> <p>Resident #2's care plan did not include Resident #2 wished to smoke at the facility.</p> <p>On 7/25/18 at 4:05 PM, the DNS stated the facility completed a smoking assessment upon admission, quarterly, and as needed and included smoking in the residents' care plans. The DNS was unable to provide smoking assessments after the 1/13/17 assessment and evidence his desire to smoke was included in his care plan.</p>	F 689	<p>plan is in place. Adjustments have been made as indicated.</p> <p>Facility systems:</p> <p>Nursing staff, MDS coordinator, and social services staff are educated on completion of quarterly smoking assessments and care plan updates. Re-education was provided by the Director of Nursing and/or designee to include but not limited to; completion of quarterly smoking assessments, the facility's smoking policy, and accurate reflection of person-centered desires on the care plans. The system is amended to include oversight by the MDS coordinator with review in the clinical meeting for residents with upcoming quarterly reviews.</p> <p>Monitor:</p> <p>Resident Care Manager and/or designee will audit new admissions and residents with quarterly reviews for appropriate completion of quarterly smoking assessments and reflective care plans for twelve weeks. Starting the week of September 10th, 2018. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance:</p>		

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F 689	Continued From page 31	F 689	September 10th, 2018		
F 690 SS=D	<p>Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)</p> <p>§483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p>	F 690		9/10/18	

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NAME OF PROVIDER OR SUPPLIER LEWISTON OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
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F 690	<p>Continued From page 32</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and resident interview, review of the facility's bowel care protocol, and record review, it was determined the facility failed to consistently monitor bowel function and provide appropriate urinary (condom) catheter care for residents in accordance with standard nursing practice. This was true for 1 of 2 sampled residents (#206) for bowel care. The facility failed to implement a bowel protocol order for Resident #206. Resident #206 had the potential for harm from constipation or impaction. Findings include:</p> <p>1. Resident #206 was admitted to the facility on 7/18/18 with a diagnosis of stable burst fracture (traumatic spinal injury in which a vertebra is severely compressed) of unspecified lumbar vertebra (lower back).</p> <p>On 7/24/18 at 1:39 PM, Resident #206 said he had not had a bowel movement since he was admitted to the facility (7 days).</p> <p>The facility's Bowel Management Protocol included:</p> <ul style="list-style-type: none"> * Prune Juice 180 mls (milliliters), as necessary, for no bowel movement in 6 shifts. Give an extra 120 mls of water with each meal. * Lactulose 20 mg/30 mls, 2 tablespoons by mouth, up to three times a day as necessary, for no bowel movement in 9 shifts. * Dulcolax 10 mgs Suppository rectally, in early morning, for no bowel movement in 12 shifts. If no results within 6 hours call the medical doctor for further directives. 	F 690	<p>F 690: Bowel and Bladder</p> <p>Resident specific:</p> <p>The clinical team has reviewed resident #206 for implementation of facility bowel protocol and MD notification. Regular bowel movements are occurring.</p> <p>Other residents:</p> <p>The clinical management nursing staff has reviewed all residents for proper bowel protocol interventions in the last 7 days. Adjustments have been made as indicated.</p> <p>Facility Systems:</p> <p>Nursing staff are educated to the facility bowel protocol. Re-education was provided by Director of Nursing and/or designee to include but no limited to; the facility bowel protocol and physician specific directives, MD notification and monitoring. The system is amended to include oversight by the Director of Nursing with review of bowel monitors in the clinical meeting.</p> <p>Monitors:</p> <p>The Director of Nursing and/or designee will audit residents for timely use of facility bowel protocol/physician specific directives implementation three times</p>		

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F 690	<p>Continued From page 33</p> <p>Resident #206's July 2018's physician's admitting orders included:</p> <ul style="list-style-type: none"> * Prune Juice 180 mls - 3 times a day for no bowel movement in 48 hours (6 shifts), as needed. Give an extra 120 mls of water with meals. * Lactulose Solution 20 grams/30 mls - give 30 mls by mouth 3 times a day for no bowel movement in 72 hours (9 shifts), as needed. * Dulcolax Suppository 10 mgs - insert one suppository rectally in early morning for no bowel movement in 96 hours (12 shifts), as needed. If no results call medical doctor for directives. <p>Resident #206's Nurse's Progress Notes and physician's orders documented the following:</p> <ul style="list-style-type: none"> * 7/21/18 Nursing Progress Note - Resident #206 said he had not had a bowel movement since Sunday (7/15/18) but was able to pass gas. Resident #206 also stated he was not eating a lot. * 7/22/18 - A physician's order included Miralax 17.5 grams by mouth once a day in the morning, hold for loose stools and Colace 100 mg by mouth twice a day, hold for loose stools. <p>Resident #206's Bowel Movement Record, documented he did not have a bowel movement 7/18/18 through 7/24/18 (7 days)</p> <p>Resident #206's MAR, dated 7/18/18 to 7/23/18, did not include documentation he was given a Dulcolax Suppository 10 mg during the days he was constipated.</p>	F 690	<p>weekly twelve weeks. Starting the week of September 10th, 2018. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance: September 10th, 2018</p>		

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F 690	Continued From page 34 On 7/24/18 at 4:07 PM, RN #1 said a Dulcolax Suppository 10 mg should be given to a resident if the resident does not have a bowel movement for four days. RN #1 said she did not know why Resident #206 did not receive a Dulcolax Suppository.	F 690			
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 observation, record review and resident and staff interview, and policy review, it was determined the facility failed to ensure BiPAP (bilevel positive airway pressure/CPAP (continuous positive airway pressure) were not administered without a physician's order and care plans were revised to reflect resident's current respiratory needs. This was true for 2 of 2 residents (#32 and #55) reviewed who used a CPAP or BiPAP machine. These failures created the potential for residents' to experience increased respiratory problems if they did not receive treatment necessary to meet their respiratory needs. Findings include: The facility's CPAP/BiPAP Support Policy and Procedure, included the following documentation,	F 695	F 695: Respiratory/ Tracheostomy Care and Suctioning Resident Specific: Resident #55 is no longer in the facility The clinical team reviewed resident #32. Physician orders have been received to address the use of the residents' CPAP. Resident #32 care plan has been revised to reflect current respiratory needs. Other Residents: The clinical management nursing staff has reviewed other residents who utilize CPAP or BiPAP for proper physician	9/10/18	

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F 695	<p>Continued From page 35</p> <p>* Preparation:</p> <ul style="list-style-type: none"> - Review the resident's medical record to determine his/her baseline oxygen saturation - Review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure [positive end expiratory pressure] for the machine - Review and follow manufacturer's instructions for CPAP machine set-up and oxygen delivery. <p>* Procedures: Set mode settings on the machine, as prescribed..</p> <p>* Documentation: General assessment (including vital signs, oxygen saturation, respiratory, circulatory and gastrointestinal status) prior to procedure may indicate the following:</p> <ul style="list-style-type: none"> - Time CPAP was started, duration or the therapy - Mode and settings [for machine] - Oxygen concentration and flow if used - How the resident tolerated the procedure <p>1. Resident #55 was admitted to the facility on 11/01/17 and was readmitted on 6/13/18 with multiple diagnoses, which included morbid obesity and sleep apnea (sleep disorder in which breathing repeatedly stops and starts).</p> <p>Resident #55's admission MDS assessment, dated 5/9/18, did not document he used a BiPAP (bilevel positive airway pressure) machine.</p> <p>Resident #55's care plan identified the focus area, "...has altered respiratory status/difficulty of breathing/impaired breathing patterns r/t (related to) diagnosis of sleep apnea." One intervention was "BiPap [resident] will use his own BiPap</p>	F 695	<p>orders, cleansing directives, documentation on appropriate monitors, and person-centered care plan. The clinical management team reviewed current resident care plans for accurate respiratory needs. Adjustments have been made as indicated.</p> <p>Facility Systems:</p> <p>Nursing staff has been educated on the facility's CPAP/ BiPAP support policy. Re-education was provided by the Director of Nursing and/or designee to include but not limited to; the facility CPAP/BiPAP Support policy, necessary cleansing process, documentation of use, and care plans reflecting accurate respiratory needs. The system is amended to include oversight by Director of Nursing with review of new admissions and new orders obtained for appropriate implementation of facility CPAP/BiPAP Support policy and that care plans address resident current respiratory needs in the clinical meeting.</p> <p>Monitors:</p> <p>The Director of Nursing and/or designee will audit new admission and/or residents with new orders for CPAP/BiPAP devices for proper physician orders and care plans. In addition, documentation of CPAP/BiPAP use will be reviewed in clinical meeting for twelve weeks. Starting the week of September 10th, 2018. Any concerns will be addressed immediately</p>		

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F 695	<p>Continued From page 36 machine at sleep time..."</p> <p>On 7/25/18 at 8:42 am, Resident #55 was observed in his room. A BiPAP machine was noted on his side table next to a white plastic container of distilled water. Resident #55 said he used his BiPAP machine at night and the staff set it up for him.</p> <p>Resident #55's July 2018 active physician orders did not include an order for use of a BiPAP machine.</p> <p>Resident #55's June 2018 TAR, documented "BiPAP Machine Daily Care: Remove mask from head gear. Clean mask with warm soapy water or with a BiPAP wipe. Clean humidifier chamber with warm soapy water. Rinse the humidifier chamber with water and let air dry. Refill the water in the humidifier chamber using sterile or distilled water one time a day related to Sleep Apnea."</p> <p>Resident #55's July 2018 TAR did not include documentation about his BiPAP machine or its care and use,</p> <p>On 7/26/18 at 7:14 PM, RN #3 said Resident #55 had been in and out of the hospital and the order for resident's BiPAP "fell" in July 2018 because it was not on the discharge order from his latest hospitalization.</p> <p>2. Resident #32 was admitted to the facility on 3/5/18 with multiple diagnoses which included obesity and sleep apnea.</p> <p>Resident #32's quarterly MDS assessment, dated</p>	F 695	<p>and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. .</p> <p>Date of Compliance: September 10th, 2018</p>		

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F 695	<p>Continued From page 37 3/12/18, and annual MDS assessment dated 6/6/18, documented she was cognitively intact and did not use a CPAP/BiPAP machine.</p> <p>Resident #32's care plan identified a focus area initiated on 7/26/18 of "[resident] has Oxygen Therapy r/t [related to] CHF (congestive heart failure) and CPAP." Interventions were "give medications as ordered by physician, monitor/document side effects and effectiveness, monitor for signs and symptoms of respiratory distress and report to MD as necessary..."</p> <p>On 7/24/18 at 9:56 am, Resident #32 was observed in her room. A CPAP machine was observed on her side table. Resident #32 said she used the machine once or twice a week.</p> <p>Resident #32's July 2018 active physician orders included an order, dated 3/5/18, for the use of a BiPAP machine at night, which stated "BiPAP @ cmH2O Inspiration; cmH2O Expiration [on room air/with O2 at ___ liters [with/without] humidification." The order was incomplete and not consistent with the device in the resident's room and should have been clarified in March.</p> <p>Resident #32's June and July 2018 MARs and TARs did not include documentation of Resident #32's use of the CPAP machine.</p> <p>On 7/26/18, RN #3 said Resident #32 had a physician order for a CPAP machine but did not have documentation that it was administered to the resident.</p>	F 695			
F 698 SS=D	<p>Dialysis CFR(s): 483.25(l)</p>	F 698		9/10/18	

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F 698	<p>Continued From page 38</p> <p>§483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to communicate assessments with the dialysis center and assess a resident after returning from the dialysis center. This was true for 1 of 1 (#51) sample resident who received dialysis. This failure created the potential for harm if Resident #51 experienced complications and/or compromised medical status due to a lack of communication. Findings include:</p> <p>Resident #51 was admitted to the facility on 3/28/17 with multiple diagnoses, including end stage renal disease.</p> <p>Resident 51's quarterly MDS assessment, dated 7/6/18, documented Resident #51 was cognitively intact and received dialysis before and after admission to the facility.</p> <p>The facility's policy for Patients Receiving Dialysis, dated 10/1/17, documented, "The center provides the necessary medical and nursing care and treatment to manage the resident's end-stage renal disease. The center communicates resident information on the day of dialysis pertinent to receiving therapy. [FRM 66205] Dialysis Communication Record."</p> <p>Resident #51's care plan section addressing</p>	F 698	<p>F 698: Dialysis</p> <p>Resident specific:</p> <p>The clinical team has assessed resident #51 for complications and/or compromised medical status. Residents has had pre and post Dialysis Communication forms completed.</p> <p>Other residents:</p> <p>There are currently no other residents receiving dialysis services at this time.</p> <p>Facility Systems:</p> <p>Nursing staff educated on pre and post dialysis assessment completion and facility's dialysis policy. Re-education provided by Director of Nursing and/or designee to include but not limited to; pre and post Dialysis communication form completion, pre and post dialysis assessment of the resident/site, completion of the TAR, missing documentation on the TAR, and facility dialysis policy. The system is amended to include oversight by the Resident Care Manager with review in the clinical</p>		

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F 698	<p>Continued From page 39</p> <p>dialysis documented she received dialysis on Monday, Wednesday, and Friday at a local dialysis center. The facility's licensed staff were to communicate with the dialysis center and coordinate Resident #51's care with the dialysis center.</p> <p>Resident #51's clinical record included 23 Dialysis Communication Forms with date ranges from 5/2/18 to 7/25/18. On the forms the section, "To be completed by Skilled Nursing Care Facility" was crossed out or blank.</p> <p>Resident #51's July 2018 Physician Order Report documented, "Dialysis Log Vital Signs and Weight every Monday, Wednesday, Friday for dialysis monitoring."</p> <p>Resident #51's TAR documented the licensed staff were to obtain Resident #51's vital signs and weight after she returned from dialysis. On Resident #51's TAR, dated 5/2/18 to 5/25/18, 6 out of 11 documentation opportunities were left blank; from 6/1/18 to 6/25/18 8 out of 11 documentation opportunities were left blank; and from 7/2/18 to 7/25/18 had 8 out of 11 documentation opportunities were left blank.</p> <p>On 7/24/18 4:35 PM, Resident #51 stated she went to the dialysis center on Monday, Wednesday, and Friday. Resident #51 stated she had been receiving dialysis for a few years. Resident #51 stated she currently had a central line, because her fistulas in her right arm had failed 3 times. Resident #51 stated the facility provided her a lunch and paperwork to hand deliver to the dialysis center and she returned the paperwork to the facility's nurse.</p>	F 698	<p>meeting to validate communication goes out and comes back from dialysis.</p> <p>Monitors:</p> <p>The Director of Nursing and/or designee will audit current residents on dialysis for the completion of pre and post dialysis communication on dialysis days for 4 weeks, then weekly for eight weeks. Starting the week of September 10th, 2018. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of compliance:</p> <p>September 10th, 2018</p>		

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

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F 698	Continued From page 40 On 7/26/18 at 4:15 PM, the DNS stated Resident #51 had a binder that stored the communication form with the dialysis center. The licensed staff documented on the communication form, Resident #51's weight, vital signs, medications that were given prior to dialysis, and lunch was sent with her. The DNS stated the dialysis center documented Resident #51's dry weight after dialysis, vital signs, medications that were given during treatment, and new orders or changes then Resident #51 returned the communication form to the licensed nurse. On 7/26/18 at 4:57 PM, RCM (RN #3) stated when Resident #51 returned from dialysis the licensed staff documented Resident #51's post dialysis weight and vital signs in the TAR. On 7/26/18 at 5:44 PM, the DNS and RCM (RN #3) were unaware the "To be completed by Skilled Nursing Care Facility" sections of the Dialysis Communication Forms were crossed out or left blank. The DNS and RCM (RN #3) were unaware the TAR's for May, June, and July had blanks. The DNS stated if the TAR areas were left blank then the licensed nurses did not assess Resident #51's vital signs or weight.	F 698			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		9/10/18	

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F 757	<p>Continued From page 41</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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, it was determined the facility failed to ensure residents receiving psychotropic medications had resident-specific target behaviors identified and side effects were monitored consistently. This was true for 3 of 4 (#22, #37, and #202) 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 #37 was admitted to the facility on 5/26/18, with multiple diagnoses which included major depressive disorder and anxiety disorder.</p> <p>Resident #37's admission MDS assessment, dated 6/2/18, documented she was cognitively intact, had moderate depression, with symptoms of little interest or pleasure in doing things and</p>	F 757	<p>F757: Drug Regimen is free from unnecessary drugs</p> <p>Resident specific:</p> <p>Resident <input type="checkbox"/>s #22, 37, and 202 on psychotropic medications, behavior monitors have been updated to include resident specific target behaviors and care plans reflect appropriately. Resident #37 antidepressant monitors for side effects and effectiveness was updated to reflect appropriately.</p> <p>Other residents</p> <p>The clinical management team reviewed current residents for missing resident specific target behaviors and side effect monitors. Adjustments have been made as indicated.</p>		

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F 757	<p>Continued From page 42</p> <p>feeling down, depressed or hopeless several days of the week, feeling tired or having little energy almost every day, and received antidepressant and antianxiety medications daily.</p> <p>Resident #37's July 2018 Physician Order Summary Report, included the following orders: * Ativan 0.5 mg tablet (Lorazepam), give 0.5 mg by mouth as needed for increased anxiety related to Anxiety Disorder until 9/12/18. * Clonazepam 1 mg tablet, give 1 mg by mouth two times a day related to Anxiety Disorder. * Duloxetine HCl 30 mg capsule delayed release particles, give 90 mg by mouth one time a day related to Major Depressive Disorder. * Behavior Monitoring - Antidepressant: Document number of episodes per shift or target behaviors 1. states she is sad/depressed 2. tearfulness 3. withdraws from activities/social interaction. *Interventions were to encourage her to attend activities, validate her concerns, and reassure her. *Monitor/document side effects and effectiveness of the antianxiety medication. Side effects were listed as drowsiness, lack of energy, clumsiness...</p> <p>Resident #37's care plan initiated on 6/7/18, documented she used Psychoactive medication related to diagnoses of Major Depressive Disorder as evidenced by "[resident] stating she is sad/depressed, tearful, and/or withdrawing from activities/social interactions." Interventions included in the care plan "Monitor and document for medication effectiveness or possible side effects...Monitor/record occurrence for target behavior symptoms, Pharmacy referral for</p>	F 757	<p>Facility systems:</p> <p>Nursing staff and the Social Service Director educated on resident specific behavior monitors and side effect monitors. Re-education was provided by Director of Nursing and/or designee to include but not limited to; psychotropic medication monitors for resident specific target behaviors, care plan implementation, and side effect monitoring. The system is amended to include oversight by the Social Service Director with review in the clinical meeting for new orders, changes in behaviors, and effective monitoring of behaviors and side effects.</p> <p>Monitors:</p> <p>Social Services and/or designee will audit 5 residents who are utilizing psychoactive medications for the completion of resident specific target behaviors and side effect monitoring weekly for four weeks, then 2 residents weekly for eight weeks. Starting the week of September 10th, 2018. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance:</p> <p>September 10th, 2018</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/27/2018
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F 757	<p>Continued From page 43 medication review, as needed..."</p> <p>A July 2018 Behavior Monitoring Flowsheet, documented Resident #37's target behaviors were monitored daily as well as the side effects of antianxiety medications. The Behavior Monitoring Flowsheet did not include monitoring of side effects or effectiveness of the antidepressant.</p> <p>On 7/24/18 at 9:38 AM, Resident #37 was observed in bed and said she was very sleepy.</p> <p>On 7/24/18 at 11:30 AM, Resident #37 was observed in bed and was crying.</p> <p>On 7/27/18 at 2:49 PM, 3:17 PM and 4:07 PM, resident was observed in bed and stated she was very sleepy.</p> <p>On 7/25/18 at 3:45 PM, RN #3 said Resident #37 had a Behavior Monitoring Flowsheet but her antidepressant medication was not monitored for its side effects or effectiveness. RN #3 said she would initiate the monitoring for side effects of the antidepressant medication right away.</p> <p>2. Resident #22 was admitted to the facility on 5/3/18, with multiple diagnoses which included heart failure.</p> <p>Resident #22's 30-day MDS assessment, dated 5/30/18, documented she was moderately cognitively intact, had mild depression with symptoms of feeling tired or having little energy and poor appetite nearly every day, and received antidepressant medication daily.</p>	F 757			

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F 757	<p>Continued From page 44</p> <p>Resident #22's June 2018 Physician Order Summary Report, documented she was to receive Amitriptyline HCl tablet 25 mg, one tablet by mouth one time a day for depression. The physician order also directed staff to monitor and document Resident #22's target behavior #1, #2 and #3 per shift. The order did not indicate what Resident #22's target behavior staff were to monitor. The order also directed staff to monitor for the side effects of Resident #22's anti-depressant coded as: A=Sedation, B=Drowsiness, C=Dry Mouth, D=Blurred vision, E=Urinary Retention...if observed.</p> <p>A care plan initiated 5/22/18, documented Resident #22 had behavior problems related to calling out. Interventions included: Administer medications as ordered, Monitor/document for side effects and effectiveness, Explain all procedures to the resident before starting and allow the resident a minute to adjust to changes of what is being asked of her. If [resident] was calling out, offer incontinent care, pain control, reposition or snack, Staff to provide opportunity for positive interactions, attention and stop and talk to her."</p> <p>A care plan initiated on 6/22/18, documented Resident #22 had depression. Interventions included: "Administer medications as ordered. Monitor/document for side effects and effectiveness...Monitor/document/report to Nurse/MD s/sx [sign and symptoms] of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health related complaints and tearfulness."</p>	F 757			

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

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FORM APPROVED
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F 757	<p>Continued From page 45</p> <p>Resident #22's June 2018 and July 2018 Behavior Monitoring Flowsheet documented "Behavior Monitoring-Antidepressant: Document Number of Episodes per shift of target behaviors [Specify] 1. 2. 3. every shift for Behavior Monitoring." The Behavior Monitoring Flowsheet did not indicate what Resident #22's target behavior staff were to monitor. The June and July 2018's Behavior Monitoring Flowsheet documented the following:</p> <p>*6/5/18 - Resident #22 had one episode of behavior #1 during the night, *7/7/18 - it was blank *7/24/18 - Resident had one episode of behavior #1, behavior #2 and behavior #3 in the evening and at night. *7/25/18 - Resident #22 had one episode of behavior #1, behavior #2 and behavior #3 during the day.</p> <p>There was no documentation on Resident #22's Nurses Progress Notes dated 6/5/18, 7/7/18, 7/24/18 and 7/25/18, the resident exhibited behaviors.</p> <p>On 7/27/18 at 9:17 AM, RN #3 said she was aware Resident #22's behaviors monitoring was not specific for the resident and the facility was doing an "audit" of all the residents who required behavior monitoring. RN #3 said she was not sure what were the behaviors the nurses observed for Resident #22 on 6/5/18, 7/24/18 and 7/25/18.</p> <p>On 7/27/18 at 9:41 AM, The LSW said in June 2018 she was asked to create a Behavior Monitoring Flowsheet for residents whose</p>	F 757			

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F 757	<p>Continued From page 46</p> <p>behaviors needed to be monitored. If it was a newly admitted resident, she would ask the family during the care conference what kind of behavior the resident had or if the resident was cognitively intact she would ask the resident how they manifest depression. If she could not get information from the resident or the family she would put the most common behaviors like isolation, decrease appetite, increase sleepiness and tearful as the behavior to be monitored. She then revised the care plans as she learned what behaviors were being manifested by the resident by reviewing the Nurse's Progress Notes and asking the staff. The LSW said she was aware Resident #22 did not have a specific target behavior on her Behavior Monitoring Flowsheet and Resident #22 was included on her list of residents who require a Behavior Monitoring Flowsheet.</p> <p>3. Resident #207 was admitted to the facility on 7/9/18, with multiple diagnoses which included anxiety disorder and dementia.</p> <p>Resident #207's admission MDS assessment dated 7/16/18, documented he was severely cognitively impaired, had minimal depression, with symptom of trouble concentrating on things such as reading the newspaper or watching television several days of the week.</p> <p>Resident #207's July 2018 Physician Order Summary Report, documented he was to receive Quetiapine Fumarate (antipsychotic) 200 mg tablet, 1 tablet by mouth two times a day related to unspecified dementia, and Trazodone HCl (antidepressant) 50 mg tablet, 3 tablet by mouth as needed for insomnia at bedtime. The</p>	F 757			

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F 757	<p>Continued From page 47</p> <p>Physician Order also documented an order directing staff to monitor the side effects of the antidepressant and antipsychotic medication and monitor the number of episodes per shift of Resident #22's target behaviors #1, #2 and #3. The order did not indicate what Resident #22's target behaviors staff were to monitor.</p> <p>Resident #207's care plan initiated on 7/18/18, documented he used antipsychotic medication related to dementia with behavior disturbances. Interventions included in the care plan were:</p> <p>* Administer medications as ordered, Monitor/document for side effects and effectiveness...Document number of per shift of target behaviors 1. wanders/elopement 2. yells/curses 3. refusal of cares."</p> <p>* Assess resident's care needs, if agitated, stop and return once calm, use diversion activity like pack things, put things together, allow resident to express himself, take resident to a quiet/calm environment.</p> <p>Resident #207's July 2018 Behavior Monitoring Flowsheet documented "Behavior Monitoring - Anti-psychotic: Document Number of Episodes per shift or target behavior [SPECIFY]1., 2., 3. every shift for Behavior Monitoring." The Behavior Monitoring Flowsheet did not indicate what Resident #207's target behaviors staff were to monitor. The July 2018 Behavior Monitoring Flowsheet documented the following:</p> <p>* 7/12/18 - Resident #207 had 4 episodes of behavior #2. * 7/18/18 - Resident #207 had 4 episodes of</p>	F 757			

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F 757	Continued From page 48 behavior #1, 2 episodes of behavior #2 and 1 episode of behavior #1. On 7/25/18 at 11:58 AM, LPN #1 said the behavior monitoring flowsheet did not include what kind of behavior was being monitored for Resident #207, and said she did not know why the target behaviors were blank on the Behavior Monitoring Flowsheet. On 7/24/18 at 3:24 PM, the LSW said she prepared the resident's care plan with target behaviors and interventions, and she would inform the nurses that the care plan had been prepared. The LSW said it was the nurses who would put the target behaviors and interventions on the Behavior Monitoring Flowsheet, and she did not know why the target behaviors were blank in the Behavior Monitoring Flowsheet.	F 757			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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. §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: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and	F 880		9/10/18	

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F 880	<p>Continued From page 49</p> <p>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 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</p>	F 880			

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F 880	<p>Continued From page 50 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, record review, and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 1 of 2 sample residents (#30) reviewed for urinary catheter use and 1 of 5 residents (#30) whose direct resident care was observed. The failure created the potential for infection from cross contamination when the resident's uncovered urinary drainage bag was on the floor and when a staff member did not remove her gloves after providing toileting assistance. Findings include:</p> <p>Resident #30 was originally admitted to the facility in 2015 and readmitted on 11/14/16 with multiple diagnoses including benign prostatic hyperplasia, urinary retention, history of urinary tract infection, and constipation.</p> <p>A 7/11/18 significant change MDS assessment documented Resident #30 had moderately impaired cognition; required extensive assistance for transfers, dressing, and toileting; and, used an external (condom) urinary catheter.</p>	F 880	<p>F880: Infection Prevention and Control</p> <p>Resident specific:</p> <p>As noted in the CMS-2567, resident # 30's environment was sanitized during the survey. Resident assessment reveals that no infection occurred related to the break in the infection control process.</p> <p>Other residents:</p> <p>The clinical management team makes rounds to coach staff and validate infection control practices include hand hygiene, glove use, and catheter placement.</p> <p>Facility systems:</p> <p>The clinical nursing management and nursing staff are educated on hand washing protocol and infection control measures. Re-education was provided by Director of Nursing and/or designee to</p>		

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F 880	<p>Continued From page 51</p> <p>Resident #30's urinary incontinence care plan, revised 12/28/16, documented he wore a condom catheter during the day. Interventions included, "Do not let the urinary drainage bag, or the tubing, touch the floor." This intervention was revised 12/28/16.</p> <p>Resident #30's ADL self care performance deficit care plan, initiated in 2015, included an intervention for toilet use that was revised on 9/30/17 and documented the condom catheter during the day and, "uses the toilet, for bowel movements."</p> <p>Resident #30's active physician orders included a 4/13/16 order for a licensed nurse to place the condom catheter one time a day and change the drainage bag daily with the condom catheter application.</p> <p>a. On 7/24/18 at 10:37 AM, RN #4 was observed as she applied Resident #30's condom catheter with a drainage bag. The RN also applied a leg strap to the resident's left lower thigh, secured the catheter tubing to the leg strap, then she hung the drainage bag on the bed frame.</p> <p>On 7/24/18 at 10:53 AM, CNA #1 and CNA #2 were observed as they provided direct care for Resident #30. As the resident was repositioned from laying to sitting on the side of the bed, the uncovered urinary drainage bag fell to floor. The drainage bag remained on the floor for three minutes until CNA #2 picked it up and hung it on the sit-to-stand mechanical lift they used to transfer the resident into his restroom.</p> <p>On 7/24/18 at 10:59 AM, CNA #1 said Resident</p>	F 880	<p>include but not limited to; proper hand hygiene, glove use, infection control policy and procedures, foley catheter management, and what to do if a catheter touches the floor or other beeches in protocol occur. The system is amended to include surveillance from the SDC and clinical leadership with review of results in monthly infection control meeting for trending and education provision.</p> <p>Monitors:</p> <p>The Director of Nursing and/or designee will observe 5 CNAs for proper hand hygiene/glove use and implementation of proper infection control measures with catheters and/or breeches in protocol for 4 weeks, then 2 weekly for eight weeks. Starting the week of September 10th, 2018. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of compliance:</p> <p>September 10th, 2018</p>		

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F 880	<p>Continued From page 52</p> <p>#30's urinary drainage bag was on the floor and it should not have touched the floor.</p> <p>b. 7/24/18 at 11:02 AM, CNA #1 and CNA #2 were observed as they transferred Resident #30 out of his restroom using the mechanical lift. CNA #1 did not remove her exam gloves before she assisted CNA #2 to transfer the resident into his wheelchair, helped straighten the resident's clothing, and adjusted the back of wheelchair. At 11:03 AM, CNA #2 said that CNA #1 had cleaned the resident after he had a small bowel movement on the toilet. CNA #2 then left the room to get coffee for the resident and CNA #1 changed the resident's bed linens, handed the resident's I-pad to him, and placed a hat on his head while wearing the same used gloves. At 11:04 AM, CNA #2 returned with the coffee. CNA #1 then removed the lid off the resident's mug while still wearing the same used gloves and was about to pour coffee in the mug when the surveyor asked her to stop.</p> <p>On 7/24/18 at 11:05, CNA #1 said she did not change her gloves after cleaning bowel movement off the resident but she should have changed her gloves and washed her hands.</p> <p>On 7/26/18 at 7:00 PM, the DNS said the staff informed her of the urine drainage bag and hand hygiene issues and she had a nurse change Resident #30's bed linens and sanitize his items on 7/24/18.</p>	F 880			

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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state licensure survey conducted from July 23, 2018 to July 29, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Linda Kelly, RN Presie Billington, RN</p>	C 000		
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, Resident Group interview, and staff interview, it was determined the facility failed to ensure each floor or nursing unit was equipped with at least one tub or shower for licensed beds. This affected 17 of 17 (#2, #8, #9, #10, #20, #22, #26, #29, #30, #32, #37, #49, #51, #55, #107, #206, and #207) 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 96 beds and had 56 residents who lived in the facility.</p>	C 422	<p>C422: Capacity requirements for Toilets/ Bath areas</p> <p>We respectfully request to extend our waiver for bathing facilities. With our current census, calculations exceed the required bathing facilities; however, we do have a portable bathing unit that may be utilized for residents who desire to bathe in their room. This also provides an alternative and may be utilized upon resident choice. As indicated in the CMS-2567, the residents in group</p>	9/10/18

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 08/21/18
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001370	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2018
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NAME OF PROVIDER OR SUPPLIER LEWISTON OF CASCADIA	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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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	<p>Continued From page 1</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>On 7/24/18 at 9:00 AM,, the residents in the Group interview stated they did not have a problem with receiving baths or showers.</p> <p>On 7/26/18 at 10:35 AM, during the "General Observations of the Facility" 5 bathing areas were observed, which included one bathing area in the therapy area.</p> <p>On 7/27/18 at 12:40 PM, the Administrator stated the facility wanted to renew their waiver for the tub and shower requirement.</p>	C 422	interview stated that they do not have a problem with receiving baths or showers.	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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February 26, 2019

Breanna Jameson, Administrator
Lewiston of Cascadia
3315 8th Street
Lewiston, ID 83501-4966

Provider #: 135021

Dear Ms. Jameson:

On **July 27, 2018**, an unannounced on-site complaint survey was conducted at Lewiston of Cascadia. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from July 23, 2018 through July 27, 2018.

Facility staff were observed providing personal care, interacting with residents, and responding to residents needs and requests promptly. The facility's grievance files and incident and accident reports from October 2017 to July 2018 were reviewed.

Several residents were interviewed regarding quality of care and quality of life concerns. Several nurses, CNAs, and management staff were interviewed regarding quality of care and quality of life concerns. The Director of Nursing and the Administrator were interviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007696

ALLEGATION #1:

The facility is not informing the responsible party of residents diagnoses and change of condition.

FINDINGS #1:

The resident was no longer residing in the facility at the time of the complaint survey. The resident's clinical record documented the responsible party was notified of diagnoses and change of condition. The record documented voicemail messages were left for the responsible party to contact the facility.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION#2:

The identified resident obtained a right leg fracture, developed wounds, and a surgeon recommended amputation, while residing at the facility.

FINDINGS #2:

Based on staff interview and record review, the allegation was substantiated and the facility was cited at F686. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility had a delay of diagnosing a fracture for a resident.

FINDINGS #3:

The facility's grievance file and incident and accident reports from October 2017 to July 2018 were reviewed and no concerns were identified for delay in diagnosing. There were no identified concerns for another fall for an identified resident.

The identified resident's clinical record was reviewed and no concerns were identified for an additional fall with a fracture.

Two nurse managers, the Director of Nursing, and the Administrator were interviewed regarding delay of diagnosing an additional fracture and no concerns were identified.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Staff's documentation for meal intake were not accurate in the facility.

FINDINGS #4:

Facility staff were observed documenting meal intake percentages after residents ate a meal.

Several CNAs, nurses, and nurse managers were interviewed regarding staff documentation for meal intake percentages accurately and no concerns were identified. The Director of Nursing and the Administrator were interviewed regarding staff documentation for meal intake percentages accurately and no concerns were identified.

The identified resident's clinical record was reviewed and the documentation showed the identified resident was eating less than 50% every meal with staff offering supplements with the resident refusals.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Staff shove dentures in residents mouth without fixodent.

FINDINGS #5:

Facility staff were observed providing denture care appropriately for several residents during the survey.

Five resident's voiced no concerns when asked about staff providing denture care and/or assisting with placing their dentures in their mouths.

Several CNAs, nurses, and the Director of Nursing were interviewed about denture care and placing dentures in a resident's mouth. Deficient practice was not identified.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Staff do not know how to provide care to end of life residents.

FINDINGS #6:

Facility staff were observed interacting with several residents throughout the survey and did so appropriately.

Two residents were observed and interviewed regarding staff providing end of life care. No concerns were identified.

The facility's grievance file from October 2017 to July 2018 were reviewed and no identified concerns with staff providing care to end of life residents.

Several CNAs, nurses, and the Director of Nursing were interviewed regarding providing care to end of life residents and no concerns were identified.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Residents wore the same clothes all week in the facility.

FINDINGS #7:

Facility staff were observed providing assistance with changing residents clothing daily throughout the survey.

Breanna Jameson, Administrator
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Several residents were interviewed regarding staff providing assistance with changing clothes every day and no concerns were identified.

Several CNAs were interviewed regarding providing assistance with changing clothes daily for the residents and they voiced no concerns. The Director of Nursing and the Administrator were interviewed regarding staff providing assistance with changing residents clothing daily and voiced no concerns.

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

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