



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

September 28, 2018

Robert Deloach, Administrator
Karcher Post-Acute & Rehabilitation Center
1127 Caldwell Boulevard
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr. Deloach:

On **September 14, 2018**, a survey was conducted at Karcher Post-Acute & Rehabilitation 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 federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

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Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 8, 2018**. Failure to submit an acceptable PoC by **October 8, 2018**., may result in the imposition of additional civil monetary penalties by **October 31, 2018** .

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

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

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

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

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

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

- Civil money penalty
- Denial of payment for new admission **December 14, 2018**

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We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 14, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

F0883 -- S/S: F -- 483.80(d)(1)(2) -- Influenza And Pneumococcal Immunizations

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

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

- Residents # **#4, #13, #15, #25, #44** as identified on the enclosed Resident Identifier List.

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

If you believe the deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required

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information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

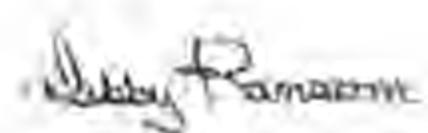
- BFS Letters (06/30/11)

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

This request must be received by **October 12, 2018**.. If your request for informal dispute resolution is received after **October 12, 2018**., the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

dr/lj
Enclosures

cc: Chairman, Board of Examiners - Nursing Home Administrators

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/14/2018
NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from September 10, 2018 through September 14, 2018. The surveyors conducting the survey were: Edith Cecil, RN, Team Coordinator Presie Billington, RN Wendi Gonzales, RN Belinda Day, RN Abbreviations CDC = Center for Disease Control and Prevention CNA = Certified Nursing Assistant DNR/DNI = Do Not Resuscitate/Do Not Intubate DNS = Director of Nursing LPN = Licensed Practical Nurse LSW = Licensed Social Worker MDS = Minimum Data Set mg = milligram POA = Power of Attorney POST = Physician Orders for Scope of Treatment	F 000			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		10/15/18	

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

TITLE

(X6) DATE

Electronically Signed

10/08/2018

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 578	Continued From page 1 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance 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	F 578	F578 For resident #4 a new Living Will/medical DPOA was completed with the resident as the original had been asked of resident and family, but they were unable to provide. The Living Will/DPOA was		

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F 578	<p>Continued From page 2</p> <p>the residents' advance directives, or documentation of their decision not to formulate advance directives. This was true for 3 of 7 (#4, #15, and #24) residents reviewed for advance directives. This failure created the potential for harm if a resident's medical treatment wishes were not honored should the resident be unable to communicate them to a doctor. Findings include:</p> <p>The facility's advance directives policy and procedure dated June 2018, documented residents had 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. During the admission process, the facility would identify if the resident had an advance directive. If the resident had an advance directive, a copy would be requested and kept in the resident's medical record. If the resident did not have an advance directive, assistance would be provided. Any changes to the resident's advance directive and/or POST would be updated and documented in the resident's medical record as necessary.</p> <p>This policy was not followed. Examples include:</p> <p>a. Resident #4 was readmitted to the facility on 11/17/17, with multiple diagnoses including kidney failure, congestive heart failure, chronic obstructive pulmonary disease and depression.</p> <p>Resident #4's admission MDS assessment, dated 11/17/17, readmission MDS assessment dated 3/15/18, and significant change MDS assessment dated 6/8/18, documented she was cognitively intact, and family or significant other</p>	F 578	<p>placed in the resident's medical record. Completed 10/2/18</p> <p>For resident #15 A new Living will/Medical DPOA was completed with the resident as the original was unable to be provided when asked. The Living Will/DPOA was placed in the resident's medical record. Completed on 9/24/18.</p> <p>For resident #24 a copy was provided by the resident's husband and placed into the resident's medical record. Completed 9/27/18</p> <p>All residents were identified to be at risk for the same deficient practice and all current in-house residents had an audit of their medical records to determine if a Living Will/DPOA information was provided to the resident; that documentation was present that this occurred; and if assistance was needed to complete appropriate forms was provided. Any resident without above mentioned information, the families and/or resident have been contacted to complete appropriate paperwork for Advanced Directives and to have in the resident's medical record. Complete by 10/15/18</p> <p>Education to social services and medical records was provided on policy and procedures for Idaho State Guidelines on Advanced Directives and maintaining copies/documentation in the medical record. Completed 9/14/18.</p>		

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F 578	<p>Continued From page 3</p> <p>did not participate in the assessment.</p> <p>Resident #4's medical record did not include documentation of advance directives, or documentation advance directives were discussed with her.</p> <p>b. Resident #15 was admitted to the facility on 4/12/17, with multiple diagnoses including heart disease, osteoarthritis, depression and anxiety.</p> <p>Resident #15's quarterly MDS assessment dated 7/12/18, documented she was cognitively intact, and family or significant other did not participate in the assessment.</p> <p>Resident #15's medical record did not include documentation of advance directives, or documentation advance directives were discussed with her.</p> <p>c. Resident #24 was admitted to the facility on 9/13/17, with multiple diagnoses including progressive supranuclear ophthalmoplegia (a degenerative disease involving the gradual deterioration and death of specific volumes of the brain), and dysphagia (difficulty swallowing).</p> <p>Resident #24's quarterly MDS assessment dated 8/3/18, documented she was cognitively impaired, and family or significant other did not participate in the assessment.</p> <p>Resident #24's medical record did not include documentation of advance directives, or documentation advance directives were discussed with her and/or her representative.</p>	F 578	<p>Systematic change to ensure that the Advanced Directive is reviewed and received for all new admissions include: Advanced Directive added to the admission check list for the admitting nurse to be the first to ask the resident/family if they have an Advanced Directive and to have them bring it in; Admissions Coordinator will review this with the resident/family during signing of admission paperwork; During the 72 hour care conference again the Social Worker will request this information on Advanced Directives and assist resident/family with paperwork if needed. The Social Worker will ensure to document appropriately in the resident's medical record regarding Advanced Directive. During Quarterly/Annual/Significant change care planning, the social worker will review with the resident/family the Advanced Directives to ensure accuracy and if any changes need to be made. The IDT will review all new admissions during morning MACC meeting to assure the proper procedure has been followed. Complete 10/15/18.</p> <p>To ensure that corrective actions are effective and compliance maintained, the Social Worker will audit all new admissions weekly x4, then monthly x3, and then quarterly x3. The Medical Records coordinator will complete an audit on all new admissions by use of the admission check list to ensure that the completed Advanced Directive is present and placed in the resident's medical</p>		

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F 578	Continued From page 4 On 9/11/18 at 10:02 AM, the LSW stated that on admission, residents were provided a packet with advance directives information. The resident or their family or POA would provide a copy of the resident's advance directives, or complete the paperwork and submit it to the facility. If the resident needed help formulating advance directives, the LSW said she provided assistance and it would be documented in the progress notes. On 9/12/18 at 12:09 PM, the LSW stated advance directives should be in the residents' records.	F 578	record. To ensure that corrective action is maintaining compliance, the Social Worker and Medical Records will report all audit findings at every QAPI meeting. Responsible party will be the Social Services Director and/or Medical Records.		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		10/15/18	

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F 656	<p>Continued From page 5</p> <p>rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interviews, it was determined the facility failed to develop and implement comprehensive resident-centered care plans. This was true for 5 of 12 residents (#4, #6, #29, #44, and #100) whose care plans were reviewed. Resident #4's care plan did not address safety concerns when smoking off the facility property. Resident #29's and Resident #44's care plans did not address the identification of resident-specific behaviors to monitor related to the use of psychotropic medications. Resident #100's care plan did not address he was on isolation precautions. Resident #6's care plan did not include the settings for use of an air mattress to prevent pressure ulcers. These failures created the potential for decline in health and potential for harm due to inappropriate or</p>	F 656	<p>F656</p> <p>For resident #100-this resident was discharged from the facility to home.</p> <p>For resident #6 the setting for the Air Mattress was added to her comprehensive care plan and in-room care plan. Completed 9/14/18.</p> <p>For resident #4 the care plan for resident's safety when going off property to smoke unsupervised has been updated to include her smoking objectives, goals, preferences and outcomes. Completed 9/24/18.</p>		

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F 656	<p>Continued From page 6 inadequate care. Findings include:</p> <p>1. Resident #100 was admitted to the facility on 8/11/18 and was readmitted on 8/31/18 with multiple diagnoses including enterocolitis (inflammation of the small intestine and colon) due to Clostridium difficile, often called C. diff, a bacteria that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon.</p> <p>A Physician's order, dated 8/31/18, included Vancomycin (antibiotic) 50 mg/ml by mouth four times a day and directed staff to put Resident #100 on contact isolation precautions.</p> <p>Resident #100's care plan dated 9/3/18, documented Resident #100 had C. diff and was at risk for future recurrence of C. diff. Interventions included in the care plan were:</p> <ul style="list-style-type: none"> *Assess the duration, frequency, characteristics, consistency, and quantity or any episodes of diarrhea. * Check labs as ordered by the medical doctor and notify the doctor of the results. * Encourage fluids throughout the day and when awake at night. * Teach resident to wash hands after defecation. * Encourage resident to wash hands before meals. * Teach visitors to wash hands upon entering and leaving the resident's room. 	F 656	<p>For resident #44-this resident has been discharged to lower level of care.</p> <p>For resident #29 the resident's care plan was reviewed and updated to include the resident's diagnosis for use of psychotropic medication (anti-depressant), specific behaviors to monitor, and interventions to be done if these behaviors were present. Completed 9/24/18.</p> <p>Any resident that requires any type of precautions is at risk for this deficient practice. Currently in-house there is one resident that is on Contact Precautions. The care plan has been reviewed to ensure that it includes "Contact Precautions" and appropriate interventions immediately upon noted Diagnosis. Completed 9/28/18.</p> <p>Any resident that has an air mattress is at risk for this deficient practice. All resident's with an air mattress were audited and the comprehensive care plan and in-room care plans have been updated to include the setting of the air bed. The licensed (LN) nurse will monitor every shift that the air mattress is set as per required setting and will document on the Treatment Administration Record (TAR). The nursing staff have been educated regarding this change to the TAR, care plan, and in-room care plans. Complete 10/15/18.</p> <p>Any resident who smokes is at risk for</p>		

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F 656	<p>Continued From page 7</p> <p>* Use principles of infection control and universal/standard precautions when providing cares.</p> <p>Resident #100's care plan did not include documentation he needed to be placed on contact isolation precautions as ordered by the physician.</p> <p>On 9/14/18 at 10:29 AM, the DNS said Resident #100's care plan did not include all information related to contact isolation.</p> <p>2. Resident #6 was admitted to the facility on 2/13/17, with multiple diagnoses including chronic kidney disease stage 3 (with moderate kidney damage).</p> <p>Resident #6's annual MDS assessment, dated 3/14/18, documented she had a Stage III pressure ulcer and used a pressure reducing device for her bed.</p> <p>Resident #6's current care plan documented she was on hospice and had a Stage III pressure ulcer. One intervention, initiated on 12/15/17, was "Resident has pressure reduction air support mattress" .</p> <p>On 9/10/18 at 3:51 PM, 9/11/18 at 9:22 AM and 9/12/18 at 8:47 AM, Resident #6 was observed in bed. The mattress pump showed an alternating cycle, 4 bars were lit for time (every 15 minutes) and 5 bars were lit for pressure range.</p> <p>On 9/13/18 at 9:25 AM, CNA #1 said she did not know the setting for Resident #6's mattress pump</p>	F 656	<p>safety concerns when smoking off property without supervision as facility is a non-smoking facility. There is one other resident that prefers to smoke unsupervised off property. Reviewed with this resident on his objectives, goals and preferences for smoking. Smoking cessation has been discussed with him, but prefers to smoke. Per this resident, he verbalized no fear of safety issues. For resident #4 and the aforementioned resident, they have now agreed to have an identifying tag that will have their name, facility address, and phone number; the facility phone number as "ICE" in their cell phone that they carry; reflectors on their wheel chair; Complete 10/15/18.</p> <p>Any resident that has a diagnosis that requires a psychotropic medication has had their comprehensive care plan audited and updated appropriately to ensure that there is an appropriate diagnosis for psychotropic medication use, that individualized specific behaviors are present on the care plan and that the goal and interventions reflect how the staff are to intervene when any behaviors are present. Completed 10/15/18.</p> <p>The interdisciplinary team (IDT) have been re-educated on proper formulation of the care plan to include specific problem areas for each individual resident, that the goals are realistic and measurable, and that the interventions are specific to reflect how staff are to care</p>		

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F 656	<p>Continued From page 8</p> <p>and it was hospice staff who set it up. CNA #1 said if the mattress pump alarmed she would press the reset button.</p> <p>On 9/13/18 at 9:36 AM, the DNS reviewed Resident #6's care plan and said the settings for the air mattress were not in his care plan. The DNS said the air mattress was set up according to the Resident #6's weight and she understood the importance for the staff to know the settings of the air mattress.</p> <p>3. Resident #4 was readmitted to the facility on 11/17/17, with multiple diagnoses including kidney failure, congestive heart failure, chronic obstructive pulmonary disease, and depression.</p> <p>Resident #4's admission MDS assessment dated 11/17/17, readmission MDS assessment dated 3/15/18, and significant change MDS assessment dated 6/8/18, documented she was cognitively intact and current tobacco use.</p> <p>Resident #4's care plan dated 3/8/18, did not document her smoking objectives, goals, preferences, and outcomes.</p> <p>On 9/12/18 at 3:16 PM, the DNS stated residents who smoked were assessed to make sure they were safe to smoke and it would be documented in the resident's care plan. After the residents were assessed for safety and independence, residents were able to leave the facility to smoke off campus with assistance, with family, or independently.</p> <p>4. Resident #44 was readmitted to the facility on 10/31/17, with multiple diagnoses including</p>	F 656	<p>for the resident for any problem area. Completed 10/15/18.</p> <p>The IDT will review the care plan during the morning MACC meeting for any new orders or changes in resident's condition that include measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs.</p> <p>the resident's medical, nursing, and mental/psychosocial needs.</p> <p>To ensure that corrective action is maintaining compliance, the Director of Nursing/designee will report all audit findings at every QAPI meeting.</p> <p>Five resident care plans will be audited to ensure these actions are effective for maintaining long term compliance: weekly x 4, monthly x 3, quarterly x 3.</p> <p>To ensure corrective action is maintained, the Director of Nursing/Designee will report all audit findings at each QAPI meeting.</p> <p>Responsible party: Director of Nursing/designee</p>		

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F 656	<p>Continued From page 9</p> <p>dementia, depression, chronic kidney disease, peripheral vascular disease, and diabetes mellitus.</p> <p>Resident #44's quarterly MDS assessment, dated 8/29/18, documented he was cognitively intact and received antipsychotic and antidepressant medications on a routine basis.</p> <p>Resident #44's physician orders, dated 10/26/17 and 10/31/17, documented bupropion hydrochloride (antidepressant) 300 mg by mouth one time daily for depression, escitalopram oxalate (antidepressant) 10 mg by mouth one time daily for depression, and risperdal (antipsychotic) 0.5 mg by mouth one time at bedtime for dementia.</p> <p>Resident #44's current care plan documented he was at risk for adverse reactions and side effects related to the use of the bupropion hydrochloride, escitalopram oxalate, and risperdal. The care plan interventions directed staff to document "episodes of anxiety, behaviors, etc." on a behavior sheet and monitor for side effects. The care plan did not document resident-specific behaviors to monitor Resident #44 for related to the use of the antidepressant and antipsychotic medications.</p> <p>On 9/14/18 at 11:00 AM, the DNS stated the facility would be reviewing and updating care plans to ensure they were comprehensive and addressed psychotropic medications, resident-specific target behaviors, and behavioral interventions.</p> <p>5. Resident #29 was admitted to the facility on</p>	F 656			

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F 656	Continued From page 10 2/6/18 with diagnoses that included vascular dementia with behavioral disturbance and depression. Resident #29's physician orders for September 2018, included escitalopram (antidepressant) 20 mg by mouth one time daily for depression. A quarterly MDS assessment, dated 8/17/18, documented Resident #29 received antidepressant medication daily. A Psychotropic Drug Use care plan, dated 2/14/18, documented Resident #29 was at risk for adverse reaction/side effects related to the use of the antidepressant. The care plan did not include resident-specific behaviors staff were to monitor for or interventions staff were to implement when he exhibited resident-specific depressive symptoms. A Psychotropic Drug Assessment, dated 8/6/18, documented sadness, withdrawal, and agitation as the indications for use of escitalopram. On 9/14/18 at 11:00 AM, the DNS stated the facility would be reviewing and updating care plans to ensure they were comprehensive and addressed psychotropic medications, resident-specific target behaviors, and behavioral interventions.	F 656			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/15/18	

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F 689	<p>Continued From page 11</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 observation, record review, policy review, and resident and staff interview, it was determined the facility failed to identify environmental hazards and assess the risk of an accident a resident may sustain while smoking off campus from the facility. This was true for 1 of 3 (#4) residents sampled for ensuring the safety of residents smoking. This failure created the potential for harm should an individual resident sustain an injury from smoking off campus from the facility. Findings include:</p> <p>The facility's admission packet dated February 2016, documented the resident group assumed all responsibility for failure to comply with the smoking policy. If the resident chose to smoke either on or off the facility premises in violation of the smoking policy, the facility assumed no responsibility for the resident's choice or injury sustained there from. The resident group agreed to hold the facility harmless for any injury suffered in the act of noncompliance with laws, regulations and the facility's smoking policy.</p> <p>The facility's policy and procedure dated July 2018, documented the facility was to provide a safe environment for residents by limiting the use of smoking materials on its grounds. Residents who wished to smoke would be assessed on admission for their ability to smoke safely. An established set of criteria would be used to evaluate safety risks. Residents who did not</p>	F 689	<p>F 689 Currently there are two residents who reside at the facility that smoke, and are also independent. Additionally, there are two more independent residents who leave the facility unattended. Both smoking residents have been offered smoking cessation classes in conjunction with nicotine patches to help them quit smoking. This facility remains a non-smoking facility so reasonable accommodations must be met to help assure the safety of these residence while off premises.</p> <p>Reasonable accommodations are not limited to the following and can be provided to our other independent residents as they wish. All residents, who are assessed and deemed independent, will periodically be reassessed as part of their continuing care plan development and care conference routine. Residents will be offered additional reflective tape, reflectors, or flags that can be affixed to their wheelchairs as desired and as applicable. The facility has a number of reflective jackets that can be worn while residents are out of the facility and off premises if they desire. Complete 10/15/18</p>		

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F 689	<p>Continued From page 12</p> <p>meet the established criteria to smoke independently would be provided assistance and/or supervision during all smoking activities. No smoking or use of smoking materials would be allowed on the grounds, including parking lots, and would only be allowed off campus. Should any incidents of unsafe smoking or unsafe management of smoking materials occur, nursing staff would be notified immediately and a new smoking assessment completed, to determine further safety measures. Supervision for smoking was to be provided solely by facility staff or the resident's family or designated individual.</p> <p>1. Resident #4 was readmitted to the facility on 11/17/17, with multiple diagnoses including kidney failure, congestive heart failure, chronic obstructive pulmonary disease and depression.</p> <p>Resident #4's admission agreement dated 11/10/17, documented she agreed to abide by the facility's smoking policy and applicable state regulations.</p> <p>Resident #4's admission MDS assessment dated 11/17/17, readmission MDS assessment dated 3/15/18, and significant change MDS assessment dated 6/8/18, documented she was cognitively intact and current tobacco use.</p> <p>Resident #4's care plan dated 3/8/18, did not include her smoking objectives, goals, preferences and outcomes.</p> <p>Resident #4's smoking assessment, dated 6/28/18, documented she was alert and oriented and fully understood the risks of smoking. She was assessed for safety and the ability to smoke</p>	F 689	<p>Residents will also be offered identification bracelets, dog tags, or other forms of identification they prefer. These forms of identification can also be their own government issued identification cards. Their cell phones will include, where desired and applicable, the facility's address and telephone number in case of emergency. Periodically, independent residents who check themselves out of the facility will continue to be assessed appropriately for independent egress and entry to and from the facility. Sign out sheets are currently made available to residents who check themselves out of the facility. The facility will conduct a resident in-service to teach and train the importance of safety and proper procedure of checking themselves in and out of the building. Staff will continue to urge residents to sign in and out. Complete 10/15/18</p> <p>While the building remains a non-smoking facility, smokers and non smokers alike can take advantage of these additional safety accommodations until such time the resident prefers they be enhanced or altered.</p> <p>Social Services personnel will conference with residents who leave the facility independently at scheduled care conference to assure their safety concerns are addressed and alterations to safety measures are made where appropriate. Social Service concerns and/or resident feedback will be reviewed</p>		

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F 689	<p>Continued From page 13</p> <p>without difficulty. The assessment documented Resident #4 understood the facility property was not a smoking area/facility. The assessment noted Resident #4 would be monitored daily for any burn areas on her clothing or body to ensure continued proper smoking safety. A smoking assessment, dated 9/6/18, documented Resident #4 was deemed safe to smoke off the property and could continue to do so.</p> <p>On 9/10/18 through 9/14/18, during survey, Resident #4 was observed to smoke off campus from the facility in two separate areas designated with a painted yellow line with a metal can provided for her to dispose of cigarettes. On 9/10/18 at 5:45 PM, Resident #4 was observed smoking in the north center of the parking lot within a painted yellow line area. On 9/12/18 at 1:31 PM, Resident #4 was observed off campus in her wheelchair in the northwest corner off the property within a painted yellow line area. Resident #4 could not be seen by staff from the entrances to the facility. The facility property included three units including long term care, assisted living, and independent living. There were three entrances to the facility property for vehicles and a number of businesses that were near the facility, such as two thrift stores and two restaurants.</p> <p>On 9/10/18 at 2:59 PM, Resident #4 stated she had to go off campus to smoke and she could go if she completed a safety assessment and signed an agreement of smoking by herself.</p> <p>On 9/11/18 at 3:30 PM, CNA #2 stated the residents could smoke outside in the front of the facility, in the parking lots, and outside by the</p>	F 689	<p>daily in stand up meetings or as part of the daily MACC meeting with IDT.</p> <p>Social Services will review and provide a summary report on continuing safety concerns for residents who leave the building independently during regularly scheduled QAPI meetings.</p>		

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F 689	Continued From page 14 dining areas. On 9/12/18 at 1:31 PM, Resident #4 stated she did not feel safe smoking near the parking lot and was afraid of getting hit by a car. She stated her daughter would not let her have her purse because she was afraid it might get stolen. Resident #4 stated the last time she was at the facility, they allowed her to smoke in and around the building and now the rules had changed to no smoking on the property. She said caregiver would bring her out to the smoking area and came to see her from time to time, but she usually came out alone to the smoking areas. On 9/12/18 at 3:16 PM, the DNS stated that residents who smoked were allowed to smoke but they had to smoke off campus. She said residents were not monitored or watched during the time they smoked. The DNS said residents were assessed to make sure they were safe to smoke. She said staff did not make sure residents were safe when they were off campus. The DNS stated the facility was a nonsmoking facility and she was not aware of any residents concerned about their safety or afraid of items being stolen. The DNS said after the residents were assessed for safety and independence, they were able to leave the facility to smoke off campus with assistance, with family, or independently. The DNS stated the residents who smoked were required to smoke off the property and behind a yellow painted line adjacent to the facility's parking lot.	F 689			
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits	F 712		10/15/18	

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F 712	<p>Continued From page 15</p> <p>§483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.</p> <p>§483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>§483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.</p> <p>§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on review of residents' records and staff interviews, it was determined the facility failed to ensure residents were provided with physician visits every 60 days as required to ensure an appropriate program of care. This was true for 1 of 12 residents (#148) reviewed for frequency of physician visits and had the potential for harm should residents' care needs change without the awareness or involvement of their physician. Findings include: Resident #148 was admitted to the facility on 11/20/15, with diagnoses which included diabetes mellitus and chronic kidney disease. Resident #148's medical record included a Physician Progress Note, dated 3/7/18. There</p>	F 712	<p>F712</p> <p>Resident #148 was discharged from the facility to acute care hospital on 7/28/18.</p> <p>All residents have the potential to be affected by this deficiency. For all current in-house residents, an audit of their medical record has been performed to determine that the physician visits have been completed timely and are in compliance. Those found to not be in compliance have been immediately scheduled for physician visit. Complete 10/15/18</p> <p>Education has been provided to the</p>		

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F 712	Continued From page 16 were no subsequent Physician Progress Notes between 3/7/18 and 7/28/18, or other evidence of visits from the physician, nurse practitioner, or physician assistant. On 9/13/18 at 10:30 AM, Medical Records Staff #1 stated there was a period of time when the nurse practitioner did not see residents in the facility. He stated he could not find documentation of physician visits for Resident #148 during the months of April, May, June, or July 2018.	F 712	Medical Records coordinator regarding Policy and Procedures for maintaining the resident compliance visits with the Physician and ensuring that the medical record is current for each resident. Completed 10/2/18 A Physician Visit Schedule Report will be printed out by the Medical Records coordinator daily and brought to the morning MACC meeting. The Administrator, DNS and RCMs will receive a copy of this schedule to review and discuss with Medical Records to assure new residents have been captured. Upon admission, Medical Records will audit any new resident to assure an MD visit has been added to the MD visit schedule. A Monthly Physician Visit Audit will be completed for the entire facility once a month to assure all short-term and long-term resident physician visits have been scheduled and/or seen per the schedule. An updated visit schedule will be placed in the in-house MD/NP folder for the providers that come into the facility for their visit. A physician visit schedule will be sent to outside facility Providers every month. The Medical Records coordinator will keep the list of residents that have been seen until the physician notes have been		

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F 712	Continued From page 17	F 712	<p>received. The Medical Records coordinator will bring the physician visit notes to morning MACC meeting for the RCM to review. The Medical Records coordinator will then scan the notes into the electronic medical record.</p> <p>Complete 10/15/18</p> <p>Medical Records will perform an audit of 5 resident's medical record to ensure that all visits are in compliance and the physician visit note is present in the medical record weekly x4, monthly x3, and then quarterly x3.</p> <p>Physician Visits process will go through QAPI to assure process is working. Once assured visits are scheduled and timely, Physician Visit Schedule Report in stand-up may decrease gradually down once every Monday or as needed.</p> <p>Responsible party: Medical Records</p>		
F 758 SS=D	<p>Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)</p> <p>§483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic</p>	F 758		10/15/18	

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F 758	<p>Continued From page 18</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs 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 staff interview and record review, it</p>	F 758			
			F758		

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F 758	<p>Continued From page 19</p> <p>was determined that the facility failed to ensure there was behavior monitoring for residents receiving an antidepressant medication. This was true for 3 of 3 residents (#26, #29 and #44) who were reviewed for psychotropic medications. This deficient practice had the potential for harm should residents experience adverse reactions and/or behavior symptoms from the use of psychotropic medications. Findings include:</p> <p>1. Resident #44 was readmitted to the facility on 10/31/17, with multiple diagnoses including dementia, depression, chronic kidney disease, peripheral vascular disease, and diabetes mellitus.</p> <p>Resident #44's quarterly MDS assessment dated 8/29/18, documented he was cognitively intact and received antipsychotic and antidepressant medications on a routine basis.</p> <p>Resident #44's physician orders dated 10/26/17 and 10/31/17, documented bupropion hydrochloride (antidepressant) 300 mg by mouth one time daily for depression, escitalopram oxalate (antidepressant) 10 mg by mouth one time daily for depression and risperdal (antipsychotic) 0.5 mg by mouth one time at bedtime for dementia.</p> <p>Resident #44's Psychotherapeutic Medications Disclosure and Consent, dated 11/1/17, documented his acceptance of the use of the medications, but did not include the specific medications he agreed to the use of. The Psychotherapeutic Medications Disclosure and Consent listed 27 antidepressant medications, 19 antipsychotic medications, 10 hypnotic</p>	F 758	<p>Resident #44 has been discharged from the facility to a lower level of care.</p> <p>Resident #26 and #29 The Diagnosis, behaviors, and appropriate interventions were reviewed and a "Target Behavior monitoring log was initiated on the Electronic Medication Administration Record (EMAR) to include the behaviors specific to the resident, the frequency that these behaviors have occurred, non-pharmacological interventions to address the resident's behaviors, and if the interventions were effective or not. These behaviors are scheduled to be monitored every shift. Completed 9/24/18</p> <p>All residents who receive psychotropic medication are at risk for this deficiency. These residents have had an audit of their medical record to ensure that their behaviors are being monitored every shift. All residents with a Diagnosis that requires psychotropic medication have a behavior log added to the EMAR under "Target Behaviors to include specific resident behaviors to monitor according to medication use, the frequency that any behaviors have been present per shift, non-pharmacological interventions attempted and if the interventions are effective or not. Completed 10/15/18</p> <p>All nurses have been educated on this new process and instructed on the EMAR entry for any new psychotropic medication ordered, and how to</p>		

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F 758	<p>Continued From page 20</p> <p>medications, 9 anti-anxiety medications, and 7 "anti-manic" medications. The area on the consent to indicate the classification of medications Resident #44 received and the specific medication, was blank.</p> <p>Resident #44's current care plan documented he was at risk of adverse reactions and side effects related to the use of the bupropion hydrochloride, escitalopram oxalate, and risperdal. The care plan interventions directed staff to document "episodes of anxiety, behaviors, etc." on a behavior sheet and monitor for side effects. The care plan did not document resident-specific behaviors to monitor Resident #44 for related to the use of the antidepressant and antipsychotic medications.</p> <p>The facility did not provide completed behavior sheets for the months of July, August, and September 2018.</p> <p>Resident #44's psychoactive drug review, dated 6/4/18, documented target behaviors of low mood or sad affect with the use of bupropion, target behaviors of low mood or difficulty sleeping with the use of escitalopram, and target behaviors of any psychotic features with the use of risperdal.</p> <p>Resident #44's psychotropic drug assessment, dated 8/3/18, documented indications for use of bupropion, escitalopram, and risperdal as depression, sadness, withdrawal, anger, and agitation.</p> <p>On 9/12/18 at 3:14 PM, LPN #3 said Resident #44's behaviors were only documented on the</p>	F 758	<p>appropriately document behavior monitoring. Completed 10/15/18.</p> <p>5 audits will be completed on any resident receiving psychotropic medication to ensure that the documentation has been completed on the EMAR weekly x4, monthly x3, and then quarterly x3.</p> <p>To ensure that the corrective action is maintaining compliance, the Director of Nursing/designee will report all audit findings at every QAPI meeting.</p> <p>Responsible party: Director of Nursing/designee</p>		

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F 758	<p>Continued From page 21 behavior sheet when they occurred.</p> <p>On 9/12/18 at 3:54 PM, the DNS, with the Administrator present, stated the facility documented behaviors when they occurred.</p> <p>The facility did not document the presence or absence of Resident #26's behaviors during each shift of staff, to ensure consistent monitoring.</p> <p>2. Resident #26 was readmitted to the facility on 5/4/17, with diagnoses that included chronic respiratory failure, opioid use, major depressive disorder, and anxiety.</p> <p>A quarterly MDS assessment dated 8/4/18, documented Resident #26 had depression and received a psychotropic medication.</p> <p>Resident #26's psychoactive drug review, dated 5/7/17, signed by her physician on 5/11/17, documented she was receiving Venlafaxine (antidepressant) 75 mg twice a day for major depressive disorder.</p> <p>Resident #26's care plan, updated 8/15/18, documented she had depression and her behaviors included making negative comments and appearing sad or withdrawn. Under the section for psychotropic drug use, the care plan stated any episodes of anxious behaviors were to be documented in the behavior log.</p> <p>A social work progress note, dated 9/6/18 at 4:48 PM, documented 5 residents reported Resident #26 was disruptive and rude to them during activities. Resident #26's behavior log for September 2018, included verbal outbursts</p>	F 758			

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F 758	<p>Continued From page 22</p> <p>directed toward others, as a behavior to monitor. The behavior log for September 2018 did not include documentation of verbal outbursts.</p> <p>Resident #26's behavior logs for August 2018 and September 2018, under the section of behaviors to monitor, included tearfulness or appearing down, isolation or decrease in facility activity participation, and verbal outbursts directed toward others. The behavior logs were blank, with no entries.</p> <p>On 9/12/18 at 3:03 PM, LPN #2 said the facility kept a behavior log at the nurses' station to monitor behaviors for residents taking psychotropic medication. LPN #2 said behaviors were only documented in the log when they occurred.</p> <p>On 9/12/18 at 3:14 PM, LPN #3 said behaviors being monitored were only documented on the behavior log when they occurred.</p> <p>On 9/12/18 at 3:54 PM the DNS with the Administrator present, stated the facility documented behaviors by exception. She stated behaviors were documented on the behavior log when they occurred.</p> <p>The facility did not document the presence or absence of Resident #26's target behaviors during each shift of staff, to ensure consistent monitoring.</p> <p>3. Resident #29 was admitted to the facility on 2/6/18 with diagnoses that included depression and vascular dementia with behavioral disturbance.</p>	F 758			

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F 758	Continued From page 23 Resident #29's physician orders for September 2018, included escitalopram (antidepressant) 20 mg by mouth one time daily for depression. A quarterly MDS assessment, dated 8/17/18, documented Resident #29 had minimal depression, no behaviors, and received antidepressant medications daily. A Psychotropic Drug Use care plan, dated 2/14/18, documented Resident #29 was at risk for adverse reaction/side effects related to use of the antidepressant. The care plan did not include resident-specific behaviors staff were to monitor Resident #29 for or interventions staff were to implement when he exhibited the behaviors. A Psychotropic Drug Assessment, dated 8/6/18, documented sadness, withdrawal, and agitation as the indications for the use of escitalopram. On 9/14/18 at 11:00 AM, the DNS stated resident-specific target behaviors and behavioral interventions were not identified.	F 758			
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		10/15/18	

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F 842	<p>Continued From page 24</p> <p>§483.70(i) Medical records.</p> <p>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p>	F 842			

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F 842	<p>Continued From page 25</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure residents' clinical records included the certification of terminal illness for residents receiving hospice services. This was true for 1 of 3 residents (#6) who received hospice services. Failure to maintain complete and accurate clinical records placed residents at risk for medical decisions based on incomplete information and for complications related to inappropriate care. Findings include:</p> <p>Resident #6 was admitted to the facility on 2/13/17, with multiple diagnoses including end stage renal disease.</p> <p>Resident #6's quarterly MDS assessment, dated 6/12/18, documented she received hospice services.</p>	F 842	<p>F842</p> <p>Resident #6 certification of terminal illness was obtained from Hospice Services and placed into the resident's medical record. Completed 9/13/18.</p> <p>All resident's receiving Hospice Services is at risk for this deficiency. An audit of each resident receiving Hospice Services medical record was completed to ensure that the appropriate paperwork is present in the medical record, including the certification of terminal illness within the regulatory time frames. Completed 10/2/18</p> <p>The Medical Records coordinator was educated on the proper scheduling of the</p>		

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F 842	Continued From page 26 Resident #6's March 2017 certification of terminal illness, documented Resident #6 was admitted to hospice care due to end stage renal disease. Further certification of Resident #6's terminal illness by the physician was not found in her clinical record. On 9/12/18 at 4:07 PM, the LSW said she would look for Resident #6's current certification of terminal illness. On 9/12/18 at 4:07 PM, Medical Records Staff #1 said he had not received Resident #6's current certification of terminal illness and it should be done every six months. On 9/13/18 at 9:47 AM, the DNS said Resident #6's certification of terminal illness was to be completed every 90 days for two certification periods and every 60 days thereafter. The DNS said Resident #6's certification of terminal illness was requested from the hospice provider and would be added to the resident's clinical record.	F 842	physician visit dates with the certification of terminal illness, and the required paperwork that needs to be present in the resident's medical record timely. Completed 10/2/18 A change in process includes the paper chart from Hospice residents has been uploaded into the Electronic Health Record (EHR). The medical records coordinator has provided education and instruction to all Hospice Agencies that this facility is contracted with. The General Managers of all contracted Hospice agencies will educate all of their staff who provide care in this facility on this new process. All communication between facility and Hospice agency, such as notes, visits, physician terminal of illness documentation will be placed in the designated box for Medical records on each nursing unit after the notes have been reviewed. The Hospice Agency will also be sending any paperwork that has been dictated directly through secured email. The Medical Records coordinator will print off all communication notes and give to the resident care manager (RCM) for their review. The RCM will place the reviewed notes into the Medical Records box for scanning to the medical record under the appropriate Hospice tab. The facility nurses have been educated on this new process. Completed 10/15/18. Medical Records will perform an audit of 5 residents medical record to ensure that all visits are in compliance and that the		

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F 842	Continued From page 27	F 842	paperwork is present in the medical record weekly x4, monthly x3, and then quarterly x3. Medical Records will review and report on the findings of the audit during QAPI meetings. Responsible party: Medical Records		
F 880 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include,</p>	F 880		10/15/18	

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F 880	<p>Continued From page 28 but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its</p>	F 880			

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F 880	<p>Continued From page 29</p> <p>IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure contact isolation precautions were maintained for a resident with Clostridium difficile (C. diff). This was true for 1 of 1 resident (#100) reviewed for isolation precautions. This failure placed other residents, staff, and visitors at risk of contracting C. diff, a bacterial infection that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon. Findings include:</p> <p>Resident #100 was admitted to the facility on 8/11/18 and was readmitted on 8/31/18 with multiple diagnoses including enterocolitis (inflammation of the small intestine and colon) due to C. diff.</p> <p>A Physician's order, dated 8/31/18, included Vancomycin (antibiotic) 50 mg/ml by mouth four times a day and directed staff to put Resident #100 on contact isolation.</p> <p>On 9/10/18 at 3:57 PM, Resident #100 was observed in bed in his room. On Resident #100's door was a hanging device which contained personal protective equipment (PPE) including disposable gowns, masks, and gloves. A yellow triangle was observed posted on top of the PPE.</p> <p>On 9/11/18 at 9:32 AM, LPN #1 said the yellow triangle was a precautionary sign to warn staff and visitors Resident #100 was on contact isolation precaution and they must put on the PPE before entering his room. When asked how</p>	F 880	<p>F880</p> <p>For resident #100 the precaution sign was immediately placed on the door upon notification and the staff member that failed to follow proper procedure for Personal Protective Equipment (PPE) application was re-educated by the Director of Nursing. Completed 9/10/18</p> <p>This resident has been discharged from the facility.</p> <p>Any resident that requires any type of precautions is at risk for this deficient practice. Currently in-house there is one resident that is on Contact Precautions. At the time of diagnosis that required precautions, the room was checked to ensure that proper signage is placed on the door along with proper PPE available. Staff provided report that resident is on contact precautions and the reason. Education for proper contact precautions for current diagnosis has been reviewed with staff, resident, and family. Completed 9/28/18</p> <p>All staff have been re-educated on Infection Control to include facility Policy and Procedure, different types of precautions and guidelines to follow which included setting up a resident's room for appropriate precautions and PPE application, along with proper hand</p>		

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NAME OF PROVIDER OR SUPPLIER KARCHER POST-ACUTE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BOULEVARD NAMPA, ID 83651		
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F 880	Continued From page 30 visitors would know they must put on the PPE before entering the resident's room, LPN #1 said there should be a "STOP please see the nurse" sign at Resident #100's door. The surveyor and LPN #1 then looked at Resident #100's door and a "STOP" sign was not found on or near the door. LPN #2 said she would get one and put it on the resident's door. On 9/11/18 at 11:01 AM, Physical Therapy Assistant #1 (PTA #1) was observed inside Resident #100's room not wearing PPE. On 9/11/18 at 1:40 PM, PTA #1 said she did not put on the PPE when she entered Resident #100's room and it was a mistake. PTA #1 said she was in a hurry and was trying to save time. On 9/12/18 at 1:48 PM, the DNS said all staff and visitors entering Resident #100's room should be wearing the PPE and a "STOP please see the nurse" sign should be at the resident's door. The DNS said the yellow triangle had nothing to do with isolation precautions and it could be from the previous administration using it as a "Fall Risk" sign. The DNS said she would remove the yellow triangle sign.	F 880	hygiene. Completed 10/15/18 An audit will be completed weekly with any resident on Precautions for the proper set up of the room to include PPE available and proper signage on the door. The audit will include visual monitoring of staff entering the resident's room ensuring that PPE is applied and worn properly while in the room, and that proper hand washing has occurred before exiting the room. The findings from these audits will be reported in the QAPI meetings. Responsible party: Director of Nursing/designee		
F 883 SS=F	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		10/15/18	

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F 883	<p>Continued From page 31</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits</p>	F 883			

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F 883	<p>Continued From page 32 and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review and staff interview, it was determined the facility failed to ensure the development and implementation of processes to provide pneumococcal (bacterial pneumonia) immunizations consistent with current CDC guidelines. Specifically,</p> <p>a. The facility failed to ensure residents who were offered the pneumococcal vaccine received information and education consistent with current CDC [Centers for Disease Control and Prevention] recommendations for pneumococcal immunizations. This was true for for 5 of 5 (#4, #13, #15, #25, #44) residents sampled for review of the pneumococcal vaccination, and had the potential to affect all residents.</p> <p>b. The facility's pneumococcal immunization process and pneumococcal immunization consent form did not reflect current CDC recommendations.</p> <p>c. The facility did not implement an immunization program to ensure residents' pneumococcal vaccines were being tracked with receiving or declining the pneumococcal vaccines PCV13 the first year, followed by the PPSV23 one year later.</p> <p>This deficient practice placed residents at risk of developing pneumococcal pneumonia and</p>	F 883	<p>For resident #44 he has been discharged from the facility and the paperwork had been located in his medical record that states that the resident did have both Pneumococcal 23 and Pevnar 13 vaccination prior to admission to the facility.</p> <p>For resident #4, she received information and education consistent with current CDC recommendations for pneumococcal immunizations. Consent was reviewed and signed by the resident for both Pneumococcal 23 and Pevnar 13. The resident received Pevnar 13 on 9/28/18 and is scheduled for Pneumococcal 23 on 9/28/19 in which the education and consent will be obtained prior to administering vaccination. The information for the Pevnar 13 administration was placed into the resident's medical record under "Preventative Health Care" indicating that the resident received the vaccination.</p> <p>For resident #13, she received information and education consistent with current CDC recommendations for pneumococcal immunizations. The resident stated that she had already received the vaccinations. The Community provider was contacted and</p>		

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F 883	<p>Continued From page 33</p> <p>developing subsequent serious, potentially life threatening, complications.</p> <p>Findings include:</p> <p>The CDC website, updated 12/6/17, documented recommendations for pneumococcal vaccination (PCV13 or Pevnar13, and PPSV23 or Pneumovax23 for all adults 65 years of older:</p> <p>**Adult 65 years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23.</p> <p>**If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most recent dose of PPSV23.</p> <p>The facility's infection reporting and tracking policy and procedure dated June 2017, documented the facility would maintain a record of infections and corrective actions related to infections, however, the policy did not address a tracking system for implementing immunizations.</p> <p>The facility's influenza and pneumococcal immunizations policy and procedure dated July 2017, documented:</p> <p>* The facility would offer the influenza and pneumococcal immunizations to residents in accordance with federal regulations.</p> <p>* Residents may also be offered the PCV13 in series with Pneumovax23. The PCV13 vaccine should be administered first, and then the</p>	F 883	<p>her immunization information was obtained with the pneumococcal 23 received 1/9/13 and Pevnar 13 received 4/25/17. This information was placed into the resident's medical record under "Preventative Health Care" indicating that the resident received the vaccination. For resident #15, she received information and education consistent with the current CDC recommendations for pneumococcal immunizations. The resident had already received the Pneumococcal 23 on 4/6/18. This information was placed into the resident's medical record under "Preventative Health Care", indicating that the resident has received the vaccination. The resident is scheduled to receive the Pevnar 13 vaccination on 4/7/19 at which time the education for Pevnar 13 immunization and the consent will be obtained. For resident #25, she received information and education consistent with current CDC recommendations for pneumococcal immunizations. The resident declined the pneumococcal 23 vaccination on 9/20/18 and the Pevnar 13 on 9/26/18. The resident signed both consent forms as declination. The resident is scheduled 9/1/19 to review the educational material for pneumococcal vaccinations again. The information on her refusal has been placed into the resident's medical record under "Preventative Health Care" indicating that the resident has declined the vaccinations.</p>		

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F 883	<p>Continued From page 34</p> <p>Pneumovax23 administered one year later. If the resident had already received the Pneumovax23, the facility should wait one year before administering the PCV13 vaccine.</p> <p>* The resident or representative would receive education regarding the benefits and potential side effects of the pneumococcal immunization prior to administration of the vaccine and had the opportunity to refuse the vaccine.</p> <p>Each resident referenced below is 65 years of age or older.</p> <p>a. Resident #13 was admitted to the facility on 4/3/18, with multiple diagnoses including lung cancer, diabetes mellitus, and bipolar disorder.</p> <p>Resident #13's quarterly MDS assessment dated 7/3/18, documented she was cognitively intact and her pneumococcal vaccination was up to date.</p> <p>The facility's Preventive Health Care Summary, dated 10/1/17 through 9/12/18, documented the date Resident #13's pneumococcal vaccine was administered was unknown and she had not refused the vaccine.</p> <p>Resident #13's medical record did not include a physician's order for the pneumococcal vaccine or indication it was clinically contraindicated.</p> <p>A consent for the administration of the pneumococcal vaccine, signed by Resident #13 on 4/3/18, documented she had received a pneumococcal vaccine within the last 5 years and she declined the pneumococcal vaccine</p>	F 883	<p>All residents are at risk to be affected by this deficiency. All resident's medical record have been audited to determine if the resident has received information and education consistent with current CDC recommendations for the pneumococcal vaccination along with if and when the date that the vaccination has already been received. If the vaccination information was unknown regarding if the resident had previously received the vaccinations, the community provider was contacted to obtain the information. If the resident had not received either the Prevnar 13 or Pneumococcal 23 vaccination, they received the information and education along with receiving the vaccination accordingly. The vaccination record was then updated under "Preventative Health Care" in the medical record for tracking purposes. For any vaccination that is due at a later date, the date has been placed on the vaccination log sheet to track when the vaccination is next due. Completed 10/15/18.</p> <p>The nursing staff has been educated on the policy and procedure for immunizations according to CDC guidelines to include proper pneumococcal vaccination schedule, information of the CDC recommendations, and obtaining consent from the resident or DPOA if applicable. The nursing staff was also educated regarding documentation on the "Preventative Health Care" when the</p>		

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F 883	<p>Continued From page 35</p> <p>offered. The consent was signed by a facility representative. The consent did not include Resident #13's signature/date or documentation she communicated her desire to decline in another way.</p> <p>The 4/3/18 consent did not include the type of pneumococcal vaccine Resident #13 received within the last 5 years (PCV13 or Pneumovax23). The consent documented "The Pneumovac is typically given once in a life time, however, there may be indications to repeat this vaccine after a determined amount of time has passed since the initial vaccine was given." Resident #13's medical record did not include documentation she was provided with the current CDC pneumococcal vaccine recommendations and the risks and benefits of receiving the vaccine.</p> <p>b. Resident #4 was readmitted to the facility on 11/17/17, with multiple diagnoses including, kidney failure, congestive heart failure, chronic obstructive pulmonary disease and depression.</p> <p>Resident #4's admission MDS assessment, dated 11/17/17, readmission MDS assessment dated 3/15/18, and significant change MDS assessment dated 6/8/18, documented she was cognitively intact and her pneumococcal vaccination was up to date.</p> <p>The facility's Preventive Health Care Summary, dated 10/1/17 through 9/12/18, documented the date Resident #4's pneumococcal vaccine was administered was unknown and she had not refused the vaccine.</p> <p>Resident #4's medical record did not include a</p>	F 883	<p>vaccination has been administered. Complete 10/15/18</p> <p>A new tracking log has been formulated to track all residents currently in house and any new admissions going forward to ensure that their vaccination record (to include Pneumococcal, Influenza, and PPD) is current and when the next vaccination is due. The log will include education information has been reviewed with the resident/family, the consent has been signed, the date that the vaccination has been administered, and the date that the vaccination (if applicable) is due. This log will be reviewed at morning MACC meeting to ensure that it has been updated for any new admissions and that the "Preventative Health Care" is up to date. This log will also be reviewed in MACC meeting at the beginning of each month to ensure that any due vaccinations are present in the Electronic Medication Administration Record (EMAR), education and consent are signed, and the vaccination is available in the facility from the Pharmacy.</p> <p>An audit of 5 residents weekly will be completed weekly x4, monthly x3, and then quarterly x3. The audit will include that the information has been provided to the resident, that the consent has been signed, the vaccination has been administered if applicable, and that the next due date has been scheduled. The audit will also include if the "Preventative Health Care" has been updated</p>		

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F 883	<p>Continued From page 36</p> <p>physician's order for the pneumococcal vaccine or indication it was clinically contraindicated. Documentation the risks and benefits of the vaccine were provided to Resident #4 was not included in her medical record. A consent from Resident #4 for administration of the pneumococcal vaccination PCV13, and if appropriate the PPSV23 vaccine one year later, was not found in her medical record.</p> <p>c. Resident #15 was admitted to the facility on 4/12/17, with multiple diagnoses including heart disease, osteoarthritis, depression, and anxiety.</p> <p>Resident #15's quarterly MDS assessment, dated 7/12/18, documented she was cognitively intact and her pneumococcal vaccination was up to date.</p> <p>Resident #15's medical record did not include a physician's order for the pneumococcal vaccine or indication it was clinically contraindicated.</p> <p>The facility's Preventive Health Care Summary, dated 10/1/17 through 9/12/18, documented Resident #15's pneumococcal vaccine was administered on 4/6/18. The summary did not include documentation of the type of pneumococcal vaccine Resident #15 received.</p> <p>A consent for the administration of the pneumococcal vaccine, documented Resident #15 gave verbal consent for administration of the vaccine on 4/5/18. The consent documented "I have received the information regarding the Pneumococcal infections, and have been educated on the benefits and risks associated with the Pneumococcal Polysaccharide Vaccine</p>	F 883	<p>appropriately in the medical record. The audit will include ensuring that the appropriate documentation is present in the medical record.</p> <p>To ensure that corrective action is maintaining compliance, the Director of Nursing/designee will report all audit findings at every QAPI meeting.</p> <p>Responsible party: Director of Nursing/designee</p>		

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F 883	<p>Continued From page 37 (PPSV)." The PPSV is described on the CDC website as PPSV23.</p> <p>Resident #15's medical record did not include documentation Resident #15 was provided with the current CDC pneumococcal vaccine recommendations, which state the PCV13 vaccine is to be administered first, followed in one year by the PPSV23. Resident #15's medical record did not include documentation the risks and benefits of receiving the PCV13 and PPSV23 vaccine series, was provided to Resident #15.</p> <p>d. Resident #25 was readmitted to the facility on 8/1/17, with multiple diagnoses including post traumatic stress disorder, mood and bipolar disorder, delirium, anxiety, and adult failure to thrive, dementia, dysphagia (difficulty swallowing) and diabetes mellitus.</p> <p>Resident #25's annual MDS assessment dated 8/5/18, documented she was cognitively intact and her pneumococcal vaccination was not up to date.</p> <p>Resident #25's medical record did not include a physician's order for the pneumococcal vaccine or indication it was clinically contraindicated.</p> <p>The facility's Preventive Health Care Summary, dated 10/1/17 through 9/12/18, documented the date Resident #25's pneumococcal vaccine was administered was unknown and she refused the vaccine.</p> <p>Resident #25's medical record did not include documentation she was provided with the current</p>	F 883			

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F 883	<p>Continued From page 38</p> <p>CDC pneumococcal vaccine recommendations and the risks and benefits of receiving the vaccine or documentation she declined refused the vaccine based on that information.</p> <p>e. Resident #44 was readmitted to the facility on 10/31/17, with multiple diagnoses including dementia, depression, chronic kidney disease, peripheral vascular disease, and diabetes mellitus.</p> <p>Resident #44's quarterly MDS assessment dated 8/29/18, documented he was cognitively intact and his pneumococcal vaccination was up to date.</p> <p>The facility's Preventive Health Care Summary, dated 10/1/17 through 9/12/18, documented Resident #44's pneumococcal vaccine was administered on 3/28/18. The summary did not include documentation of the type of pneumococcal vaccine Resident #44 received.</p> <p>Resident #44's medical record did not include a physician's order for the pneumococcal vaccine or indication it was clinically contraindicated.</p> <p>Resident #44's medical record did not include a consent or other documentation he was provided with the current CDC pneumococcal vaccine recommendations and the risks and benefits of receiving the vaccine or documentation agreed to administration of the vaccine based on that information.</p> <p>On 9/12/18 at 3:16 PM, the DNS stated she was the infection control nurse with the assistance of the MDS nurse. She stated she would provide</p>	F 883			

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F 883	<p>Continued From page 39</p> <p>resident information regarding pneumococcal and influenza immunizations. She stated the facility followed CDC recommendations and performed a tracking system. However, medical records did not document the implementation of PCV13 vaccine given first, followed by the PPSV23 one year later. The DNS said a tracking system was not in place to track the administration of the vaccine series.</p> <p>On 9/12/18 at 3:30 PM, the MDS Nurse stated the PPSV23 or pneumococcal polysaccharide vaccine was offered to residents and was documented in the facility preventive health care system. The MDS Nurse said the facility had not administered PCV13 or Prevnar13 and it was not available in the facility. The MDS nurse also stated the facility had a plan in place to provide both the vaccines and initiate a tracking system.</p>	F 883			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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June 10, 2019

Robert Deloach, Administrator
Karcher Post-Acute & Rehabilitation Center
1127 Caldwell Boulevard
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr. Deloach:

On **September 10, 2018** through **September 14, 2018**, an unannounced on-site complaint survey was conducted at Karcher Post-Acute & Rehabilitation Center.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007894

ALLEGATION #1:

The facility did not provide adequate supervision to prevent the resident from falling and sustaining a fracture.

FINDINGS #1:

During the investigation, observations of residents and staff were conducted. The facility's policy for falls was reviewed. Facility records, including Incident and Accident reports, facility staffing, and grievances for the past year were reviewed.

The facility's staffing for July 27, 2018 through July 29, 2018 was reviewed for adequate staffing. No concerns were identified.

One resident was interviewed as well as CNAs, nurses, and the Director of Nursing. The clinical record for 2 residents were reviewed for events related to falls. One resident reviewed experienced a fall with major injury that required a discharge to the hospital. The record review included physician orders, the care plan, physical therapy evaluation and plan of treatment, and progress notes.

Robert Deloach, Administrator
June 10, 2019
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Based on the investigative findings it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to adequately monitor a resident's blood sugar.

FINDINGS #2:

During the investigation, observation of resident and staff was completed. The facility's Diabetic Management policy was reviewed.

One resident's clinical record was reviewed related to the management of diabetes. The physician orders, physician progress notes, and laboratory values were reviewed. No concerns were identified.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



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HEALTH & WELFARE

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DAVE JEPPESEN – Director

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June 20, 2019

Robert Deloach, Administrator
Karcher Post-Acute & Rehabilitation Center
1127 Caldwell Boulevard,
Nampa, ID 83651-1701

Provider #: 135110

Dear Mr. Deloach:

On **September 14, 2018**, an unannounced on-site complaint survey was conducted at Karcher Post-Acute & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007904

ALLEGATION #1:

A resident was discharged from the hospital with orders for a wound vacuum and supplies, for a wound to her buttocks, but the wound vacuum supplies did not arrive until a day or two later.

FINDINGS #1:

An unannounced complaint survey was investigated in conjunction with the facility's on-site recertification survey conducted from 9/10/18 to 9/14/18. During the investigation, four resident records were reviewed and the Director of Nursing (DNS) was interviewed.

The resident's record included a wound progress note that documented the resident's wound had tunneling which was four centimeters deep and was packed with four centimeters of white foam. The note documented when they removed the resident's dressing they saw the resident's wound had 8 centimeters of tunneling, which required 8 centimeters of white foam packing. The wound

vacuum supplies delivered to the facility had 3.75 cm of white foam. The facility called their supplier but the person who answered the phone was not certain they had the right size of white foam the facility needed. Several local hospitals were called for availability of supply and one hospital said they would do the wound vacuum dressing change for the resident. The resident was sent to the hospital via a non-emergent vehicle the following day but when the resident reached the hospital they were told the wound nurse was gone for the weekend. The resident was sent back to the facility and was given a wet to dry dressing as per the nurse practitioner's order.

On 9/14/18 at 9:40 AM, the DNS said the facility had the wound vacuum supplies for the resident. The DNS stated the facility had the supplies, but it was not the right size needed to safely pack the wound as the tunneling had increased in size.

The facility had the supplies for the wound vacuum but due to the increase in the size of the resident's wound the facility's supplies was not appropriate to use for the condition of the resident's wound.

CONCLUSIONS:

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

ALLEGATION #2:

Facility staff did not know how to change the wound vacuum and they did not use infection control prevention practices when applying the wound vacuum.

FINDINGS #2:

During the survey there was no resident in the facility who had a wound vacuum. Four resident records were reviewed, staff were interviewed, observations of wound care for residents were conducted, a Resident Council meeting was attended and residents were interviewed.

One resident's record documented she had a wound on her right buttock which required a wound vacuum that was changed three times a week. Nursing notes documented the resident had a short-term memory loss and would pull/pick at her wound vacuum causing malfunction of suction and interfere with maintaining a sealed wound.

Two LNs were interviewed and said they changed the resident's dressing without any issues. The LNs said because of the location of the resident's wound, two staff members were needed to change the resident's dressing. One staff helped to reposition the resident and the other LN changed the dressing and applied the wound vacuum. Two observations of wound care were completed and there were no issues noted. The staff were observed for infection control

prevention practices and there were no concerns noted.

The grievance file was reviewed and there was no concerns regarding staff not knowing how to do wound dressings. Fifteen residents attended the group meeting with the surveyors and no concerns were raised regarding their quality of care.

CONCLUSIONS:

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

ALLEGATION #3:

Staff did not use proper hand hygiene when caring for a resident's wound and a resident's ostomy bag was not changed in a timely manner.

FINDINGS #3:

Staff were observed for hand hygiene and infection prevention practices. Two wound dressing changes were observed. Residents were interviewed and a Resident Council meeting was attended.

Staff were observed to perform hand hygiene before and after a wound dressing change. Staff were observed changing gloves and performing hand hygiene during wound dressing changes. Staff were observed to perform hand hygiene before and after leaving a resident's room.

Fifteen residents were interviewed during the group interview and none expressed concerns related to infection prevention practices by staff.

One resident with a urinary catheter was observed and there was no concern. The urinary bag had a protective covering and was off the floor during each observation.

One resident with an ostomy said he changed his own ostomy bag and the nurses regularly checked on him and he had no concern.

CONCLUSIONS:

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

ALLEGATION #4:

A resident was discharged from the facility with home health and supplies were not delivered to

the home on the date of discharge.

FINDINGS #4:

Staff were interviewed and resident records were reviewed for equipment and supplies related to wounds.

An LSW was interviewed regarding one resident whose record documented they were discharged home and required equipment and supplies for a wound vacuum. The LSW said the request for the wound vacuum supplies was sent to the company who processed the request, and the request was sent to another company who delivered the supplies. The resident's clinical record documented the LSW made a follow up call and received confirmation the wound vacuum supplies were delivered two days after the request was sent to the supply company.

The LSW said she got a message from the resident's family member the wound vacuum supplies were not delivered to the resident's home. When she made a follow-up call to the company who delivers the supplies she was told they did not receive the request. The LSW found out later the request she made for the wound vacuum supplies was not processed correctly by the first company. The LSW stated the delay in the delivery of wound vacuum supplies was due to the first company not processing the request in a timely manner.

The LSW was asked why she did not ask the supplier to deliver the supplies for the resident at the facility so the resident would have it prior to leaving the facility. The LSW said the insurance company would not pay for the supply if it was delivered in the facility as this was a home supply for the resident. The LSW said she called the family member of the resident and apologized and explained the reason for the delay in the delivery of the wound supplies over the weekend.

CONCLUSIONS:

Based on the investigative findings the allegation could not be substantiated due to the facility acknowledging and addressing the delay of supply delivery.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit. If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Robert Deloach, Administrator
June 20, 2019
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Sincerely,

A handwritten signature in cursive script, appearing to read "Laura Thompson".

LAURA THOMPSON, RN Supervisor
Long Term Care Program

LT/slj