



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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September 14, 2018

Sherrie Nunez, Administrator  
Apex Center  
8211 Ustick Road  
Boise, ID 83704-5756

Provider #: 135079

Dear Ms. Nunez:

On **August 24, 2018**, a survey was conducted at Apex Center 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 24, 2018**. Failure to submit an acceptable PoC by **September 24, 2018**, may result in the imposition of penalties by **October 17, 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **September 28, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **November 22, 2018**. A change in the seriousness of the deficiencies on **October 8, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **November 22, 2018** includes the following:

Denial of payment for new admissions effective **November 24, 2018**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **February 24, 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.**

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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 24, 2018** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, 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>

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

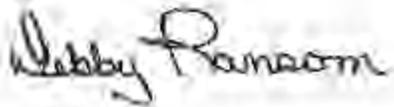
- BFS Letters (06/30/11)

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

This request must be received by **September 24, 2018**. If your request for informal dispute resolution is received after **September 24, 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,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive, flowing style.

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

dr/lj

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

PRINTED: 10/09/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/24/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>APEX CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8211 USTICK ROAD BOISE, ID 83704</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the Federal recertification survey conducted on August 20, 2018 to August 24, 2018.  The surveyors conducting the survey were:  Edith Cecil, RN, Team Coordinator Presie Billington, RN Cecilia Stockdill, RN Teri Hobson, RN  ADL = Activity of Daily Living CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DNR = Do Not Resuscitate DNS = Director of Nursing Services HCL = hydrochloride Kcal = Kilocalorie (1000 calories equals one kilocalorie) lbs = pounds LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set NA = Nursing Assistant mg = milligram POST = Physician Scope of Treatment RN = Registered Nurse SW = Social Worker	F 000			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)  §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		10/4/18	

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

TITLE

(X6) DATE

Electronically Signed

09/24/2018

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

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F 550	Continued From page 1  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.  §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.  §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure staff avoided the use of derogatory labels	F 550	Residents Affected  Resident #316 had a psychosocial		

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F 550	<p>Continued From page 2</p> <p>when discussing residents. This was true for 1 of 17 (#316) residents reviewed for residents' rights. This created the potential for harm should a resident's sense of self-worth and self-esteem be negatively affected. Findings include:</p> <p>Resident #316 was admitted to the facility on 7/27/18 with multiple diagnoses, which included dementia without behavioral disturbances.</p> <p>Resident #316's admission MDS assessment, dated 8/3/18, documented he was moderately cognitively impaired and required extensive assistance of two staff members for all ADLs, except for eating.</p> <p>On 8/21/18 at 2:07 PM, Resident #316 was observed sitting in his Geri-chair (medical recliner) in his room with CNA #6 and CNA #7. CNA #6 was giving a report to CNA #7 about Resident #316. CNA #6 was heard saying to CNA #7 Resident #316 was a "feeder."</p> <p>On 8/21/18 at 2:10 PM, CNA #7 said CNA #6 told her Resident #316 was a "feeder." CNA #6, who was still at the resident's room, confirmed she told CNA #7 Resident #316 was a "feeder."</p>	F 550	<p>assessment by licensed social worker (LSW) on 9/20/2018 regarding being referred to as a derogatory label (feeder) during CNA to CNA report with no negative findings noted.</p> <p>Residents with the potential to be affected Center nurse managers will interview CNA staff on or before 9/30/2018 on how they would classify resident's level of assistance needed with eating. Staff that responded with "feeder" will be re-educated at time of interview.</p> <p>Education and System Changes</p> <p>Center staff including CNA # 6 and 7 will be re-educated on treating residents with dignity and respect on or before 9/30/2018 including use correct verbiage to communicate support for dining include "requires assistance".</p> <p>By date of compliance resident dignity and respect including correct verbiage to describe residents' who require assistance will be educated during new employee orientation by center nurse educator.</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/1/2018, 5 CNA to CNA reports will be completed with a nurse manager weekly for 4 weeks and monthly for 2 months to ensure proper verbiage is used for those that require assistance. Re-education will occur as indicated through report given. Results of</p>		

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F 550	Continued From page 3	F 550	these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.		
F 558 SS=D	<p>Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)</p> <p>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a residents' call lights were within reach and could be used when needed. This was true for 1 of 17 (#18) sampled residents, reviewed for call light accessibility. This created the potential for harm if Resident #18 could not call staff for assistance when needed. Findings include:</p> <p>Resident #18 was readmitted to the facility on 6/5/18, with diagnoses which included muscle wasting, amputation of both legs below the knee, and COPD.</p> <p>An MDS assessment, dated 8/2/18, documented Resident #18 as cognitively intact and required extensive, two-person assistance with transfers.</p> <p>On 8/20/18 at 2:24 PM, Resident #18 was heard calling out that she needed to go back to bed. Resident #18 was observed in a reclining</p>	F 558	<p>Residents Affected</p> <p>Resident # 18 was reviewed for psychosocial distress by LSW on 9/20/2018 related to call light being out of reach with no negative findings.</p> <p>Residents with the potential to be affected</p> <p>Other residents residing in the center will be observed during a center wide room round to ensure call lights were within reach or accessible by members of the IDT on or before 9/30/2018. Corrections were made as indicated at time of review</p> <p>Education and System Changes</p> <p>Center staff will be re-educated by director of nursing or designee on or before 9/30/2018 regarding placement</p>	10/4/18	

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F 558	Continued From page 4 Geri-chair and her call light was still attached to the curtain, out of reach.  On 8/22/18 at 12:56 PM, CNA #1 stated a resident's call light should be attached to the resident, or in reach, when the resident is unattended.  On 8/22/18 at 2:41 PM, NA #1 stated a resident left unattended should have had access to the call light.  On 8/22/18 at 3:06 PM, RN #1 stated she would expect the call light to be clipped on to the resident's clothing or placed within reach.  On 8/24/18 at 9:06 AM, the DNS stated she expected the call light to be placed in reach when a resident is unattended.	F 558	and accessibility of call lights. Center IDT will review residents as part of the "partner program" and ensure that the residents they are assigned to have call lights within reach and/or accessible.  Ongoing Monitoring  Beginning the week of 10/1/2018, 5 residents will be reviewed weekly for 4 weeks and monthly for 2 months to ensure call lights are within reach and/or accessible. Re-education will occur as indicated through report given. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		10/4/18	

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F 578	Continued From page 5 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a) residents were provided information regarding Advance Directives upon admission and if necessary, assisted to formulate advance directives, and b) the residents' medical records included documentation of this process, a copy of the residents' advance directives, or documentation of their decision not to formulate advance directives. This was true for 3 of 17 residents (#15 #28, and #30) reviewed for advance directives. These failures increased the risk of residents not having their decisions	F 578	Resident Affected  Residents # 15, and 30 or representatives will be contacted by a member of social services on or before 9/30/2018 to offer assistance with formulating an advanced directive. Advanced directives and/or declination notes will be drafted as indicated at time of meeting in the resident's medical record. Resident # 28 is no longer eligible to complete advanced directive.		

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F 578	<p>Continued From page 6</p> <p>documented, honored, and respected when they were unable to make or communicate health care preferences. Findings include:</p> <p>The facility's Health Care Decision Making policy, revised 1/2013, documented:</p> <p>Advance Directives are written instruction, such as a living will or durable power of attorney for health care, recognized under state law relating to the provision of health care when the individual is incapacitated. Upon admission:</p> <ul style="list-style-type: none"> <li>* Advance directive information will be available and provided to patients/responsible party by the Center Admission Designee as part of the admission process.</li> <li>* A signed acknowledgement that such information has been received by the patient/family is required.</li> <li>* The Social Worker will follow up with the patient/family to obtain a copy of the advance directive and document accordingly.</li> <li>* If a capable patient does not have an advance directive upon admission, the patient will be approached by the Social Worker or other designated staff person on admission, quarterly, and with change in condition to discuss whether he/she wishes to consider developing an advance directive.</li> <li>* Upon admission, quarterly, and with change in condition, the physician, in collaboration with designated Center staff, will meet with the patient or health care decision maker to complete or</li> </ul>	F 578	<p>Residents with the potential to be affected</p> <p>Other residents residing in the center will be reviewed by a member of social services on or before 9/30/2018 to ensure an advanced directive is included in the medical record. Residents and/or representatives were contacted as indicated at time of review to offer assistance with advanced directive planning. Notes will be written in the medical record by a member of social services at time of review for those that decline.</p> <p>Education and System Changes</p> <p>Social serviced department will be re-educated by the center executive director or designee on or before 9/30/2018 regarding ensuring advanced directives are added to the medical record, or the resident/ resident representative were offered assistance to complete advanced directives.</p> <p>New admissions and quarterly care conferences notes will be reviewed by center IDT to ensure that advanced directives are offered at time of admission and re-offered quarterly if previously declined.</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/1/2018, 5 residents will be reviewed weekly for 4 weeks and monthly for 2 months to</p>		

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F 578	<p>Continued From page 7 review advance directives.</p> <p>This policy was not followed. Examples include:</p> <p>1. Resident #15 was initially admitted to the facility on 3/25/10, with diagnoses which included cerebrovascular accident (stroke) with hemiparesis, (weakness or partial paralysis on one side of the body,) essential hypertension, and diabetes mellitus.</p> <p>Resident #15's physician order summary, dated August 2018, documented a do not resuscitate (DNR) order.</p> <p>The Minimum Data Set (MDS) assessment, dated 6/11/18, documented Resident #15 was cognitively intact.</p> <p>Resident #15's POST (Physician's Orders for Scope of Treatment) documented Do Not Resuscitate and was signed by the resident on 5/10/18.</p> <p>Resident#15's Care Plan, dated 1/22/15 and revised on 8/21/18, documented Resident #15 had an established POST which included her wishes of DNR. The care plan interventions directed staff to activate Resident #15's advance directive as indicated and review the advance directives with Resident #15 and/or healthcare decisionmaker quarterly.</p> <p>The facility's Social Services Assessment, dated 6/11/18, 3/13/18, and 12/14/17, documented Resident #15 was her own decisionmaker, advance directives (Living Will, Power of Attorney or Health Care Proxy) were not in place, an</p>	F 578	<p>ensure advanced directives are in place/offered at time of admission and quarterly if previously declined. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Center executive director responsible for compliance.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/24/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>APEX CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8211 USTICK ROAD BOISE, ID 83704</b>		
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F 578	<p>Continued From page 8</p> <p>opportunity to complete advance directives was not offered to her, and advance directive educational materials were not provided to her.</p> <p>On 8/23/18 at 1:15 PM, Social Worker #1 (SW #1) stated she was unable to find an Advance Directive in Resident #15's medical record. She stated she would call Resident #15's son to see if he had a copy.</p> <p>In a progress note, dated 8/23/18 at 2:09 PM, SW #1 documented Resident 15's son did not have power of attorney for her. SW #1 documented she spoke with Resident #15 who stated she would not go to the hospital and that her family knew that. SW #1 documented she provided education to Resident #15 regarding the benefit of having that information in writing and Resident #15 declined the opportunity at that time.</p> <p>On 8/23/18 at 5:28 PM, the Director of Nursing Services (DNS) stated if residents did not have an advance directive, Social Services should provide the information to them.</p> <p>2. Resident #30 was admitted to the facility on 6/24/13, with multiple diagnoses including schizoaffective disorder, bipolar disorder, anxiety disorder, and obsessive-compulsive disorder.</p> <p>Resident #30's annual MDS assessment, dated 6/21/18, documented he was cognitively intact.</p> <p>Resident #30's August 2018 physician orders documented DNR was ordered on 9/2/14.</p> <p>Resident #30's current care plan documented he</p>	F 578			

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F 578	<p>Continued From page 9</p> <p>had a DNR order in place and directed staff to review the advanced directives with the resident/family quarterly.</p> <p>Resident #30's POST documented Do Not Resuscitate and was signed by the resident.</p> <p>A Progress Note, dated 3/5/18 at 2:00 PM, documented a care plan meeting was held and the social worker reviewed the POST with Resident #30.</p> <p>There was no documentation of an Advanced Directive found in Resident #30's clinical record.</p> <p>On 8/23/18 at 1:45 PM, the DNS said she thought the POST was an Advanced Directive.</p> <p>3. Resident #28 was admitted to the facility on 10/25/06, with multiple diagnoses, which included cerebrovascular accident (stroke) with hemiplegia and hemiparesis (paralysis on one side of the body).</p> <p>An annual MDS assessment, dated 6/18/18, documented Resident #28 was moderately cognitively impaired</p> <p>Resident #28's POST, signed on 10/29/10 by a family representative, documented "Do Not Resuscitate with comfort measures."</p> <p>Resident #28's August 2018 recapitulated physician's orders documented an order dated 9/1/14, "Do Not Resuscitate."</p> <p>Resident #28's care plan, dated 1/5/15 and revised on 8/21/18, documented she had an</p>	F 578			

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F 578	Continued From page 10 established advanced directive and DNR order in place. Interventions included in the care plan directed staff to activate Resident #38's Advance Directives as indicated and review Advance Directives with the resident and/or her healthcare decisionmaker quarterly.  A Social Services Notes, dated 5/16/18, documented a care plan meeting was held with Resident #28 and her family representatives, and there were no changes made regarding her care plan or Advance Directives.  There was no documentation of Advance Directives found in Resident #28's clinical record or that information about advance directives was provided to her and/or her representatives.  On 8/23/18 at 5:15 PM, the SW #1 said Resident #28 did not have a Living Will and when she discussed the Advanced Directives with the resident she was referring to the POST.	F 578			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)  §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 record review, staff interview, and facility policy and procedure review, the facility failed to ensure the MDS assessment accurately reflected a resident's hospice status. This was true for 1 of 17 residents (#9) reviewed for MDS assessment accuracy. This failure created the potential for harm should residents receive inappropriate care related to inaccurate MDS	F 641	Residents Affected  Resident # 9 had a modification to his 5/30/2018 MDS on or before 9/20/2018 to reflect hospice services by center clinical reimbursement coordinator.  Residents with the potential to be affected	10/4/18	

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F 641	<p>Continued From page 11 assessments. Findings include:</p> <p>The facility's policy and procedure for Nursing Assessment, revised 11/28/16, documented "The Center will conduct initially and periodically a comprehensive, standardized, reproducible assessment of each patient's functional capacity. The assessment must accurately reflect the patient's status at the time of assessment."</p> <p>Resident #9 was readmitted to the facility on 2/28/18 with multiple diagnoses, including cerebral palsy, epilepsy, and heart failure.</p> <p>Resident #9's quarterly MDS assessment, dated 5/30/18, documented the following:</p> <ul style="list-style-type: none"> <li>* Severe cognitive impairment in daily decision making.</li> <li>* Hospice care was not indicated.</li> </ul> <p>Resident #9's physician orders, dated 8/24/18, documented hospice was ordered to evaluate and treat Resident #9 on 3/6/18.</p> <p>Resident #9's current care plan documented hospice care started on 3/8/18, related to end stage cardiovascular disease, heart failure.</p> <p>On 8/23/18 at 4:17 PM, RN #4 said she failed to indicate Resident #9's hospice status on the 5/30/18 MDS assessment, and she would initiate an amendment to the MDS assessment.</p> <p>On 8/24/18 at 5:05 PM, the DNS said if a resident was on hospice it should be indicated on the MDS assessment.</p>	F 641	<p>Other residents in the center receiving hospices services MDS' will be reviewed by members of the nurse management team on or before 9/30/2018 to ensure hospice services are reflective within the MDS. Modifications were completed as indicated at time of review.</p> <p>Education and System Changes</p> <p>Clinical Reimbursement Coordinator, responsible for accuracy of the MDS, will be re-educated by the director of nursing on or before 9/30/2018 regarding accurate coding of MDS'.</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/1/2018, 5 residents will be reviewed weekly for 4 weeks and monthly for 2 months to ensure hospice services are coded as indicated on the MDS. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.</p>		
F 656	Develop/Implement Comprehensive Care Plan	F 656		10/4/18	

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F 656 SS=D	Continued From page 12 CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656			

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F 656	<p>Continued From page 13</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, record review, policy review, review of investigation reports, and resident and staff interview, it was determined the facility failed to develop and implement a comprehensive resident-centered care plans. This was true for 1 of 17 residents (#51) whose care plans were reviewed. Resident #51's care plan did not address the risk for elopement and use of a wanderguard to monitor his whereabouts. This failure created the potential for harm if Resident #51 had been injured by motorists, or otherwise harmed, when he eloped from the facility. Findings include:</p> <p>The facility's elopement policy dated 5/15/14, documented a resident at risk for elopement should have an interdisciplinary elopement prevention care plan developed with family and resident participation. Individual risk factors and patterns should be identified and addressed within the care plan.</p> <p>Resident #51 was admitted to the facility on 7/11/18, with diagnoses which included cirrhosis of the liver, orthostatic hypotension, and impaired mobility. He used a wheelchair for mobility.</p> <p>An MDS admission assessment dated 7/18/18, document Resident #51 was slightly cognitively impaired and required one-person physical assistance with personal hygiene.</p>	F 656	<p>Residents Affected Resident #51s care plan was updated to reflect risk for elopement and use of a wander guard by a licensed nurse on or before 9/20/2018</p> <p>Residents with the potential to be affected</p> <p>A review of other residents in the center at risk for elopement and/or utilize a wander guard, will be reviewed by a member of the nurse management team on or before 9/30/2018 to ensure an elopement care plan was developed.</p> <p>Education and System Changes</p> <p>Clinical reimbursement coordinator, nurse responsible for comprehensive care planning, will be re-educated by director of nursing regarding care planning the current status of residents when developing the comprehensive care plan to include but not limited to review of history, IDT notes, and assessments.</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/1/2018, 5 residents will be reviewed weekly for 4 weeks and monthly for 2 months to ensure comprehensive care plan is</p>		

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F 656	<p>Continued From page 14</p> <p>A summary of an investigation report, dated 7/30/18, documented Resident #51 eloped from the facility at 11:20 AM that day.</p> <p>A progress note, dated 7/30/18, documented Resident #51 was found outside on the sidewalk by a social worker and the licensed nurse was notified. A wanderguard was placed on Resident #51's left wrist for continued use in monitoring his whereabouts.</p> <p>An event summary report, dated 8/20/18, documented Resident #51 eloped at 11:20 AM from the facility. An untitled note documented by the Admissions Director on 8/20/18 at 12:20 PM, stated the Admissions Director canvassed the surrounding area via vehicle and found Resident #51 on a road in front of a public library. The note documented it appeared Resident #51 had been to a convenience store as he had a diet coke and shopping bag with him. He was transported back to the facility.</p> <p>On 8/23/18 2:43 PM, Resident #51 stated until they took his wanderguard off, he could not go anywhere by himself.</p> <p>Resident #51's care plan was updated on 8/20/18 to include he was at risk of elopement and a wanderguard was in use. The care plan was not updated after Resident #51's first elopement on 7/30/18 and initiation of the use of the wanderguard.</p> <p>On 8/24/18 at 3:03 PM, RN #1 stated she knew Resident #51 was an elopement risk because he had eloped that morning. She stated she knew he had a history of elopement because he had</p>	F 656	<p>reflective of current conditions. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.</p>		

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F 656	Continued From page 15 eloped on 7/30/18.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy and procedure review, it was determined the facility failed to ensure residents' care plans were revised and updated to maintain consistency and accuracy.	F 657		10/4/18	
			Residents Affected  Residents # 30, 34, will have care plan updates to reflect classifications of psychoactive medications and the		

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F 657	<p>Continued From page 16</p> <p>This was true for 3 of 17 residents (#30, #34, and #46) whose care plans were reviewed. This failed practice had the potential for harm if cares and/or services were provided inappropriately due to inaccurate information in residents' care plans. Findings include:</p> <p>The facility's policy and procedure for Person-Centered Care Plan, revised 3/1/18, documented the following:</p> <ul style="list-style-type: none"> <li>* The care plan must be specific to each resident's preferences and needs.</li> <li>* The care plan will be reviewed and modified by the interdisciplinary team after each assessment and as needed to reflect the resident's reaction to care and changing needs.</li> </ul> <p>This policy was not followed. Examples include:</p> <ol style="list-style-type: none"> <li>1. Residents care plans were not updated to reflect the use of psychoactive medications.             <ol style="list-style-type: none"> <li>a. Resident #30 was admitted to the facility on 6/24/13, with multiple diagnoses including schizoaffective disorder, bipolar disorder, anxiety disorder, and obsessive-compulsive disorder.</li> </ol> </li> </ol> <p>Resident #30's annual MDS assessment, dated 6/21/18, documented the following:</p> <ul style="list-style-type: none"> <li>* He was cognitively intact.</li> <li>* Antipsychotic and antidepressant medications were administered on seven out of the previous seven days.</li> </ul> <p>Resident #30's August 2018 physician orders documented the following:</p>	F 657	<p>interventions specific to them, on or before 9/30/2018 by a member of the social services department. Resident # 46 care plan was updated by a licensed nurse on or before 9/30/2018 to reflect the removal of bed cane from his bed.</p> <p>Residents with the potential to be effected</p> <p>Other residents utilizing psychoactive medications care plans will be reviewed on or before 9/30/2018 by a member of the social services department to ensure that medication classifications were listed on the care plan with specific interventions.</p> <p>Other residents residing in the center with positioning devices will have care plan reviews by members of the nurse management team on or before 9/30/2018 to ensure only current adaptive equipment was reflected on care plan.</p> <p>Education and System Changes</p> <p>Center nursing and social services staff will be re-educated on or before 9/30/2018 by center director of nursing or designee regarding care plan updates to reflect current status of resident to include but not limited to medication classes and positioning equipment used. Provider orders will be reviewed by IDT during morning clinical meeting to ensure that care plans are updated to reflect current status of resident including but not limited to the use of psychoactive</p>		

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F 657	<p>Continued From page 17</p> <ul style="list-style-type: none"> <li>* Escitalopram (antidepressant medication) 20 mg once per day for depression.</li> <li>* Risperidone (antipsychotic medication) 1 mg twice per day for schizoaffective disorder.</li> <li>* Zyprexa (antipsychotic medication) 20 mg at bedtime for schizoaffective disorder.</li> </ul> <p>Resident #30's August 2018 MAR documented the following:</p> <ul style="list-style-type: none"> <li>* The escitalopram and risperidone were administered each day from 8/2/18 - 8/23/18.</li> <li>* The Zyprexa was administered each day from 8/1/18 - 8/23/18.</li> </ul> <p>Resident #30's current care plan documented Resident #30 was at risk for complications related to psychotropic drugs. The care plan did not document the use of antidepressant and antipsychotic medications and the appropriate interventions specific to those medications.</p> <p>b. Resident #34 was readmitted to the facility on 6/19/18, with multiple diagnoses including bipolar disorder, major depressive disorder, anxiety disorder, and personality disorder.</p> <p>Resident #34's quarterly MDS assessment, dated 6/27/18, documented the following:</p> <ul style="list-style-type: none"> <li>* She was cognitively intact.</li> <li>* Antidepressant medication was administered on seven out of the previous seven days.</li> </ul> <p>Resident #34's August 2018 physician orders documented the following</p>	F 657	<p>medications and interventions.</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/1/2018, 5 residents will be reviewed weekly for 4 weeks and monthly for 2 months to ensure care plans are reflective of current medication classes and adaptive equipment. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.</p>		

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F 657	<p>Continued From page 18</p> <ul style="list-style-type: none"> <li>* Lexapro (antidepressant medication) 15 mg each morning for depression.</li> <li>* Quetiapine (antipsychotic medication) 200 mg at bedtime for depression.</li> </ul> <p>Resident #34's current care plan documented Resident #34 was at risk for complications related to psychotropic drugs. The care plan did not address the use of antidepressant and antipsychotic medication and the appropriate interventions specific to those medication.</p> <p>Resident #34's August 2018 MAR documented the following:</p> <ul style="list-style-type: none"> <li>* The Lexapro was administered each day from 8/1/18 - 8/21/18, except for 8/12/18.</li> <li>* The quetiapine was administered each day from 8/1/18 - 8/20/18.</li> </ul> <p>On 8/24/18 at 3:46 PM, the DNS said for residents who received psychotropic medications, she would expect the care plan to reflect the classification of medication, the reason for the medication, discussion of the behaviors, and interventions to be used for the behaviors.</p> <p>2. Resident #46 was admitted to the facility on 8/22/17, with multiple diagnoses including muscle wasting and atrophy and unsteadiness on feet.</p> <p>Resident #46's August 2018 physician orders documented a physician order on 8/17/18 for bed canes to be used, if the resident preferred, to assist with steadiness.</p> <p>Resident #46's current care plan documented a bed cane to the left side of his bed was initiated</p>	F 657			

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F 657	Continued From page 19 on 6/28/18.  On 8/20/18 at 10:38 AM, 8/21/18 at 10:23 AM, and 8/24/18 at 9:54 AM, Resident #46 was observed in his room. A bed cane was not present on Resident #46's bed.  On 8/24/18 at 10:01 AM, LPN #4 said she was not aware of Resident #46 having a bed cane. LPN #4 said a concave mattress was tried and Resident #46 did not like it so it was removed. LPN #4 said maybe the mattress got in the way of the bed cane and that was the reason it was removed.  On 8/24/18 at 10:02 AM, the DNS said she did not know when the bed cane was removed from Resident #46's bed and she would try to find out.  On 8/24/18 at 11:30 AM, the DNS said she was not aware that Resident #46's bed cane was removed, and any nurse could update the care plan. The DNS said the care plan was commonly updated by the floor nurse, MDS nurse, and herself.	F 657			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)  §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were not initialed as given on the	F 658	Resident Affected  Resident # 9 and 10 were assessed by a	10/4/18	

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F 658	<p>Continued From page 20</p> <p>Medication Administration Record prior to administration of the medication. This was true for 2 of 8 (#9 and #10) residents observed during medication pass. This failed practice had the potential for harm if residents were documented as having received medications they either refused or were not given. Findings include:</p> <p>On 8/24/18 at 7:39 AM, during the medication pass observation, LPN #4 was observed pre-initialing the MAR as she prepared Resident #10's medications: Baclofen 5 mg, furosemide 20 mg, duloxetine 40 mg, multivitamins, timolol maleate (eye drops), Norco 10 mg, and Miralax 17 grams, prior to the actual administration.</p> <p>On 8/24/18 at 7:56 AM, during the medication pass observation, LPN #4 was observed pre-initialing the MAR as she prepared Resident #9's medications: Paroxetine 1/2 tab, Novolin 50 units, Amlodipine 10 mg, Aspirin 81 mg, Vit D3, Cranberry, Furosemide 20 mg, carbamazepine 200 mg, carvedilol 6.25 mg, guaifenesin 400 mg, risperidone 1 mg and Senna 8.6 mg prior to the actual administration.</p> <p>On 8/24/18 at 8:09 AM, LPN #4 said she initialed the MAR as she "popped" the residents' medications from the medication cards.</p>	F 658	<p>licensed nurse on 9/20/2018 to ensure no adverse effects related to nurse initialing medications prior to administration with none found.</p> <p>Residents with the potential to be affected</p> <p>Medication pass competencies will be completed with licensed nurses on or before 9/30/2018 by center licensed nurses to ensure that medications were not initialed prior to administration. Re-education will be provided at time of review as indicated.</p> <p>Education and System Changes</p> <p>Center nurses including licensed nurse # 4 will be re-educated by director of nursing or designee on or before 9/30/2018 regarding initially after the medications have been administered to ensure that any refusals are correctly documented.</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/1/2018, 5 licensed nurses administering medications will be reviewed weekly for 4 weeks and monthly for 2 months to ensure medications are initialed after administration. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.</p>		
F 679	Activities Meet Interest/Needs Each Resident	F 679		10/4/18	

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F 679 SS=D	Continued From page 21 CFR(s): 483.24(c)(1)  §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family member, and staff interview, and record review, it was determined the facility failed to ensure there was an ongoing activity program to meet individual resident needs. This was true for 1 of 17 residents (#31) sampled for quality of life concerns and created the potential for residents to become bored or depressed when not provided with meaningfully engagement throughout the day. Findings include:  Resident #31 was admitted to the facility on 7/28/17, with multiple diagnoses including dementia without behavioral disturbance, diabetes mellitus, and recurrent depressive disorders.  The annual MDS assessment, dated 8/2/18, documented Resident #31 had cognitive impairment and required staff assistance to meet her activities of daily living needs.  The section of Resident #31's care which	F 679	Resident Affected  Resident # 31 discharged from the center on 9/8/2018.  Residents with the potential to be effected  On or before 9/30/2018 the activities director or designee will review other residents residing in the center for activities preferences, and materials available to residents for use. Other residents residing in the center will have their activity preferences updated by a member of the recreation team on or before 9/30/2018.  Education and System Changes  Center recreation director will be re-educated by center executive director on or before 9/30/2018 to update resident recreation preferences when noted to		

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F 679	<p>Continued From page 22</p> <p>addressed activities, dated 7/29/17 and revised 8/2/18, documented the importance for Resident #31 to have the opportunity to engage in daily routines that were meaningful to her preferences, such as resting, reading, and watching TV.</p> <p>Care plan meeting notes, dated 11/29/17, documented Resident #31 enjoyed art activities. The care plan meeting notes documented Resident #31's daughter spoke of a painting Resident #31 painted which impressed the daughter. Resident 31's daughter communicated at the meeting that her mother enjoyed reading and would benefit from having books on tape available to her. The note documented the Recreation Director would arrange for books on tape to be brought to Resident #31.</p> <p>On 8/20/18 at 2:48 PM, Resident #31 was laying on her bed watching TV. She stated she liked being around people.</p> <p>On 8/21/18 at 2:51 PM, a family member stated Resident #31 enjoyed coloring and painting, but it was only offered once a month. The family member stated they had requested books on tape. The family member stated Resident #31 was very artistic but she never had anything to do but watch TV. Resident #31's daughter stated her mother complained of a decline in her vision and stated she listened to TV more than watched it.</p> <p>On 8/22/18 at 2:00 PM, the Activity Director (AD) stated she was aware of the Care Plan Conference note and would move forward with obtaining books on tapes, newspaper, and art materials. The AD stated that when she had</p>	F 679	<p>have refusals and to ensure that current preferences are being offered, and that supplies/ materials are available for residents based on their individualized preferences. .</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/1/2018, 5 residents will be reviewed weekly for 4 weeks and monthly for 2 months to ensure recreation preferences are being offered and that supplies and materials are available for based on resident activities preferences. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Center executive director responsible for compliance.</p>		

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F 679	Continued From page 23 spoken with Resident #31, she had stated she enjoyed reading the newspaper but did not appear to be interested in activities.  On 8/22/18 at 5:16 PM, a progress note documented the AD ordered a talking book player through Idaho Talking Book Service. The AD documented Resident #31 identified her reading preferences and the AD provided her with information regarding the process for utilizing the service.  On 8/23/18 at 4:30 PM, Resident #31 was in her room. There were no art supplies or newspapers available in her room.  On 8/24/18 at 11:42 AM, Resident #31 and her husband were in her room. Resident #31's husband stated the staff mentioned they would provide art supplies but there was nothing brought in yet. Resident #31 stated, "Why would I get them?" When it was explained to Resident #31 that she should be able to do things she enjoyed, Resident #31 nodded her head in agreement.  On 8/24/18 at 1:52 PM, the DNS stated she would expect resident activity needs to be provided timely.	F 679			
F 684 SS=E	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		10/4/18	

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F 684	<p>Continued From page 24</p> <p>accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, policy review, review of incident and accident reports, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 5 of 17 sampled residents (#9 #26, # 51, #52, and #316) reviewed for standards of practice. Resident #9's clinical record failed to document parameters for when to notify the physician for high blood glucose (sugar) levels. Resident #26 had incomplete documentation in all ADL areas. Resident #51 had a documented weight increase of 50 pounds in one week that was not rechecked. Resident #52's weight was not recorded as ordered by the physician. Resident #316's 1:1 caregiver did not know she was on a dysphasia puree diet. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include:</p> <p>A Weights and Heights policy dated 5/15/17, documented if a resident was less than or greater than five pounds from the previous weight, the resident should be re-weighed and the weight verified by a licensed nurse with follow-up as indicated.</p> <p>1. Resident #316 was admitted to the facility on 7/27/18, with multiple diagnoses which included dementia without behavioral disturbances.</p> <p>Resident #316's admission MDS assessment,</p>	F 684	<p>Resident #9 had orders for hyperglycemia parameters on or before 9/20/2018.</p> <p>Resident # 26 had ADL documentation completed on or before 9/20/2018.</p> <p>Resident # 51 had a weight obtained on or before 9/20/2018 with no significant changes noted. Resident # 52 was re-weighed on or before 9/20/2018 with no significant changes noted.</p> <p>Resident # 316 care giver was able to correctly identify dietary needs of resident on or before 9/20/2018.</p> <p>Resident # 316 was assessed by a licensed nurse on 9/20/2018 to ensure no neurological deficits were noted related to no neurological assessments completed post fall. No deficits were noted at time of assessment.</p> <p>Residents with the potential to be affected A review of other residents that reside in the center requiring blood sugar checks will be reviewed by members of the nurse management team on or before 9/30/2018 to ensure hyperglycemic parameters are in place. Those residents found to be without will be communicated to provider for parameters.</p> <p>A review of other residents residing in the center will have ADL records reviewed by members of the nurse management team on or before 9/30/2018 to ensure documentation is completed.</p>		

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F 684	<p>Continued From page 25</p> <p>dated 8/3/18, documented he was moderately cognitively impaired, required extensive assistance of two staff members for all ADLs except for eating, and he had a feeding tube. The MDS assessment also documented he had history of falls on admission.</p> <p>a. Resident #316's August 2018 MAR documented an order, dated 8/14/18, for "Enteral Feed Order two times a day: Jevity 1.5 cal @ (at) 80 ml (milliliters) x 10 hours = 800 ml, 1,200 kcals/24 hours. Administer via continuous feed. On at 1900 [7:00 PM] and off at 5:00 AM."</p> <p>A Diet Order and Communication form, dated 8/13/18, documented a dysphagia puree diet for Resident #316.</p> <p>On 8/21/18 at 9:04 AM, Resident #316 was observed in his room with his 1:1 sitter, CNA #6. CNA #6 worked for a contracted staffing agency which provided staff on an as needed basis. CNA #6 said she was with Resident #316 during breakfast and he ate only two teaspoons of cream of wheat, and she was unable to encourage Resident #316 to eat more. When asked what type of diet Resident #316 was on, CNA #6 said she was not sure, and said she had not looked at his meal card. CNA #6 said she knew Resident #316 required two staff members for transfers and that was all she knew about him. CNA #6 said the outgoing 1:1 sitter CNA did not give her information about Resident #316. When asked where she could get more information about Resident #316, CNA #6 said she should have asked the other CNAs on the floor.</p>	F 684	<p>Documentation will be completed as indicated at time of review.</p> <p>A review of other residents residing in the center will have weight reviews completed for the last 30 days by center dietician on or before 9/30/2018 to ensure weights and re-weights are obtained per center policy. Weights and re-weights will be obtained at time of review as indicated.</p> <p>A review of other residents residing in the center that sustained falls in the last 30 days will be reviewed by members of the nurse management team on or before 9/30/2018 to ensure that safety checks and neurological evaluations were completed post falls. Follow-up including/reassessment or evaluation will be completed as indicated.</p> <p>Education and System Changes Licensed staff will be re-educated by director of nursing on or before 9/30/2018 regarding ensuring parameters are in place at time of checking blood glucose levels and notifying provider if no parameters are currently in place. Center IDT will review provider orders during morning clinical meeting including but not limited to diabetic orders to ensure that hyperglycemic parameters are in place. Center CNAs will be re-educated by director of nursing on or before 9/30/2018 regarding completion of ADL care and documentation requirements. CNA charting will be reviewed during morning clinical meeting to ensure documentation is completed. Center nursing staff will be re-educated</p>		

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F 684	<p>Continued From page 26</p> <p>b. The facility's Policy and Procedure for Falls revised on 3/15/16, directed staff to perform Neurological Assessment for all unwitnessed falls and witnessed falls with head injury.</p> <p>A care plan dated 7/28/18 documented Resident #316 was at risk for falls due to cognitive loss, lack of safety awareness, impaired mobility, Lewy Body dementia (problems with thinking, movement and behavior), Parkinson's (nervous system disorder that affects movement), cerebrovascular accident (stroke) and impulsiveness.</p> <p>Fall Incident and Accident Reports documented Resident #316 had four unwitnessed falls between 8/3/18 and 8/16/18 as follows:</p> <p>* 8/3/18 at 3:00 AM - A noise was heard, and the RN went to Resident #316's room and saw the resident on the floor.</p> <p>* 8/4/18 at 10:45 PM - Resident #316 was found on the floor. No injuries were identified.</p> <p>* On 8/9/18 at 11:30 AM - Resident had a fall. No injuries were identified.</p> <p>* On 8/16/18 at 6:30 AM - Resident #316 was found on the floor. No injuries were identified.</p> <p>Resident #316 had four unwitnessed falls from 8/3/18 to 8/16/18, and there were no neurological assessment found in his clinical record.</p> <p>On 8/23/18 at 4:26 PM, the DNS said she knew neurological assessment were completed following Resident #316's unwitnessed falls but</p>	F 684	<p>on or before 9/30/2018 by director of nursing regarding center weight policy. Weekly and monthly weights will be reviewed by center IDT during morning clinical meeting to ensure weights and re-weights are obtained per policy. Interviews will be conducted on or before 9/30/2018 with CNAs by members of the nurse management team to ensure that CNAs are able to correctly identify the dietary needs of residents. Dietary requirements for residents will be added to the shift report / assignment communication sheet for CANs assigned to provide one-one care. CNAs will be re-educated by director of nursing on where to find the information or to ask a nurse if unsure for the dietary needs of residents. Center nursing staff will be re-educated by director of nursing on or before 9/30/2018 regarding completion of neurological evaluations and adding safety checks post falls. Nurses will be required turn in completed neurological evaluations sheets to nurse managers for review and filing. Assigned nurse manager will validate completion of neurological evaluation prior to closure of events that require neurological evaluation. Center IDT will review risk management system during morning clinical meeting to ensure that residents that sustain falls have safety checks added for 2 or more falls and neurological evaluations completed. Ongoing Monitoring</p>		

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F 684	<p>Continued From page 27 she was unable to find the documentation.</p> <p>2. Resident #51 was admitted to the facility on 7/11/18, with diagnoses which included cirrhosis of the liver.</p> <p>A physician's order, dated 7/11/18, with a start date of 7/15/18, documented Resident #51 was to be weighed on the day shift each Sunday for 4 weeks.</p> <p>An order, dated 7/11/18, with a start date of 8/1/18, documented Resident #51 was to be weighed on the day shift every month.</p> <p>An MDS admission assessment, dated 7/18/18, document Resident #51 was slightly cognitively impaired and required one-person physical assistance with ADL's.</p> <p>A progress note, dated 8/12/18, documented the physician instructed staff to weigh Resident #51 daily.</p> <p>An ADL documentation report for August 2018, documented Resident #51's weights as follows:</p> <ul style="list-style-type: none"> <li>* 8/13/18 at 11:56 AM, 142 lbs.</li> <li>* 8/19/18 at 12:59 PM, 192 lbs.</li> <li>* 8/19/18 at 2:44 PM, 192 lbs.</li> </ul> <p>Documentation of follow up to the 50 lb weight increase from 8/13/18 to 8/19/18 was not found in Resident #51's medical record.</p> <p>On 8/23/18 at 3:41 PM, RN #1 stated if a resident's weight difference was large, staff were expected to re-weigh the resident to verify the</p>	F 684	<p>Beginning the week of 10/1/2018, 5 resident's orders will be reviewed weekly for 4 weeks and monthly for 2 months to ensure hyperglycemic parameters are in place, ADL documentation is completed, weights are obtained per order and policy, and neurological assessments are completed post non-witnessed/head involvement fall. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Center executive director responsible for compliance.</p> <p>Beginning the week of 10/1/2018, 5 CNAs will be interviewed weekly for 4 weeks and monthly for 2 months to ensure dietary needs of one resident each are correctly stated. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/24/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>APEX CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8211 USTICK ROAD BOISE, ID 83704</b>		
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F 684	<p>Continued From page 28</p> <p>weight was correct. She stated if the resident was weighed in a wheelchair, staff were expected to subtract the weight of the wheelchair and any extra items that may be present at that time such as blankets, foot pedals or clothing, to determine the resident's correct weight.</p> <p>The facility failed to clarify direction in the the physician progress notes dated 8/12/18 or to weigh the resident daily.</p> <p>3. Resident #52 was readmitted to the facility on 7/11/18, with diagnoses which included multiple sclerosis and chronic pain syndrome.</p> <p>A physician's order, dated 7/10/18, with a start date of 7/15/18, documented Resident #52 was to be weighed on the day shift every Sunday for 4 weeks.</p> <p>An MDS Admission assessment, dated 7/18/18, documented Resident #52 was cognitively intact.</p> <p>A Weights and Vitals summary, dated 8/24/18, documented Resident #52 weighed 237 lbs on 7/11/18 and 232 lbs on 7/18/18.</p> <p>An ADL documentation report for August 2018, did not include documentation of Resident #52's weight from 8/1/18 through 8/22/18, nor was it found elsewhere in Resident #52's record.</p> <p>On 8/24/18 at 8:33 AM, CNA #2 stated the nurse would have told her at the beginning of the shift, if there were weekly weights to perform. She stated all shifts were responsible for weighing residents. CNA #2 stated if a resident refused, she would tell the nurse and re-approached the</p>	F 684			

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F 684	<p>Continued From page 29</p> <p>resident later. CNA #2 stated she would document the resident's refusal. She stated documentation would go into an alert charting area and was viewed by staff in the stand-up meetings every morning.</p> <p>On 8/24/18 at 8:42 AM, RN #1 stated if a resident had shown a weight loss, the dietitian would be involved.</p> <p>The facility failed to follow physician orders and weigh the resident every Sunday times 4 weeks.</p> <p>4. Resident #26 was admitted to the facility on 12/27/17 with diagnoses which included major depressive disorder, anxiety disorder, weakness, and gait abnormalities.</p> <p>An MDS assessment dated 6/19/18, documented Resident #26 was cognitively intact and required one-person for physical assistance with transfers.</p> <p>Resident #26's current care plan documented she required assistance and/or was dependent on staff for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfers, locomotion, and toileting due to impaired mobility and weakness.</p> <p>An ADL documentation report for August 2018, showed the night shift staff failed to record care for Resident #26, for 14 of 22 opportunities for the following areas: bed mobility, bladder continence, bowel continence, dressing, snack, oral fluid intake, locomotion on the unit, locomotion off the unit, mouth care, personal hygiene, preventative skin care, preventative skin care to extremities, pressure relieving device,</p>	F 684			

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F 684	<p>Continued From page 30 toilet use, transfers, walk in corridor, and walk in room.</p> <p>An ADL documentation report for August 2018, showed the evening shift staff failed to record care for Resident #26, for 2 of 22 opportunities for the following areas: bed mobility, bladder continence, bowel continence, dressing, snack, oral fluid intake, locomotion on unit, locomotion off unit, mouth care, personal hygiene, preventative skin care, preventative skin care to extremities, pressure relieving device, toilet use, transfer, walk in corridor, and walk in room.</p> <p>On 8/24/18 at 12:20 PM, the DNS stated Resident #26 seldom refused care. She stated she expected staff to document the care that was provided. She said documentation was missing in Resident #26's medical record for some evening and night shifts for all ADL areas.</p> <p>5. Resident #9 was re-admitted to the facility on 2/28/18 with multiple diagnoses, including Type 2 diabetes mellitus.</p> <p>The facility's policy and procedure for Diabetic Care, revised 1/2/14, documented the following:</p> <ul style="list-style-type: none"> <li>* Report blood glucose (BG) results to the physician/provider according to ordered parameters.</li> <li>* Notify (the physician) immediately if the BG is greater than 400 or less than 70 and not corrected with interventions according to the hypoglycemia protocol.</li> <li>* Notify (the physician) as soon as possible during normal business hours if the BG is more than 350 or more than 300 on 2 consecutive</li> </ul>	F 684			

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F 684	<p>Continued From page 31 readings.</p> <p>Resident #9's physician orders, dated 8/24/18, documented the following:</p> <ul style="list-style-type: none"> <li>* An order as of 6/20/18 to check BG twice a day.</li> <li>* An order as of 2/28/18 to monitor for signs and symptoms of hyperglycemia (high blood sugar): frequent urination, increased thirst, blurry vision, fatigue, weakness, headache, confusion, unconsciousness. Check BG and notify the physician.</li> </ul> <p>Resident #9's current care plan directed staff to do the following:</p> <ul style="list-style-type: none"> <li>* Record BG levels per the physician's order.</li> <li>* Educate the resident on signs and symptoms of hypo (low) and hyperglycemia (high).</li> <li>* Monitor for signs of hypo and hyperglycemia and report abnormal results to the physician.</li> </ul> <p>Resident #9's clinical record did not document parameters of when to notify the physician for high or low BG readings.</p> <p>On 8/23/18 at 4:42 PM, RN #3 said if there were no BG parameters ordered for Resident #9, she would go by standard parameters that everyone used of a BG reading of less than 50 or greater than 350 required physician notification. RN #3 said she did not know if that was the facility's policy, but they were common parameters she had seen written.</p> <p>On 8/23/18 at 4:55 PM, the DNS said BG parameters were for the doctor to write. The DNS</p>	F 684			

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F 684	Continued From page 32 said if a resident had no orders, staff would call the physician and get an order for clarification. The DNS said she expected to see a specific number for both high and low BG readings that required physician notification.	F 684			
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii)  §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family member, and staff interview, and record review, it was determined the facility failed to ensure residents received proper treatment and care to maintain good foot health. This was true for 1 of 1 (#38) resident reviewed for foot care. This failed practice created the potential for harm should residents experience complications from their medical condition related to the lack of foot care. Findings include:  Resident #38 was admitted to the facility on 1/19/18 and was readmitted on 3/28/18 with multiple diagnoses, including diabetes mellitus.  A quarterly MDS assessment, dated 7/5/18,	F 687	Resident Affected  Resident # 38 was seen by a podiatrist on or before 9/20/2018.  Other residents with the potential to be affected  A review of other residents with referrals within the last 30 days will be reviewed by the center IDT on or before 9/30/2018 to ensure appointments were made. Appointments will be made as indicated at time of review.  Education and System Changes	10/4/18	

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F 687	<p>Continued From page 33</p> <p>documented Resident #38 was cognitively intact and required assistance of one staff member for his ADLs (Activities of Daily Living).</p> <p>Resident #38's physician's orders and TAR (Treatment Administration Record) for August 2018, documented an order dated 3/30/18, directing licensed nurses to trim Resident #38's nails one time a week every night shift on shower days.</p> <p>A care plan, dated 1/19/18, documented Resident #38 had diagnosis of diabetes and was insulin dependent. Interventions included in his care plan included "Podiatry consult as indicated."</p> <p>On 8/22/18 at 2:42 PM, while observing a wound dressing, Resident #38's great toenails were observed to be long and thick, and yellowish in color. His other toenails were long and pointing downward. RN #4 said Resident #38 had a Podiatry consult scheduled but she did not know the date of the consult. RN #4 said the Social Worker made the list of residents to be seen by the podiatrist who came to the facility once a month.</p> <p>On 8/22/18 at 2:57 PM, RN #1 said they were in the process of looking for another podiatrist to come and see residents.</p> <p>On 8/22/18 at 3:09 PM, SW #1 said the facility previously had a Podiatrist who came to the facility once every two months, and the last time the podiatrist was in the facility was 3/29/18. SW #1 said she did not have documentation Resident #38 was seen by a Podiatrist.</p>	F 687	<p>Center scheduler will be re-educated by director of nursing or designee on or before 9/30/2018 to ensure that specialty referral appointments are sent to the appropriate provider at time of receiving referral.</p> <p>Licensed nurses will be re-educated by director of nursing on or before 9/30/2018 regarding sending referrals to center scheduler for appointments. Referral appointments will be reviewed by center IDT and followed up with scheduler within 72 hours to</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/1/2018, 5 residents will be reviewed weekly for 4 weeks and monthly for 2 months to ensure that outside referral appointments have been made and/or sent to the appropriate provider. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.</p>		

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F 687	Continued From page 34	F 687			
F 689 SS=D	<p>On 8/23/18 at 1:22 PM, Resident #38 said he wanted his toenails to be cut, and his family member said she had asked several times for his toenails to be cut and was told by the staff they were looking at it.</p> <p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§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</p> <p>§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 staff interview, record review, and review of Fall Incident and Accident Reports, it was determined the facility failed to ensure sufficient supervision of residents to prevent falls. This was true for 1 of 4 (#30) residents reviewed for falls. This created the potential for harm if residents were to experience injuries from falling, Findings include:</p> <p>Resident #30 was admitted to the facility on 6/24/13, with multiple diagnoses including Type 2 diabetes mellitus, muscle wasting and atrophy, and peripheral vascular disease.</p> <p>Resident #30's annual MDS assessment, dated 6/21/18, documented the following:</p> <p>* He was cognitively intact. * He required supervision, oversight,</p>	F 689	<p>Resident Affected</p> <p>Resident # 30 had safety checks in place on or before 9/20/2018 to increase supervision related to fall risk.</p> <p>Resident # 316 was assessed by a licensed nurse on 9/20/2018 to ensure no neurological deficits were noted related to no neurological assessments completed post fall. No deficits were noted at time of assessment.</p> <p>Other residents with the potential to be affected</p> <p>A review of other residents residing in the center that sustained falls in the last 30 days will be reviewed by members of the</p>	10/4/18	

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F 689	<p>Continued From page 35</p> <p>encouragement or cueing and one person physical assistance with bed mobility and transfers.</p> <p>* When moving from seated to standing and surface to surface transfers, he was not steady but able to stabilize with or without human assistance.</p> <p>* A wheelchair was used.</p> <p>* Walking did not occur.</p> <p>* There were no falls since admission or the prior assessment.</p> <p>* No restraints or alarms were used.</p> <p>Resident #30's August 2018 physician orders documented the following:</p> <p>* Hydrocodone (narcotic pain medication) 5-325 one tablet every four hours as needed for pain.</p> <p>* MS Contin (Morphine Sulfate - narcotic pain medication) tablet Extended Release 15 mg by mouth in the evening for pain.</p> <p>* MS Contin tablet Extended Release 30 mg by mouth in the morning for pain.</p> <p>* Escitalopram (antidepressant medication) 20 mg once per day for depression.</p> <p>* Risperidone (antipsychotic medication) 1 mg twice per day for schizoaffective disorder.</p> <p>* Zyprexa (antipsychotic medication) 20 mg at bedtime for schizoaffective disorder.</p> <p>Resident #30's current care plan documented the following:</p> <p>* Resident #30 was at risk for falls related to a left below the knee amputation.</p> <p>* The goals included no falls with injury for 90 days and less than one fall per 30 days.</p>	F 689	<p>nurse management team on or before 9/30/2018 to ensure that safety checks are initiated if greater than one fall has occurred and neurological evaluations were completed post falls.</p> <p>Education and System Changes</p> <p>Center nursing staff was re-educated by director of nursing or designee on or before 9/30/2018 regarding completion of neurological evaluations and adding supervision post non-witnessed/head involvement falls</p> <p>Center IDT will review risk management system during morning clinical meeting to ensure that residents that did sustain a fall increased supervision for multiple falls and neurological evaluations completed. Neurological evaluations will be turned into the unit manager for review.</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/1/2018, 5 residents will be reviewed weekly for 4 weeks and monthly for 2 months to ensure that supervision is added if multiple falls and neurological evaluations are completed post falls in not witnessed or have head involvement. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.</p>		

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F 689	<p>Continued From page 36</p> <p>* Interventions included:</p> <ul style="list-style-type: none"> <li>- Anti-roll back device to wheelchair.</li> <li>- Assess for changes in status and report to the physician as indicated.</li> <li>- Call light within reach.</li> <li>- Evaluate for infection.</li> <li>- Follow up with geriatric psychiatrist as needed.</li> <li>- Non-skid strips in front of the toilet.</li> <li>- Monitor for adverse effects of medications, i.e. dizziness, sedation, and follow up with the physician as indicated.</li> <li>- "Medication evaluation as needed."</li> <li>- Give verbal cues for safety and sequencing as needed.</li> <li>- Provide education to resident/caregiver to encourage slowing down when transferring to and from the toilet.</li> <li>- Remind the resident to use the call light for assistance with ambulating or transferring.</li> <li>- Keep the environment free of clutter and maintain a consistent arrangement of furniture.</li> </ul> <p>Resident #30's Incident and Accident reports documented the following falls between 8/5/18 and 8/23/18:</p> <p>* An unwitnessed fall in the bathroom on 8/5/18 at 7:00 AM. Resident #30 fell by the toilet when self-transferring. He was in a hurry due to not wanting to miss his smoke break. He missed the toilet and sat on the floor. Preventative measures in place prior to the fall included side rails along the bathroom wall, brakes on the wheelchair, and tennis shoes on. The root cause was Resident #30 being anxious about missing the smoke break and anxious about having a bowel</p>	F 689			

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F 689	<p>Continued From page 37</p> <p>movement. He also had an enlarged prostate, which could have contributed to a feeling of urgency to use the toilet. Education was provided to Resident #30 about slowing down and "watch when transferring." A request was sent for a urology appointment. Staff were to monitor Resident #30 by providing standby assistance when toileting.</p> <p>* An unwitnessed fall in Resident #30's room on 8/11/18 at 7:15 PM. The nurse heard Resident #30 yelling for help in his room and found him lying on his back on the floor. Resident #30 was alert with poor safety awareness. There was a medication error resulting in a double dose of Morphine on the day prior to the fall. Preventative measures in place prior to the fall included call light within reach and shoes on. Interventions added after the fall included having the call light in place and providing resident education to call for assistance with transfers. The root cause was Resident #30 transferring from bed to the wheelchair and the brakes were not locked. He had been sleeping more than usual. Education was provided to Resident #30 to use the call light for assistance, and an order was obtained from the nurse practitioner to hold the Morphine if the resident was sedated.</p> <p>* An unwitnessed fall on 8/12/18 at 2:00 AM. Resident #30 was found on the floor in his room. He said he tried to transfer himself to the wheelchair and he fell. "The same event happened a few hours prior [to] that fall." Education was provided to Resident #30 to use the call light. Preventative measures prior to the fall included bed in low position and call light within reach. Interventions added after the fall</p>	F 689			

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F 689	<p>Continued From page 38</p> <p>included bed in low position and call light within reach. The root cause was Resident #30 was confused and had poor safety awareness. The morning dose of Morphine was reduced.</p> <p>* An unwitnessed fall on 8/13/18 at 5:30 PM. Resident #30 was self-transferring from the wheelchair to bed. He had increased weakness due to a urinary tract infection. Preventative measures in place prior to the fall included the call light within reach and non-skid shoes. The root cause was the Resident #30 undergoing changes from his baseline (physical and mental status) and a urinary tract infection, with increased weakness and the need for more assistance. A comprehensive medical review was to be done with the regional medical director and center psychiatrist.</p> <p>* An assisted fall on 8/15/18 at 12:30 AM, when the CNA was assisting Resident #30 from the wheelchair to the toilet and his legs "gave out." The CNA assisted Resident #30 to the floor. Preventative measures in place prior to the fall included having the call light in reach, reminding Resident #30 to call for assistance, and avoiding clutter in his room. Interventions added after the fall included providing the assistance of a second person. The root cause was weakness due to "clinical changes of infection." A culture and sensitivity test, to determine which antibiotics were most successful in treating the type of infection Resident #30 had, was completed and the antibiotic was changed.</p> <p>On 8/23/18 at 1:45 PM, the DNS said most interventions for Resident #30's falls were medical interventions. The DNS said the</p>	F 689			

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NAME OF PROVIDER OR SUPPLIER  <b>APEX CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8211 USTICK ROAD BOISE, ID 83704</b>		
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F 689	<p>Continued From page 39</p> <p>psychiatrist and nurse practitioner were consulted, and medications were changed. The DNS said she did not think Resident #30 had a debility problem but it was a medical problem. The DNS said the first time Resident #30 fell he was in a hurry, it was smoke break time and he sat down too fast. The DNS said when Resident #30 fell on 8/5/18, he was still independent at that time. The DNS said Resident #30 had one fall prior to the MDS assessment on 6/21/18, so it changed the MDS assessment to indicate supervision and one person physical assistance with transfers. The DNS said she recently changed Resident #30's care plan because it took two people to assist him after a fall, but it was charted he was independent prior to that. The DNS said after Resident #30 fell on 8/13/18, his antibiotic was changed because culture results indicated it was resistant to the antibiotic he was taking. The DNS said she offered a transfer pole to Resident #30 and he did not want it. The DNS said Resident #30 was alert and oriented and he wanted to rush with everything. The DNS said if Resident #30 put his call light on he likely would not wait for help, and it was not a supervision matter.</p> <p>On 8/23/18 at 3:11 PM, Resident #30 was in bed lying on his right side and an abrasion was noted on his nose. When asked how the abrasion occurred, Resident #30 said he did not know what happened.</p> <p>On 8/23/18 at 3:12 PM, CNA #8 said it was passed on to her in shift report that Resident #30 had a fall that afternoon when he was trying to get into bed.</p>	F 689			

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F 689	Continued From page 40 The facility did not provide the supervision and assistance necessary to prevent Resident #30's six falls from 8/5/18 - 8/23/18.	F 689			
F 697 SS=D	Pain Management CFR(s): 483.25(k)  §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and record review, it was determined the facility failed to ensure pain medication was provided in a timely manner. This was true for 1 of 3 residents (#26) sampled for pain. Resident #20 had the potential for harm when she had to wait an hour for a pain pill. Findings include:  On 8/21/18 at 8:36 AM, Resident #26 stated it took a half an hour to receive pain medication after she asked for it. She stated she asked a CNA #1 for a pain pill and it had not yet been provided.  On 8/21/18 at 8:56 AM, Resident #26 was observed to ask NA #3 for pain medication.  On 8/21/18 at 9:20 AM, LPN #5 was observed at the medication cart outside Resident #26's room. She did not go into Resident #26's room.  On 8/21/18 at 9:35 AM, LPN #5 stated no-one told her Resident #26 needed a pain pill. She	F 697	Residents Affected  Resident # 26 was interviewed by RN unit manager on 9/20/2018 to ensure that pain medication requests were received timely with no complaints stated at the time of interview.  Residents with the potential to be affected  A review of other residents residing in the center will be reviewed by members of the IDT on or before 9/30/2018 to ensure that pain medication requests are received timely.  Education and System Changes  Center staff was re-educated on or before 9/30/2018 by director of nursing to communicate requests for pain control to assigned licensed nurse. If the nurse is not available, a note is to be left on the	10/4/18	

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F 697	Continued From page 41 was not told by the NAs/CNAs. She immediately headed to Resident #26's room.  On 8/22/18 at 10:25 AM, CNA #1 stated Resident #26 asked her for a pain pill earlier and she did not communicate the need for the pain pill to the nurse. She stated she asked NA #3 to alert the nurse regarding pain control for Resident #26.  On 8/22/18 at 10:37 AM, NA #3 stated Resident #26 told her she wanted a pain pill. NA #3 stated she could not find the nurse and did not relay the message.  On 8/24/18 at 9:17 AM, the DNS stated the CNA should have communicated directly to the LPN regarding Resident #26's need for the pain pill.	F 697	cart for communication.  Residents will be asked during center partner rounds if their pain medication requests are being received per their satisfaction.  Ongoing Monitoring  Beginning the week of 10/1/2018, 5 residents will be interviewed weekly for 4 weeks and monthly for 2 months to ensure that pain medication requests are received timely. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehensive assessment of a resident, the facility must ensure that---  §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758		10/4/18	

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F 758	<p>Continued From page 42</p> <p>specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy and procedure review, it was determined the facility failed to ensure the behaviors and potential medication side effects were routinely monitored for residents receiving psychotropic medications. This was true for 5 of 5 residents (#1, #30, #34, #46, and #64)</p>	F 758	<p>Residents Affected</p> <p>Residents #1, 30, 34, 46 and 64 will have behavior flow sheets and side effect monitoring updated on or before 9/30/2018.</p>		

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F 758	<p>Continued From page 43</p> <p>reviewed who received psychotropic medications. This failed practice created the potential for harm should residents receive psychotropic medications that were unnecessary, ineffective, or used for excessive duration, or should residents experience adverse reactions from psychotropic medications. Findings include:</p> <p>The facility's policy and procedure for Behaviors, revised on 11/28/17, documented the following:</p> <ul style="list-style-type: none"> <li>* The Behavior Monitoring form would be used for residents receiving psychotropic medications and would be continued as long the resident received the medication.</li> <li>* The licensed nurse would monitor and document medication side effects on the Suspected Medication Side Effects flowsheet.</li> </ul> <p>This policy was not followed. Examples include:</p> <p>a. Resident #1 was admitted to the facility on 8/27/16, and was readmitted on 4/23/18, with multiple diagnoses which included major depression.</p> <p>Resident #1's quarterly MDS assessment, dated 8/7/18, documented she was cognitively intact, had moderate depression, no behaviors, and received antipsychotic medications daily and antianxiety medications almost daily.</p> <p>Resident #1's recapitulated Physician orders for August 2018, documented she was to receive:</p> <ul style="list-style-type: none"> <li>* Buspirone HCl 15 mg tablet (anti-anxiety) by mouth two times a day for Bipolar Disorder,</li> </ul>	F 758	<p>Residents with the potential to be effected</p> <p>A review of other residents residing in the center will have updates to the behaviors to monitor and potential side effects on or before 9/30/2018 by members of the IDT</p> <p>Education and Systematic Changes</p> <p>Center nursing and social work staff were re-educated by the director of nursing on or before 9/30/2018 to document noted behaviors on the flow sheets and side effect sheets.</p> <p>Behavior flow sheets will be placed with treatment administration records for improved compliance</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/1/2018, 5 resident behavior flow sheets and side effects sheets will be reviewed weekly for 4 weeks and monthly for 2 months to ensure behaviors and side effects are documented. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.</p>		

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F 758	<p>Continued From page 44 ordered on 4/23/18</p> <ul style="list-style-type: none"> <li>* Risperidone Microsphere Suspension 37.5 mg (antipsychotic) intramuscular injection one time a day every 14 days for major depressive disorder, ordered on 5/9/18</li> <li>* Lorazepam tablet 0.5 mg (anti-anxiety) tablet by mouth, three times a day, ordered on 8/2/18</li> <li>* Lorazepam tablet 0.5 mg tablet by mouth, PRN (as needed) every six hours for anxiety for 60 days, ordered on 8/2/18</li> <li>* Depakote ER (extended release) 24-hour 500 mg (anti-seizure), one capsule by mouth at bedtime for Bipolar Disorder, ordered on 8/20/18</li> </ul> <p>A care plan, dated 1/5/18 and revised on 4/30/18, documented Resident #1 was at risk for distressed/fluctuating mood symptoms related to sadness/depression caused by placement in a long term care center and decline in overall health. Interventions included in the care plan were:</p> <ul style="list-style-type: none"> <li>* Encourage to seek support from her individual counselor</li> <li>* Utilize behavior flow sheet to document resident's undesirable actions such as perseverating on money and repeatedly asking staff about money and cigarettes</li> <li>* Monitor conditions that may contribute to mood state, including metabolic causes (delirium, diabetes, thyroid disorder, liver disease, renal failure, electrolyte imbalance) respiratory</li> </ul>	F 758			

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F 758	<p>Continued From page 45</p> <p>problems, cerebrovascular accident, delusions, hallucinations, psychiatric disorder</p> <ul style="list-style-type: none"> <li>* Monitor for worsening signs and symptoms of psychiatric disorder e.g. mania and hypomania (periods of great excitement/overactivity).</li> <li>* Monitor for signs and symptoms of worsening sadness/depression.</li> <li>* Monitor for signs and symptoms of delirium, including delusions/hallucinations, notify physician/mid-level provider.</li> <li>* Monitor laboratory test results and report abnormal results to physician/mid-level provider</li> </ul> <p>A care plan, dated 1/14/18 and revised on 4/30/18, documented Resident #1 was at risk for medication side effects including but not limited to falls, hypotension (low blood pressure) as evidenced by use of the following medication classes: narcotics, diuretics, vasodilators, anti-depressants and statins. Interventions included in the care plan were "Notify provider for any signs of adverse reactions or side effects related to medications, observe resident for abnormalities or adverse (effects) from medications and notify nurse..."</p> <p>The care plan did not include what the side effects of the specific medications were and did not include what psychotropics medications Resident #1 was taking.</p> <p>Resident #1 Behavior Monitoring Sheets for March, April, May, June, July and August 2018, documented she was monitored every shift for</p>	F 758			

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F 758	<p>Continued From page 46</p> <p>negative statements about living and repetitive statements about money and cigarettes. The Behavior Monitoring Sheet directed staff to document Resident #1's behavior by exception only. No documentation meant behaviors were not present on that shift.</p> <p>Resident #1's Nurse's Notes and Social Worker Notes documented:</p> <p>* Social Work Note dated 6/21/18 at 12:00 PM - Resident's #1 son discussed how the resident's mania was becoming worse over the last couple of months. He said Resident #1 had been calling him and his brother several times a day while they were at work and leaving the same message.</p> <p>* Nurse's Note, dated 7/31/18 at 9:59 PM - Resident #1 had increased anxiety as evidenced by pacing in her wheelchair and repetitive questions.</p> <p>* Nurse's Note, dated 8/1/18 at 11:24 AM - Resident #1 was anxious about her new medication not working. Education was provided to Resident #1 that it would take time for medication to take full effect.</p> <p>* Social Work Note, dated 8/1/18 at 3:53 PM - Resident #1 said she was more anxious lately and approaching multiple staff requesting that she go to her provider's office.</p> <p>Resident #1's Behavior Monitoring Flowsheets from March through August 2018, documented she did not have negative statements about living, and repetitive statements about money</p>	F 758			

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F 758	<p>Continued From page 47 and cigarettes.</p> <p>Resident #1's Monitoring for Side Effects Sheet for her medications included 23 standardized choices of side effects to select. The side effects monitoring did not include the specific side effects related the her current psychotropic medications.</p> <p>On 8/24/18 at 1:26 PM, SW #1 said nurses documented on the Behavior Monitoring Sheets by exception only. No documentation indicated the behavior did not occur on that shift. SW #1 said the facility had a new psychiatrist who came to the facility every Monday and discontinued some of the resident's psychotropics medications. When asked why Resident #1 was started on Depakote ER 500 mg on 8/20/18, SW #1 said she had not seen the psychiatrist notes and would look for it and give a copy to the surveyor. As of Monday, 8/27/18, the psychiatrist note had not been received from SW #1.</p> <p>b. Resident #64 was admitted to the facility on 7/27/18, with multiple diagnoses which included congestive heart failure and was on hospice care.</p> <p>Resident #64's admission MDS assessment, dated 8/3/18, documented she received antipsychotic and antidepressant daily.</p> <p>Resident #64's recapitulated Physician orders for August 2018, documented she was to receive:</p> <p>* Lorazepam Concentrate 2 mg/ml, give 0.25 ml by mouth every four hours as needed for Myoclonus (muscle spasm) or anxiety,</p>	F 758			

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F 758	<p>Continued From page 48</p> <p>* Olanzapine tablet 2.5 mg (antipsychotic), give 2.5 mg by mouth at bedtime for major depression and terminal agitation,</p> <p>* Duloxetine capsule 20 mg (antidepressant), give 20 mg by mouth in the morning for depression</p> <p>Resident #64's August 2018 Physician's orders documented the physician reviewed and agreed with the plan of care and current diagnosis by assessing the resident's condition and medications. The order stated to use psychotropic medications, including anti-psychotics, identifying the clinical rationale, and monitoring/addressing adverse consequences.</p> <p>Resident #64's Behavior Monitoring Sheet for August 1 through 23, 2018, documented she was being monitored for delusional statements, and the staff were directed to document Resident #1's behavior by exception only. No documentation meant the behavior was not present on that shift.</p> <p>Resident #64 Behavior Monitoring Sheet for 8/1/18 - 8/23/18, did not include documentation to indicate if she did, or did not, express delusional statements.</p> <p>Resident #64's Monitoring for Side Effects form included 23 standardized choices of side effects to select. The form did not indicate the specific side effects of her psychotropic medications.</p> <p>c. Resident #30 was admitted to the facility on 6/24/13 with multiple diagnoses, including</p>	F 758			

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F 758	<p>Continued From page 49</p> <p>schizoaffective disorder, bipolar disorder, anxiety disorder, and obsessive-compulsive disorder.</p> <p>Resident #30's annual MDS assessment, dated 6/21/18, documented the following:</p> <ul style="list-style-type: none"> <li>* He was cognitively intact.</li> <li>* Antipsychotic and antidepressant medications were received on seven out of the previous seven days.</li> </ul> <p>Resident #30's August 2018 physician orders documented the following:</p> <ul style="list-style-type: none"> <li>* Observe for significant side effects of antidepressant medications: sedation, drowsiness, dry mouth, weight gain, blurry vision, urine retention, agitation, and headache.</li> <li>* Monitor and notify the physician for adverse reactions and/or side effects of medications.</li> <li>* Escitalopram (antidepressant medication) 20 mg once per day for depression.</li> <li>* Risperidone (antipsychotic medication) 1 mg twice per day for schizoaffective disorder.</li> <li>* Zyprexa (antipsychotic medication) 20 mg at bedtime for schizoaffective disorder.</li> </ul> <p>Resident # 30's current care plan documented the following:</p> <ul style="list-style-type: none"> <li>* Resident #30 was at risk for complications related to psychotropic drugs.</li> <li>* Staff were directed to do the following: <ul style="list-style-type: none"> <li>- Complete the Behavior Monitoring sheet.</li> <li>- Monitor for alterations in mental status and functional level and report to the physician as needed.</li> </ul> </li> </ul>	F 758			

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F 758	<p>Continued From page 50</p> <ul style="list-style-type: none"> <li>- Monitor for the continued necessity of the medication</li> <li>- Monitor for side effects and consult the physician and/or pharmacist as needed.</li> <li>- Monitor behavior patterns and potential triggers.</li> <li>- Monitor for changes in appetite, expression, or excessive crying.</li> </ul> <p>Resident #30's August 2018 MAR documented the following:</p> <ul style="list-style-type: none"> <li>* The escitalopram and risperidone were administered each day from 8/2/18 - 8/23/18.</li> <li>* The Zyprexa was administered each day from 8/1/18 - 8/23/18.</li> </ul> <p>Resident #30's Behavior Monitoring Sheet documented the following:</p> <ul style="list-style-type: none"> <li>* Behavior symptoms were to be charted by exception only.</li> <li>* Behaviors to be monitored included impatient, "hurry up," excessive crying, and suicidal thoughts.</li> </ul> <p>There were no documented responses to the previously mentioned behaviors, to indicate if the behavior did, or did not, occur. The August 2018 nursing notes documentat a least one episode of impatience and hurring up.</p> <p>Resident #30's Suspected Medication Side Effects sheet documented the following:</p> <ul style="list-style-type: none"> <li>* Suspected medication side effects were to be charted by exception only.</li> <li>* The following medications were documented: escitalopram oxalate 20 mg, olanzapine 20 mg,</li> </ul>	F 758			

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F 758	<p>Continued From page 51 and risperidone 1 mg.</p> <p>The specific side effects to monitor Resident #30 for were not identified. Additionally, documentation of whether Resident #30 experienced side effects was not documented.</p> <p>d. Resident #34 was readmitted to the facility on 6/19/18, with multiple diagnoses including bipolar disorder, major depressive disorder, anxiety disorder, and personality disorder.</p> <p>Resident #34's quarterly MDS assessment, dated 6/27/18, documented the following:</p> <ul style="list-style-type: none"> <li>* She was cognitively intact.</li> <li>* Antipsychotic and antidepressant medications were received on seven out of the previous seven days.</li> </ul> <p>Resident #34's August 2018 physician orders documented the following:</p> <ul style="list-style-type: none"> <li>* Lexapro (antidepressant medication) 15 mg each morning for depression.</li> <li>* Quetiapine (antipsychotic medication) 200 mg at bedtime for depression.</li> </ul> <p>Resident #34's current care plan documented the following:</p> <ul style="list-style-type: none"> <li>* Document interventions and Resident #34's response.</li> <li>* Due to her history, assess Resident #34's level of suicide risk if she exhibits signs and symptoms of suicidal ideation.</li> <li>* Encourage Resident #34 to abstain from picking at her head and skin.</li> </ul>	F 758			

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F 758	<p>Continued From page 52</p> <ul style="list-style-type: none"> <li>* Use the behavior flow sheet to document excessive tearfulness (lasting longer than one hour), picking/scratching at skin, self isolation, expressions of not wanting to live, making disruptive sounds, and refusing to participate in the plan of care.</li> <li>* Document mood and behaviors on the Behavior Monitoring sheet.</li> <li>* Monitor for worsening signs/symptoms of psychiatric disorder such as mania, hypomania, frequent mood changes, or depression.</li> </ul> <p>Resident #34's August 2018 MAR documented the following:</p> <ul style="list-style-type: none"> <li>* The Lexapro was administered each day from 8/1/18-8/21/18, except for 8/12/18.</li> <li>* The Quetiapine was administered each day from 8/1/18-8/20/18.</li> </ul> <p>Resident #34's Behavior Monitoring sheet documented the following:</p> <ul style="list-style-type: none"> <li>* Behavior symptoms were to be charted by exception only.</li> <li>* Screaming/yelling at others.</li> <li>* Picking and scratching at skin.</li> <li>* Self isolation.</li> </ul> <p>There were no documented responses to the previously mentioned behaviors, to indicate if the behavior did, or did not, occur.</p> <p>Resident #34's Suspected Medication Side Effects sheet documented the following:</p> <ul style="list-style-type: none"> <li>* Suspected medication side effects were to be charted by exception only.</li> </ul>	F 758			

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F 758	<p>Continued From page 53</p> <ul style="list-style-type: none"> <li>* Escitalopram oxalate (Lexapro) 10 mg.</li> <li>* Quetiapine Fumarate 200 mg.</li> </ul> <p>The specific side effects to monitor Resident #34 for were not identified. Additionally, documentation of whether Resident #34 experienced side effects was not documented.</p> <p>e. Resident #46 was admitted to the facility on 8/22/17, with multiple diagnoses including major depressive disorder.</p> <p>Resident #46's annual MDS assessment, dated 7/13/18, documented the following:</p> <ul style="list-style-type: none"> <li>* Moderate cognitive impairment.</li> <li>* Antidepressant medication was received on seven out of the previous seven days.</li> </ul> <p>Resident #46's current care plan documented the following:</p> <ul style="list-style-type: none"> <li>* Resident #46 was at risk for complications related to the use of psychotropic drugs.</li> <li>* Staff were directed to do the following: <ul style="list-style-type: none"> <li>- Complete the behavior monitoring flowsheet to document refusal of care.</li> <li>- Monitor for the continued need of psychotropic medication "as related to behavior and mood."</li> <li>- Monitor for side effects and confer with the physician and/or pharmacist as needed.</li> <li>- Monitor medications for side effects and the resident's response contributing to his mood state.</li> <li>- Monitor for signs of delirium, delusions, hallucinations and notify the physician/provider as needed.</li> </ul> </li> </ul>	F 758			

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F 758	<p>Continued From page 54</p> <p>- Monitor for signs/symptoms of worsening depression.</p> <p>Resident #46's August 2018 MAR documented the following:</p> <p>* Cymbalta (Duloxetine) delayed release capsule 60 mg once per day for depression was administered each day from 8/1/18 - 8/24/18.</p> <p>Resident #46's Behavior Monitoring sheet documented the following:</p> <p>* Behavior symptoms were to be charted by exception only.</p> <p>* The behavior to be monitored was rejection of care.</p> <p>There were no documented responses to the previously mentioned behavior, to indicate if the behavior did, or did not, occur.</p> <p>Resident #46's Suspected Medication Side Effects sheet documented the following:</p> <p>* Suspected medication side effects were to be charted by exception only.</p> <p>* Duloxetine HCL (hydrochloride 60 mg and Trazodone HCL 50 mg.</p> <p>The specific side effects to monitor Resident #46 for were not identified. Additionally, documentation of whether Resident #46 experienced side effects was not documented.</p> <p>On 8/24/18 at 1:37 PM, LPN #4 said she did not document information on the Behavior Monitoring Sheet and Side Effect Sheet. LPN #4 stated if</p>	F 758			

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F 758	<p>Continued From page 55</p> <p>there was a behavior she would document it in a Progress Note. LPN #4 said if the resident did not have a behavior, she would not mark anything on the Behavior Monitoring Sheet.</p> <p>On 8/24/18 at 1:56 PM, LPN #4 said antipsychotics were medications and should be monitored under the umbrella of "monitor side effects of medications, any medication."</p> <p>On 8/24/18 at 2:16 PM, the DNS said staff charted by exception for behaviors and side effects, meaning it would only be documented if the resident exhibited a behavior or side effect. The DNS said monitoring for side effects of antidepressant medication was something that used to be done, and monitoring for side effects of medications was something that went into place prior to her working in the facility. The DNS said if she administered the medication and the resident exhibited a side effect or behavior, she would document a plus sign and document it in a Progress Note.</p> <p>On 8/24/18 at 4:24 PM, LPN #4 was ask to identify side effects of the following psychotropic medications: escitalopram, olanzapine, risperidone, quetiapine, duloxetine, and trazadone. LPN #4 named general side effects such as lethargy, nausea, vomiting, changes in level of alertness, and changes from the resident's baseline status. LPN #4 said she needed to look up some of the medications, and said if the resident exhibited a change it would be obvious and she would monitor for things that were different from the resident's usual status.</p> <p>On 8/28/18 at 7:45 AM, a faxed document was</p>	F 758			

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F 758	Continued From page 56 received from the facility that documented the facility's policy was to chart behaviors and side effects on the Behavior flowsheet. If there were no exhibited behaviors or side effects, the nurse would leave the area blank for that shift. If there were exhibited behaviors or side effects, the nurse would document the number of behaviors that occurred during that shift and follow up as indicated by the physician's orders.	F 758			
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)  §483.45(f) Medication Errors. The facility must ensure that its-  §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff and pharmacist interview, and record review, it was determined the facility failed to ensure the medication error rate was less than 5%. This was true for 2 of 33 medications (6.06%) which affected 2 of 10 residents (#9 and #19) whose medication administration was observed. The failure created the potential for harm should sub-therapeutic effect occur when carvedilol (medication to treat high blood pressure and heart failure) was not administered to Resident #9 and Resident #19 as ordered. Findings include:  The Nursing 2019 Drug Handbook documented carvedilol was to be given with food.  1. On 8/23/18 at 4:09 PM, RN #3 was observed as she prepared, then administered two oral medications including carvedilol 3.125 mg	F 759	Residents Affected  Resident # 9 and 19 were assessed by a licensed nurse on 9/20/2018 to ensure that there was no adverse effects related to administration of medication without food with none noted.  Residents with the potential to be effected  A review of other residents residing in the center requiring medications to be administered with food will be reviewed by a member of the nurse management team on or before 9/30/2018 to ensure medications are administered as ordered.  Education and System Changes	10/4/18	

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F 759	<p>Continued From page 57 (milligrams) to Resident #19.</p> <p>Resident #19's physician order dated 12/30/17, documented Resident #19's carvedilol 3.125 mg was to be given two times a day for hypertension (high blood pressure) with breakfast and dinner.</p> <p>On 8/23/18 at 4:15 PM, RN #3 read the physician order and said dinner was at 5:00 PM and she did not think food had any effect on how Resident #19's carvedilol worked.</p> <p>On 8/24/18 at 9:23 AM, Pharmacist #1, during telephone interview, said carvedilol should be given with meals, and if the meal was at 5:00 PM and carvedilol was given at 4:00 PM, then it was not given with a meal.</p> <p>2. On 8/24/18 at 7:48 AM, LPN #4 was observed as she crushed 11 medications including carvedilol 6.25 mg, put them in a small medication cup (30 cubic centimeter container) and mixed them with apple sauce. LPN #4 then administered the medications to Resident #9. LPN #4 also checked the blood glucose of Resident #9 and administered his insulin. LPN #4 then took Resident #9 to the dining room. The carvedilol pharmacy label documented the medication was to be administered by mouth two times a day with breakfast and dinner.</p> <p>On 8/24/18 at 9:23 AM, Pharmacist #1, during telephone interview, was asked if carvedilol mixed with apple sauce in a 30 cc (cubic centimeter) container was considered as the medication given with food or a meal. Pharmacist #1 said he would consult the senior pharmacist and get back to the surveyor.</p>	F 759	<p>Center licensed nurses will be re-educated by director of nursing or designee on or before 9/30/2018 regarding medications that require administration of medications with food.</p> <p>Center licensed nurses will have competencies completed on or before 9/30/2018 to validate correct medication administration.</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/1/2018, 5 licensed nurses will be reviewed weekly for 4 weeks and monthly for 2 months to ensure that medications that require administration with food are administered correctly. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.</p>		

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F 759	Continued From page 58	F 759			
F 761 SS=E	<p>On 8/24/18 at 10:39 AM, Pharmacist #1 called back and said 200 calories or more was considered to be a meal. A half cup of apple sauce had 50 calories and a 30 cc of apple sauce was, therefore, not a meal.</p> <p>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure pharmacy</p>	F 761		10/4/18	
			F 761 Residents Affected		

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F 761	<p>Continued From page 59</p> <p>labels matched the physician's order. This was true for 1 of 8 residents (#64) whose medication administration was observed. The facility also failed to ensure expired medications were not available for administration to residents. These failed practices created the potential for harm should Resident #64's Methadone HCl (pain medication) be administered at the wrong dose and/or residents received expired medications with decreased efficacy. Findings include:</p> <p>1. On 8/21/18 at 5:11 PM, during the inspection of the Medication Cart in the 500 Hall with RN #2 present, a bottle of Robitussin (cough syrup) approximately half full was found with an expiration date of 7/2018. RN #2 said he would dispose the expired medication.</p> <p>On 8/21/18 at 5:19 PM, during the inspection of the Medication Cart in the 700 Hall with LPN #1 present, the following were found:</p> <ul style="list-style-type: none"> <li>* Robitussin (cough syrup), approximately ¾ full, expired 7/2018</li> <li>* Centrum Silver (vitamins), expired 6/2018</li> <li>* Geri Lanta (antacid), expired 7/2018.</li> </ul> <p>LPN#1 said she would dispose the expired medications.</p> <p>On 8/22/18 at 3:37 PM, during the inspection of the Medication Room with LPN #2 present, a bottle of Robitussin approximately 1/3 full was found with an expiration date of 4/2018. LPN #2 said the facility used generic medication for most of the medications and the Robitussin was from a resident who brought the medication to the facility. LPN #2 said she would dispose the</p>	F 761	<p>Identified expired medications were destroyed on or before 9/20/2018 by a licensed nurse.</p> <p>Resident # 64 had medication label replaced on or before 9/30/2018 Residents with the potential to be affected</p> <p>Medication carts and medication rooms will be inspected by members of the nurse management team on or before 9/30/2018 to ensure that no expired medications were available for administration.</p> <p>Medication cards will be reviewed against medication administration records by members of the nurse management team on or before 9/30/2018 to ensure they match. New labels will be placed at the time of review for any that do not.</p> <p>Education and System Changes</p> <p>Licensed nurses will be re-educated by director of nursing on or before 9/30/2018 regarding obtaining new prescription with correct label</p> <p>Medication carts including medication directions will be reviewed by members of nurse management team monthly to ensure medications are not expired and medications match administration record</p> <p>Ongoing Monitoring</p>		

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F 761	Continued From page 60 expired medication.  2. On 8/22/18 at 12:34 PM, LPN #2 was observed as she administered two tablets of Methadone HCl (hydrochloride) to Resident #64. The Methadone HCl pharmacy label documented "Give four tabs (tablets) 40 mg by mouth twice daily and give three tabs every day for pain." LPN #2 said the order was changed to 2 tablets, instead of the 3 or 4 noted on the pharmacy label, and there should be a sticker on the medication card to indicate the order was changed. LPN #2 then went to the nursing station and showed the medication sticker to the surveyor, which said "direction changed refer to chart."	F 761	Beginning the week of 10/1/2018, 5 medication cards will be reviewed weekly for 4 weeks and monthly for 2 months to ensure that the medication label matches the medication administration record. The medication carts and medication room will also be reviewed weekly for 4 weeks an monthly for 2 months to ensure that they are free from expired medications. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is achieved. Director of nursing responsible for compliance.		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)  §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		10/4/18	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 883	<p>Continued From page 61</p> <p>was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, and policy review, it was determined the facility failed to ensure residents received or were re-offered,</p>	F 883	<p>Residents Affected</p> <p>Resident # 31 discharged from the center</p>		

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F 883	<p>Continued From page 62</p> <p>the pneumococcal vaccines per the Center for Disease Control (CDC) recommendations. This was true for 4 of 5 (#17, #23, #31 and #49) residents reviewed for Pneumococcal immunization. This failure created the potential for harm should residents contract pneumonia. Findings include:</p> <p>The facility's Pneumococcal Vaccine Informed Consent form, documented:</p> <p>*For persons 65 or older who have not received pneumococcal vaccination or history is unknown may receive a dose of PCV 13 followed one year later with a dose of PPSV23.</p> <p>*For persons who previously received PPSV23 at or after age of 65 years may receive PCV 13 at least one year after the most recent PPSV23.</p> <p>*For persons 65 or older who previously received one or more doses of PPSV23 before age 65 may receive PCV 13 at least one year after the most recent PPSV23 and may receive PPSV23 at least one year after PCV 13 and greater than five years after first PPSV23 dose.</p> <p>*For persons 64 and younger with high risk conditions, the pneumococcal vaccination series will be administered based on the CDC guidelines as determined by the physician.</p> <p>The above policy was not followed. Examples include:</p> <p>a. Resident #17 was readmitted to the facility on 1/12/18, with multiple diagnoses, including breast cancer. She was originally admitted to the facility</p>	F 883	<p>on 9/8/2018. Residents 17, 23, and 49 will be re-offered the pneumococcal vaccine by the infection preventionist on or before 9/30/2018.</p> <p>Residents with the potential to be affected</p> <p>A review of other residents residing in the center will be reviewed by infection preventionist on or before 9/30/2018 to ensure the pneumococcal vaccine has been offered or re-offered as indicated by consent form and documentation.</p> <p>Education and System Changes</p> <p>Licensed nurses will be re-educated on or before 9/30/2018 to offer the vaccine at time of admission and to document refusals in the medical record.</p> <p>Residents that remain in the center will be re-offered the vaccine on an annual basis during the annual care planning meeting by a nursing representative. Refusals will be documented in the medical record.</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/1/2018, 5 residents will be reviewed weekly for 4 weeks and monthly for 2 months to ensure that vaccines are offered at time of admission and annually thereafter. Results of these audits will be reviewed by center IDT for a minimum of 3 months or until substantial compliance is</p>		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 883	<p>Continued From page 63 on 12/27/07</p> <p>Resident #17's quarterly MDS assessment, dated 3/9/18, documented she was "up to date" with the Pneumococcal vaccination.</p> <p>Resident #17's Pneumococcal Immunization Consent, dated 3/11/15, documented she refused to receive the Pneumococcal vaccine. The form documented Resident #17 received the Pneumococcal vaccine three years prior. The form did not document what type of Pneumococcal vaccine she received three years ago.</p> <p>Resident #17's clinical record did not include documentation the Pneumococcal vaccine was re-offered to the resident.</p> <p>b. Resident #23 was admitted to the facility on 9/7/16 with multiple diagnoses, including cerebral infarction (stroke) with hemiplegia (weakness or paralysis on one side of the body).</p> <p>Resident #23's quarterly MDS assessment, dated 8/9/18, documented he was "up to date" with the Pneumococcal vaccination.</p> <p>A Pneumococcal Vaccine Informed Consent form, dated 9/7/16, documented Resident #23 refused to receive the Pneumococcal vaccine. The form documented Resident #23 already received the vaccination. The form did not document when Resident #23 received the vaccination and the type of Pneumococcal vaccine Resident #23 received.</p> <p>Resident #23's clinical record did not include</p>	F 883	<p>achieved. Director of nursing responsible for compliance.</p>		

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F 883	<p>Continued From page 64</p> <p>documentation the Pneumococcal vaccine was re-offered to the resident.</p> <p>c. Resident #31 was admitted to the facility on 7/28/17 with multiple diagnoses, including dementia.</p> <p>Resident #31's annual MDS assessment, dated 8/2/18, documented she was "up to date" with the Pneumococcal vaccination.</p> <p>A Pneumococcal Vaccine Informed Consent form, dated 7/28/17, documented Resident #31 refused to receive the Pneumococcal vaccine. The form documented she received the vaccine in 2015. The form did not document the type of Pneumococcal vaccine Resident #31 received.</p> <p>d. Resident #49 was readmitted to the facility on 7/10/18 with multiple diagnoses, including Alzheimer's disease (dementia). She was initially admitted to the facility on 9/7/16.</p> <p>Resident #49's quarterly MDS assessment, dated 7/17/18, documented she was "up to date" with the Pneumococcal vaccination.</p> <p>A Pneumococcal Vaccine Informed Consent form, signed on 11/24/16, documented Resident #49 refused to receive the Pneumococcal vaccine. The form did not document the reason Resident #49 refused the vaccination.</p> <p>Resident #49's clinical record did not include documentation the Pneumococcal vaccine was re-offered to the resident.</p> <p>On 8/23/18 at 10:35 AM, the Infection</p>	F 883			

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F 883	Continued From page 65 Preventionist said the Pneumococcal Vaccine Informed Consent form should be completed. The Infection Preventionist said the reason for refusal should also be documented. The Infection Preventionist said she would re-approach the residents and offer the Pneumococcal vaccine series to those who needed it.	F 883			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001320</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/24/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>APEX CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8211 USTICK ROAD BOISE, ID 83704</b>
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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the State licensure survey conducted on August 20, 2018 to August 24, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Presie Billington, RN Cecilia Stockdill, RN Teri Hobson, RN</p> <p>IP = Infection Preventionist</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure required committee members participated in Infection Control Meetings. This failure created the potential to effect all residents, staff and visitors to the facility. Findings include:</p> <p>On 8/23/18 at 2:36 PM, the Infection Preventionist said the facility conducted quarterly Infection Control Meetings.</p> <p>Infection Control Committee attendance records, dated 3/21/17, 9/17/18, 11/28/17, and 5/22/18 documented:</p>	C 664	<p>C 664 Residents Affected</p> <p>An infection control meeting will be held on or before 9/25/2018, to include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative.</p> <p>Residents with the potential to be affected</p> <p>Residents will be informed of the infection control members during the next resident</p>	10/4/18

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
Electronically Signed

TITLE

(X6) DATE  
09/24/18

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001320</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/24/2018</b>
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C 664	<p>Continued From page 1</p> <p>*A representative from housekeeping and dietary did not participate in 11/28/17 meeting.</p> <p>The Infection Preventionist did not provide an explanation as to why a representative from housekeeping did not participate in 11/28/17 meeting.</p>	C 664	<p>council meeting.</p> <p>Education and System Changes The facility Interdisciplinary team will be re-educated on or before 9/30/2018 in regards to the individuals who must participate in the quarterly Infection Control Meeting. This includes the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative.</p> <p>Ongoing Monitoring</p> <p>Beginning the week of 10/4/18, the previous month's Infection Control Attendance list will be reviewed to ensure all participants are there a minimum of quarterly. If an IDT member is absent for an Infection Control Meeting the Center Executive Director will be responsible for review of the minutes with the member of the Infection Control meeting minutes. Audits will be completed for a minimum of 3 months or until substantial compliance can be achieved. Center Executive Director is responsible for compliance.</p>	