



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
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P.O. Box 83720
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October 5, 2018

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

Provider #: 135014

Dear Mr. McNeil:

On **September 19, 2018**, we conducted an on-site revisit and complaint investigation on September 19, 2018 to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **August 22, 2018**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F656 -- Develop/Implement Comprehensive Care Plan**
- **F657 -- Care Plan Timing and Revision**
- **F686 -- Treatment/svcs to Prevent/Heal Pressure Ulcer**
- **F725 -- Sufficient Nursing Staff**
- **F758 -- Free From Unnec Psychotropic Meds/prn Use**
- **F550 -- Resident Rights/Exercise of Rights**
- **F583 -- Personal Privacy/confidentiality of Records**
- **F605 -- Right To Be Free From Chemical Restraints**

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 tag 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.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 15, 2018**.

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

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

As noted in the Bureau of Facility Standards' letter dated July 21, 2018, following the survey completed on July 29, 2018, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for imposition of a civil monetary penalty, Denial of Payment for New Admissions effective **September 29, 2018** and termination of the provider agreement on **December 29, 2018**, if substantial compliance is not achieved by that time. The findings of non-compliance on **September 19, 2018**, has resulted in a recommendation of continuance of the remedy(ies) previously recommended to CMS.

Bryan McNeil, Administrator
October 5, 2018
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Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe the deficiencies have been corrected, you may contact please 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 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:

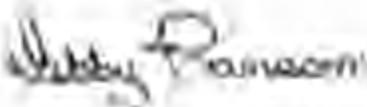
- BFS Letters (06/30/11)

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

This request must be received by **October 15, 2018**. If your request for informal dispute resolution is received after **October 15, 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

Bryan McNeil, Administrator
October 5, 2018
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/03/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/19/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS The following deficiencies were cited during a complaint survey and an on-site follow-up federal recertification and survey conducted at the facility from September 17, 2018 through September 19, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Teresa Kobza, RD Survey Abbreviations: 1:1 = One-to-one ADL = Activities of Daily Living CNA = Certified Nursing Assistant GDR = Gradual Dose Reduction IDON = Interim Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = Milligram PRN = As Needed SW = Social Worker UM = Unit Manager	{F 000}			
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		10/25/18	

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

TITLE

(X6) DATE

Electronically Signed

10/13/2018

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

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F 550	<p>Continued From page 1</p> <p>promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, it was determined the facility failed to maintain an environment that enhanced residents' dignity and respect when a resident was placed in other residents' room for staff convenience and when residents' catheter drainage bags were exposed</p>	F 550	<p>Resident #52, 53, and 164 have their personal space protected. Upon observation, other residents are not brought to their rooms, nor are they taken to other resident rooms. 1:1 care is provided as per policy. Upon rounds resident #7 and 52 catheter bags are</p>		

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F 550	<p>Continued From page 2</p> <p>at their bedsides. This was true for 5 of 11 residents (#7, #52, #53, #59, and #164) whose records were reviewed. This practice created the potential for psychosocial harm if residents experienced a lack of self-esteem due to a disregard of their personal space or experienced embarrassment due to exposed catheter drainage bags. Findings include:</p> <p>1. The facility's Dignity policy, revised October 2009, documented residents' private space shall be respected at all times.</p> <p>The facility's Resident 1:1 procedure, dated September 2018, directed staff to be within view of the resident at all times and to interact and provide activities with the resident.</p> <p>Resident #164 was admitted to the facility on 5/15/18, with multiple diagnoses including paranoid schizophrenia and anxiety.</p> <p>Resident #164's care plan documented she was impulsive and directed staff to provide 1:1 assistance. Staff were to encourage Resident #164 to adjust her room environment to help her feel at home.</p> <p>Resident #59 was admitted to the facility on 6/4/18, with multiple diagnoses including history of falling, anxiety disorder, and vascular dementia with behavioral disturbances.</p> <p>Resident #59's care plan directed staff to provide 1:1 supervision while awake and respect her wishes and give her a choice about care and activities.</p>	F 550	<p>observed with privacy covers.</p> <p>The clinical management team reviewed other residents on 1:1 supervision to validate their personal space is protected. In addition, residents with catheters were reviewed and privacy covers placed on their catheter bags.</p> <p>Nursing staff are educated to maintain an environment that enhances residents' dignity and respect. Re-education was provided by the Director of Nursing and/or designee to include but not limited to, covering catheter bags with privacy covers and supporting resident personal space by not escorting other residents on 1:1 supervision into their rooms. The system is amended to provide directives for 1:1 staff breaks and par levels for catheter bag privacy covers.</p> <p>The Director of Nursing and/or designee will audit 4 residents on 1:1 supervision for protection of privacy and 2 residents with catheters for privacy covers weekly for 8 weeks to validate staff are accommodating the rights of privacy and dignity for the residents. Starting the week of October 21st the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p> <p>Date of compliance 10/25/2018</p>		

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F 550	<p>Continued From page 3</p> <p>Resident #53 was readmitted to the facility on 9/9/18, with multiple diagnoses including traumatic brain injury, post-traumatic stress disorder, restlessness, and agitation.</p> <p>Resident #53's care plan directed staff to provide 1:1 supervision 24 hours a day due to elopement risk. Interventions included to remind Resident #53 the facility is her home and respect her wishes in choice of activities.</p> <p>On 9/17/18 at 3:37 PM, Resident #53 and Resident #164 were in their shared assigned room and awake in their beds. Resident #59 who was assigned to a different room, was in a wheelchair in Resident #53's and Resident #164's room. Two CNAs, CNA #1 and CNA #2, were present in the room at the time. Both CNAs were standing next to Resident #59 near the room door and attempting to calm her down and prevent her from rising from her wheelchair.</p> <p>CNA #1 activated Resident #164's call light as Resident #164 attempted to rise out of her bed several times. Resident #53 also attempted to rise out of bed by herself. CNA #1 and CNA #2 tried to respond to all 3 of the residents.</p> <p>At 3:46 PM, CNA #1 assisted Resident #164 to the bathroom, leaving CNA #2 with Resident #53 and #59. At 3:48 PM, Resident #53 told CNA #2 to get Resident #59 out of her room and became upset and cursed, "Get her (Resident #59) the hell shit out or I will go home."</p> <p>At 3:53 PM, CNA #5 entered the room to answer the call light. At 3:54 PM, LPN #2 said Resident #59 was just visiting the other residents and they</p>	F 550			

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F 550	<p>Continued From page 4</p> <p>were just waiting for CNA #3 to take over 1:1 duties for Resident #59.</p> <p>On 9/19/18 at 12:58 PM, the IDON said the 1:1 staff should have intervened to reduce the residents' agitation and should have considered the dignity of the residents while providing 1:1 care. She said residents were to have their own 1:1 staff member and if staff took a break then they should have had another staff member take over the 1:1 duties.</p> <p>2. The facility's Catheter Privacy Bag policy, dated September 2018, documented catheter privacy covers were to be in place to maintain residents' dignity.</p> <p>a. Resident #52 was admitted to the facility on 2/5/18, with multiple diagnoses including bladder neck obstruction and benign prostatic hyperplasia (enlarged prostate gland).</p> <p>Resident #52's physician orders, dated 4/8/18, documented an indwelling catheter for urinary retention related to benign prostatic hyperplasia.</p> <p>Resident #52's care plan directed staff to provide a privacy bag to cover the catheter drainage bag to maintain dignity.</p> <p>On 9/18/18 at 8:10 AM, 9:00 AM, 9:45 AM, 10:45 AM, and 2:38 PM, Resident #52 was in his bed and was seen from the hallway. Resident #52's catheter drainage bag was hanging from the bed without a privacy cover. Urine was visible in the drainage bag.</p> <p>b. Resident #7 was admitted to the facility on</p>	F 550			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 550	Continued From page 5 10/4/16, with multiple diagnoses including neuromuscular dysfunction of the bladder and urine retention. Resident #7's physician orders, dated 8/23/18, documented an indwelling catheter for urinary retention. On 9/17/18 at 3:15 PM and 9/18/18 at 8:05 AM, 9:40 AM, 2:35 PM, and 3:25 PM, Resident #7 was in her bed and was seen from the hallway. Resident #7's catheter drainage bag was hanging from the bed without a privacy cover. Urine was visible in the drainage bag. On 9/18/18 at 3:35 PM, UM #1 said there were no privacy bags for Resident #7 and #52. She said there were no more privacy bags in the facility and had requested central supply staff to order more bags last week. On 9/18/18 at 4:15 PM, the Central Supply representative said she was made aware of the privacy bag order 4 days prior and had just ordered them that day. She said the bags should be at the facility in a few days. On 9/19/18 at 9:50 AM, the IDON said the drainage bags should have been covered with privacy bags.	F 550			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583		10/25/18	

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F 583	<p>Continued From page 6</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, it was determined the facility failed to ensure a resident's privacy was maintained during wound treatment. This was true for 1 of 3 residents (Resident #52) observed during wound treatment. The failure created the potential for Resident #52 to be embarrassed if his wound</p>	F 583	<p>Upon rounds resident #52 is noted to have the door closed and privacy curtain pulled during dressing changes or other procedures.</p> <p>The clinical management team reviewed other residents to validate that privacy is maintained during wound treatment or</p>		

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F 583	<p>Continued From page 7</p> <p>treatment was exposed to others unnecessarily. Findings include:</p> <p>The facility's Dignity policy, dated October 2009, documented staff shall promote residents' bodily privacy during treatment procedures.</p> <p>Resident #52 was admitted to the facility on 2/5/18, with multiple diagnoses including dementia.</p> <p>Resident #52's record included a physician order, dated 9/7/18, to cleanse the wounds on his right calf and outer ankle with wound cleanser, apply Medi-Honey, and cover with border gauze every two days and as needed if the dressing became dislodged.</p> <p>On 9/19/18 from 1:22 PM to 1:38 PM, LPN #1 positioned the wound treatment cart in the hallway, which partially blocked Resident #52's doorway at mid-torso height. Resident #52 was in his bed which was in full view of the opened doorway. The privacy curtain for Resident #52 was left opened. UM #1 held up Resident #52's right leg which was in full view of the doorway, while LPN #1 removed the wound dressings and applied two new dressings to both wounds.</p> <p>LPN #1 went to the sink to wash his hands and then to the wound cart 3 times during the treatment. While changing the wound dressing, LPN #1 and UM #1 did not close the door or draw the privacy curtain. During the wound treatment, Resident #52's roommate walked back and forth in the hallway multiple times and stopped and watched the treatment on several occasions. Additionally, the facility's Clinical</p>	F 583	<p>other procedures. Adjustments have been made as indicated.</p> <p>Nursing staff are educated to provide and maintain privacy during wound treatments. Re-education was provided by Director of Nursing and/or designee to include but not limited to, provide and maintain privacy during wound treatments or other procedures by pulling the privacy curtain and closing the door. The system is amended to include organization of wound supplies taken to the bedside, treatment cart placement, and leadership monitoring for privacy during wound treatments or other procedures.</p> <p>The Director of Nursing and/or designee will audit 2 residents for privacy during wound care weekly for 8 weeks. Starting the week of October 21st the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>		

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F 583	Continued From page 8 Resource Nurse and 2 outside contracted workers walked by the room and looked in. On 9/19/18 at 1:40 PM, LPN #1 said he usually parked the wound treatment cart at or near the doorway so he could easily access the cart. LPN #1 said he did not pull the privacy curtain. On 9/19/18 at 1:50 PM, UM #1 said she wanted to keep the wound treatment cart in sight for safety of the residents. UM #1 said she did not pull the privacy curtain. On 9/19/18 at 1:55 PM, the Clinical Resource Nurse said when she walked by she looked in the room, saw the 2 nurses and the surveyor, but did not pay attention Resident #52. On 9/19/18 at 2:20 PM, the IDON said staff should have pulled the room door closed, locked the treatment cart, and pulled the privacy curtain. She said Resident #52's privacy should have been maintained.	F 583			
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	{F 656}		10/25/18	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 656}	<p>Continued From page 9</p> <p>or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(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).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure care plans addressed resident's depression and anxiety needs for 1 of 8 residents (Resident #164) whose care plans were reviewed. This failure placed residents at risk for increased depression and anxiety due to lack of direction and interventions in the care plan. Findings</p>	{F 656}	<p>The clinical management team reviewed resident #164. The care plan was updated to address resident's depression and anxiety needs, including directives and interventions to decrease depression and anxiety.</p> <p>The clinical management team reviewed</p>		

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{F 656}	Continued From page 10 include: Resident #164 was admitted to the facility on 5/15/18, with multiple diagnoses including major depression and anxiety. Resident #164's 5/28/18 admission MDS assessment, documented she received antidepressant medication. The assessment identified a potential problem with the use of antidepressant medications and triggered the need for additional assessment in this care area. Resident #164's record included physician orders for Zoloft 100 mg daily for depression dated 6/26/18, and Ativan 1 mg 3 times a day for anxiety dated 7/3/18. Resident #164's July through September 2018 MARs documented she received Zoloft and Ativan. Resident #164's care plan did not identify depression or anxiety as a potential problem. On 9/18/18 at 2:46 PM, SW #2 said the care plan did not document areas for Resident #164's depression or anxiety and she would add those.	{F 656}	other residents to validate their care plans addressed use of psychoactive medications as indicated to include depression and anxiety. Adjustments were made as indicated. Nursing staff and Social Services staff are educated to update care plans to address a resident's psychoactive medications. Re-education was provided by the Director of Nursing and/or designee to include but not limited to, updating care plans to address resident's depression and anxiety, including directives and interventions to decrease depression and anxiety. The system is amended to review new admissions and residents with order changes in clinical meeting to validate care plan goals and interventions are established and/or updated. The Director of Nursing and/or designee will audit 4 residents weekly that are new admissions or have psychoactive medication order changes for 8 weeks to validate the care plans address resident psychoactive medications, which include direction and interventions to decrease depression and anxiety. Starting the week of October 21st the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	{F 657}		10/25/18	

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{F 657}	Continued From page 11 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised as care needs changed. This was true for 1 of 8 residents (Resident #164) whose care plans were reviewed. This failure had the potential for harm if care and services were not provided due to inaccurate information. Findings include:	{F 657}	The clinical management team reviewed resident #164 updating the care plan to include the 1:1 companion as indicated. The clinical management team reviewed other residents to validated care plans were revised to include 1:1 companions as indicated.		

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{F 657}	Continued From page 12 Resident #164 was admitted to the facility on 5/15/18, with multiple diagnoses including disorientation, unsteadiness on feet, paranoid schizophrenia, and anxiety. Resident #164's 5/28/18 admission MDS assessment, documented she required the assistance of 1 person with transfers and walking. Resident #164's record included progress notes which documented she required 1:1 staff on 7/3/18, 7/4/18, 7/11/18, 7/15/18, 7/16/18, 7/23/18 - 7/27/18, and 8/28/18. The progress notes documented she required this due to her inability to sit still, she verbalized fearfulness, her low awareness of safety, and overestimating her abilities. The facility's staff schedule and 1:1 Monitors, dated 9/17/18 to 9/18/18, documented Resident #164 had 1:1 staff assigned to her 24 hours a day. Resident #164's current care plan did not include she had 1:1 staff. On 9/18/18 at 8:03 AM, Resident #53 and Resident #164 were in their shared room. Resident #53 was sleeping in her bed and Resident #164 was awake and laying in her bed. CNA #4 was Resident #53's assigned 1:1 staff and sat in a chair next to Resident #53, with her back to Resident #164. At 8:17 AM, CNA #3, Resident #164's assigned 1:1 staff, entered the room and closed both of	{F 657}	Licensed nursing staff and social services staff are educated to revise residents' care plans as the care needs change. Re-education was provided by the Director of Nursing and/or designee to include but not limited to, revising residents' care plans when 1:1 intervention is indicated. The system is amended to include review in clinical meeting for 1:1 companion changes and care plan updates. The Director of Nursing and/or designee will audit 2 residents weekly for 8 weeks to validate staff are revising residents' care plans as 1:1 companion needs are adjusted. Starting the week of October 21st the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.		

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{F 657}	Continued From page 13 Resident #164's privacy curtains approximately 90 percent of the way. Resident #164 was visible if staff were standing in front of the opening. CNA #3 walked past CNA #4 and Resident #53 to wash her hands in the room sink. Both CNAs had their backs turned away from Resident #164. Resident #164 stood up twice and took a step before the surveyor alerted CNA #3 she was attempting to walk without assistance. CNA #3 went to assist Resident #164. Resident #164 said she was afraid of falling because she had fallen at home before coming to the facility. On 9/18/18 at 2:46 PM, SW #2 said the care plan did not include documentation Resident #164 had a 1:1 and she would add those. On 9/19/18 at 12:58 PM, the IDON said the care plan should have been updated when Resident #164 started with 1:1 staff.	{F 657}			
{F 686} SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	{F 686}		10/25/18	

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{F 686}	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents did not develop avoidable pressure ulcers. This was true for 1 of 4 residents (Resident #166) reviewed for pressure ulcers. Resident #166 was harmed when he developed 2 pressure ulcers. Findings include:</p> <p>Resident #166 was admitted to the facility on 8/13/18, with diagnoses which included dementia with lewy bodies (abnormal protein deposits in the brain) and traumatic brain injury.</p> <p>The initial MDS assessment, dated 8/24/18, documented Resident #166 had moderate cognitive impairment. The MDS documented he had no pressure ulcers or skin impairments.</p> <p>The care plan area addressing Resident #166's risk for skin alteration, initiated 8/16/18, documented the goal was for Resident #166's skin to remain intact and staff were to perform weekly skin assessments.</p> <p>Resident #166's Progress Notes from 8/22/18 through 9/3/18 documented the following:</p> <ul style="list-style-type: none"> - On 8/31/18 at 1:43 PM, Resident #166 was resting in his chair and would take food and fluids when offered but he would not respond when spoken to. - On 9/1/18 at 1:39 PM, Resident #166 was in bed and did not answer questions when asked. The note documented a 3 cm by 3 cm red blanchable area on his coccyx. The note 	{F 686}	<p>Resident #166 no longer resides at the facility.</p> <p>The clinical management team completed a skin review of other residents to validate they did not develop pressure ulcers. Adjustments have been made as indicated. External wound care company has been contracted with to provide clinical expertise to prevent wound deterioration and promote wound healing.</p> <p>Nursing staff are educated on prevention and management of pressure ulcers. Re-education was provided by Director of Nursing and/or designee to include but not limited to, accurate assessment of skin alterations, monitoring of resident change of condition that may require changes in care, timely implementation of preventative devices, management of non-compliance, and documentation of care provided. The system is amended to include review of residents with changes of condition in clinical meeting to implement preventative measures in a timely manner. In addition, the external wound company will conference with nursing leadership weekly on changes to current wounds.</p> <p>The Director of Nursing and/or designee will audit 2 residents at risk of avoidable pressure ulcers and/or residents with alteration in skin integrity weekly for 8 weeks. The Clinical Resource Nurse</p>		

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{F 686}	<p>Continued From page 15</p> <p>documented the nurse applied barrier cream and the nurse instructed the CNAs to rotate Resident #166 from side to side when repositioning.</p> <p>- On 9/3/18 at 10:58 AM, Resident #166's red area on his coccyx had opened up. The note documented the skin did not blanch. The note documented Resident #166's Spouse arrived at the facility and requested Resident #166 leave with her because the facility was "killing him."</p> <p>A Hospital Consultation Note, dated 9/5/18, documented Resident #166 arrived at the hospital from a care center where he had developed 2 pressure ulcers and was stiff. The note documented Resident #166 was somnolent, lying in bed, needed assistance with feeding, was incontinent and difficult to wake. The note documented Resident #166 was non-responsive with most attempts to rouse the resident.</p> <p>A Hospital Progress Note, dated 9/7/18, documented Resident #166 was admitted to the facility for over sedation and noted to have 2 pressure injuries upon admit, to the sacrum and his left heel. The note documented the sacrum pressure injury was unstageable and the left heel was an "intact bullae" (fluid filled blister). The Hopkins Medicine website, accessed on 10/2/18, stated according to the National Pressure Ulcer Advisory Panel an Unstageable pressure ulcer is full thickness tissue loss and the base of the ulcer is covered by dead skin which may be yellow, tan, or black in color.</p> <p>On 9/19/18 at 8:40 AM, UM #2 stated on 8/27/18 a skin assessment was completed, and Resident #166 did not have areas of concern to his</p>	{F 686}	<p>Consultant will monitor management and prevention of wounds monthly and report to the QAPI committee. Starting the week of October 21st the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>		

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{F 686}	<p>Continued From page 16 coccyx.</p> <p>On 9/19/18 at 8:50 AM, LPN #3 stated he noticed the skin alteration on 9/1/18, and completed a skin alteration report. LPN #3 stated he applied barrier cream and requested CNAs turn Resident #166 every 2 hours. LPN #3 did not notice if Resident #166 lost weight. LPN #3 stated staff did assist Resident #3 with eating in the dining room after Resident #166 was more lethargic and could not assist himself.</p> <p>On 9/19/18 at 9:13 AM, CNA #8 stated after Resident #166's medications changed he was sleepy and would stay in bed. CNA #8 stated she was aware of his skin breakdown on his coccyx.</p> <p>On 9/19/18 9:24 AM, CNA #9 stated Resident #166 was independent with cares when he first arrived at the facility and after the new medications were given CNAs had to provide fluids, assist with meals, transfers, and assist with all cares. CNA #9 stated Resident #166 was a 2 person assist for all cares after the medication changes. CNA #9 stated Resident #166 was sleepier. CNA #9 stated she was aware of his skin breakdown on his coccyx.</p> <p>On 9/19/18 at 9:56 AM, UM #1 stated Resident #166 was an inconsistent eater and his skin was intact to her knowledge from admission. UM #1 stated Resident #166 walked around the facility under his own power when he first arrived. UM #1 stated she examined Resident #166's coccyx on 9/3/18 and it appeared to be an unblanchable area about "1/2 the size of her palm" with a long line that looked like a "slit." UM #1 stated she was unable to complete her assessment because</p>	{F 686}			

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

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{F 686}	Continued From page 17 Resident #166's Spouse removed Resident #166 from the facility. UM #1 stated she was on the phone ordering an air mattress for Resident #166 when his spouse arrived to remove him from the facility. On 9/19/18 at 12:58 PM, the IDON stated Resident #166 was on multiple medications in the hospital and the Psychiatrist had to "jump" fast to stabilize the resident. The IDON stated Resident #166 had a history of confusion and delusion. The IDON stated the psychotropic medications should have consents. The IDON stated the Spouse stated doing research on antipsychotics and thought the facility was killing Resident #166. The IDON stated the Spouse placed signs in Resident #166's room to not provide certain medications and she and UM #1 were unaware that they were posted. (These signs were unable to be found.) The IDON stated Resident #166 was independent when he arrived with all cares and by the time he left he was dependent of staff for all cares. The IDON stated there was no excuse for the pressure ulcer that developed on his coccyx.	{F 686}			
{F 725} SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	{F 725}		10/25/18	

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{F 725}	<p>Continued From page 18</p> <p>practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, facility policy and procedure review, and staff interview, it was determined the facility failed to ensure there was adequate staffing to provide for the needs and well-being of residents who required 1:1 staff supervision. This failed practice had a negative impact on the level of supervision and/or services provided to 3 of 3 residents (#53, #59, and #164) who were observed with 1:1 staffing. This failed practice placed the health and safety of residents at risk of serious harm should the staffing shortage result in the failure to deliver care directed by their care plans. Findings include:</p>	{F 725}	<p>The clinical management team reviewed residents #53, #59, and #164 to validate their plan of care and needs are met. Adjustments have been made as indicated.</p> <p>The clinical management team reviewed other residents who required 1:1 staff supervision for staff availability to meet their needs. Staffing patterns indicate that there is staff scheduled and available to meet the needs of the resident's current conditions.</p>		

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{F 725}	Continued From page 19 The facility's Resident 1:1 Procedure, dated September 2018, stated staff were to be within view of the resident at all times and if the staff member needed to be relieved for any reason the staff member taking over must sign they are responsible for the resident. The procedure also stated 1:1 staff were expected to interact with and provide activities to the resident. This procedure was not followed. Resident #164 was admitted to the facility on 5/15/18, with multiple diagnoses including paranoid schizophrenia and anxiety. Resident #164's care plan documented she identified as impulsive and directed staff to provide 1:1 assistance. Staff were to encourage Resident #164 to adjust her room environment to help her feel at home. Resident #59 was admitted to the facility on 6/4/18, with multiple diagnoses including history of falling, anxiety disorder, and vascular dementia with behavioral disturbances. Resident #59's care plan directed staff to provide 1:1 supervision while awake and respect her wishes and give her a choice about care and activities. Resident #53 was readmitted to the facility on 9/9/18, with multiple diagnoses including traumatic brain injury, post-traumatic stress disorder, restlessness, and agitation. Resident #53's care plan directed staff to provide 1:1 supervision 24 hours a day due to elopement	{F 725}	The Director of Nursing, licensed nurses, and staffing coordinator are educated to adequate staffing for residents requiring 1:1 staff supervision. Re-education was provided by the Administrator to include but not limited to, communication regarding staff breaks while providing 1:1 supervision to residents. The system is amended to provide 1:1 staff supervision to residents as directed by their care plans. The Administrator and/or designee will audit 2 residents weekly for 4 weeks to validate staff are accommodating residents who require 1:1 staffing supervision. In addition, review of resident response to staffing needs will be monitored through monthly resident council meetings. Starting the week of October 21st the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 4 weeks, as it deems appropriate.		

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{F 725}	<p>Continued From page 20</p> <p>risk. Interventions included to remind Resident #53 the facility is her home and respect her wishes in choice of activities.</p> <p>The facility's staff schedule and 1:1 Monitors, dated 9/17/18 to 9/18/18, documented Resident #53 and Resident #164 had 1:1 staff assigned to them 24 hours a day. Resident #59 had 1:1 staff assigned to her from 6:00 AM to 10:00 PM and was on 15 minute checks from 10:00 PM to 6:00 AM.</p> <p>On 9/17/18 and 9/18/18, observations were conducted of 1:1 care for Resident #53, Resident #59, and Resident #164. The observations included the following:</p> <p>On 9/17/18 at 3:37 PM, Resident #53 and #164 were in their shared assigned room and awake in their beds. Resident #59 who was assigned to a different room, was in a wheelchair in Resident #53's and #164's room. CNA #1 and CNA #2 were present in the room. Both CNAs were standing next to Resident #59 near the room door and attempting to calm her down and prevent her from rising from her wheelchair.</p> <p>CNA #1 activated Resident #164's call light as Resident #164 attempted to rise out of her bed several times. Resident #53 also attempted to rise out of bed by herself. CNA #1 and CNA #2 tried to respond to the 3 residents' needs.</p> <p>At 3:46 PM, CNA #1 assisted Resident #164 to the bathroom, leaving CNA #2 with Resident #53 and #59.</p> <p>At 3:48 PM Resident #53 told CNA #2 to get</p>	{F 725}			

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{F 725}	<p>Continued From page 21</p> <p>Resident #59 out of her room and became upset and cursed, "Get her (Resident #59) the hell shit out or I will go home."</p> <p>At 3:53 PM, CNA #5 entered the room to answer the call light. At 3:54 PM, LPN #2 said Resident #59 was just visiting the other residents and they were waiting for CNA #3 to take over 1:1 duties for Resident #59.</p> <p>On 9/18/18 at 8:03 AM, Resident #53 was asleep in her bed and Resident #164 was awake in her bed, both were in their shared room. CNA #4 was Resident #53's 1:1 and sat in a chair next to Resident #53 with her back to Resident #164.</p> <p>At 8:17 AM, CNA #3 Resident #164's 1:1 staff, entered the room and closed both of Resident #164's privacy curtains (vertical and horizontal) approximately 90 percent of the way where Resident #164 was visible if staff were standing in front of the opening. CNA #3 walked past CNA #4 and Resident #53, to wash her hands in the room sink. Both CNAs had their backs turned away from Resident #164. Resident #164 stood up twice and took a step before the surveyor alerted CNA #3 she was attempting to walk. CNA #3 went to assist Resident #164 and Resident #164 said she was afraid of falling because she had fallen at home before coming to the facility.</p> <p>On 9/18/18 at 8:24 AM, CNA #4 said she was watching Resident #53 and Resident #164 while CNA #3 was on a 15 minute break. CNA #4 said there should have been someone available to cover for 1:1 staff, but there was not. CNA #4 said normally when there was 1 staff member</p>	{F 725}			

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{F 725}	Continued From page 22 watching 2 residents, she could use the call light to get assistance if 1 of the residents was trying to get up and move around.	{F 725}			
{F 758} SS=G	<p>On 9/19/18 at 12:58 PM, the IDON said residents were to have their own 1:1 staff member and if someone took a break they should have had another staff member take over the 1:1 care.</p> <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> <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</p>	{F 758}		10/25/18	

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{F 758}	<p>Continued From page 23</p> <p>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:</p> <p>Based on resident and staff interview, record review, and facility policy review, it was determined the facility failed to: a) Obtain the resident's consent prior to administering psychoactive medications, b) adequately monitor and assess whether residents behaviors required the continued use of psychoactive medications, c) received duplicate therapy for the same diagnosis, and d) residents were not provided medications in excess to control behaviors without trying non-pharmacological interventions. This was true for 4 of 8 residents (#7, #164, #165, and #166) reviewed for unnecessary medications. Resident #166 was harmed when he experienced increased somnolence, sedation, weight loss, and developed two pressure ulcers. Residents #7, #164, and #166 had the potential</p>	{F 758}	<p>Resident #166 no longer resides at the facility.</p> <p>The clinical management team reviewed residents #7 and #164 and completed the process for written consent explaining the risks and benefits for their psychoactive medications.</p> <p>The clinical management team reviewed resident #165 updating the information for the GDR to accurately reflective the behavior monitor information, addressing duplicate therapy, and adjusting monitors as indicated.</p> <p>The clinical management team reviewed other residents to validate that they had</p>		

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{F 758}	<p>Continued From page 24</p> <p>for harm when they did not have consents for their medications. Resident #165 had the potential for harm when the information gathered for her GDR was not accurately reflective of her behavior monitors. Findings include:</p> <p>1. Resident #166 was admitted to the facility on 8/13/18, with diagnoses which included Lewy body dementia (abnormal protein deposits in the brain) and traumatic brain injury. Resident #166 was discharged from the facility and admitted to a local hospital on 9/3/18.</p> <p>An H&P, dated 8/14/18, stated Resident #166 was brought to the facility from a local hospital. He was living in an ALF prior to his hospital admission when his behaviors escalated. The H&P stated Resident #166 saw his neurologist and was started on Celexa, but he became more violent and it was discontinued. He was then started on Seroquel. The H&P stated while in the hospital Resident #166 hit a staff member and was sexually inappropriate. The H&P included the diagnosis of Lewy body dementia with behavioral disturbance.</p> <p>Resident #166's care plan included an area which addressed intrusive wandering and invading the personal space of others, initiated on 8/20/18. The care plan documented Resident #166 required 1:1 supervision while awake and 15 minute checks when he was asleep. Resident #166's care plan did not include his dementia, all behaviors, or the use of antipsychotic medications.</p> <p>The initial MDS assessment, dated 8/24/18, documented Resident #166 had a moderate</p>	{F 758}	<p>written consents for psychoactive medications, behavior monitors are adjusted as indicated, the information gathered for GDRs is accurately reflective of their behaviors, adjustments are made when side effects are evident, and that duplicate therapy is addressed.</p> <p>Nursing staff and Social Service staff are educated to the use of psychoactive medications and unnecessary drugs. Re-education was provided by the Director of Nursing and/or Designee to include but not limited to, obtaining written consents for psychoactive medications, updating behaviors monitors to those that are harmful to self and/or others, gather information for GDRs that accurately reflect the residents' behaviors, management when side effects are noted, communication with the physician, and physician support of duplicate therapy. The system is amended to include review of behaviors, non-pharmacologic interventions and documentation to support use of pharmacologic intervention in clinical meeting and/or with the nurse on-call prior to medication implementation. In addition, 1:1 counseling of staff will be completed as indicated.</p> <p>The Director of Nursing and/or designee will audit 4 residents weekly for 8 weeks to validate written consents for psychoactive medications, quality collection of behavioral data, communication with the physician, and</p>		

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{F 758}	<p>Continued From page 25</p> <p>cognitive impairment and he was physically aggressive 1 to 3 days a week. The MDS documented Resident #166 disturbed the environment but was not a risk to others. The MDS documented he required limited to extensive assistance of 1 to 2 staff members with all cares except eating.</p> <p>Resident #166's admission orders, dated 8/13/18, included Seroquel 75 mg twice a day for psychosis related to dementia and Seroquel 12.5 mg every 6 hours as needed for psychosis. Resident #166 also had an order for Celexa 30 mg by mouth daily for depression. Resident #166's record did not include diagnoses of depression or psychosis. The above medications included adverse reactions of drowsiness, sedation, somnolence (a strong desire for sleep), agitation, and anorexia.</p> <p>A Behavior Monitor Flowsheet for August 2018, included monitoring Resident #166 for physical aggression, wandering, elopement, being resistive to cares, and sexually inappropriate behaviors. The flowsheet included "suggested" interventions for each behavior. The interventions for each behavior were as follows:</p> <ul style="list-style-type: none"> - Physical aggression, elopement, and/or resistive to cares: redirection, offer activity, offer snack, discuss the reason the resident was upset - Wandering and/or sexually inappropriate: redirection, communicate concerns with behavior, 1:1 conversation <p>The flowsheet also included sections to document the number of times the behavior</p>	{F 758}	<p>documentation to support use and/or changes in behavioral plan. The Clinical Resource Nurse Consultant will monitor psychoactive medication use process monthly and report to the QAPI committee. Starting the week of October 21st the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 8 weeks, as it deems appropriate.</p>		

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{F 758}	<p>Continued From page 26 occurred, which interventions worked, which interventions did not work, and the initials of the staff member.</p> <p>Resident #166's Progress Notes and Behavior Monitor Flowsheets, from 8/13/18 to 9/3/18, documented the following behaviors:</p> <ul style="list-style-type: none"> - On 8/14/18 at 3:13 AM, the nurse stated Resident #166 was easy to redirect and "flirted" with staff, almost kissing a CNA. - On 8/14/18 at 1:41 PM, Resident #166 attempted to exit the facility after lunch. - On 8/14/18 at 9:20 PM, the nurse documented Resident #166 had delusions and showed signs and symptoms of aggression when receiving instruction. He was given the as needed Seroquel. - On 8/15/18 at 9:24 PM, the nurse stated Resident #166 "...does tend to make inappropriate statements with possible delusions ..." <p>There were no behaviors or interventions documented on the Behavior Monitor Flowsheet from 8/13/18 to 8/15/18.</p> <ul style="list-style-type: none"> - On 8/16/18 at 11:24 PM, the nurse stated Resident #166 was trying to touch other residents and staff, and he was combative with male CNAs. The nurse stated he was trying to kiss a nurse. The note also stated Resident #166's roommate was afraid of him because of how Resident #166 stared at him or patted his back and shook his hand. 	{F 758}		

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{F 758}	Continued From page 27 The note did not describe how or why Resident #166 was combative. The Behavioral Flowsheet documented he was resistive to cares but did not include documentation of interventions. - On 8/17/18 at 11:00 AM, the Social Service Specialist stated Resident #166 was found by the night nurse "pleasuring himself" in the hallway next to another resident's room. She stated behavior monitors for sexually inappropriate behavior were in place. The Behavior Monitor Flowsheet did not include documentation Resident #166 was sexually inappropriate or that interventions were attempted. - On 8/17/18 at 1:03 PM, the nurse stated Resident #166 attempted to exit the facility 3 times. He also was taking items from other residents such as food during a meal, markers and a book, and a walker. The note included documentation of staff intervening when Resident #166 was taking food, but not for the other items taken from other residents. - On 8/17/18 at 1:20 PM, the nurse stated Resident #166 exited the building but was easily redirected to go back inside. - On 8/17/18 at 11:21 PM, the nurse stated Resident #166 was exit seeking and easy to redirect. She documented he was combative with male CNAs and attempting to touch other residents. The note did not include	{F 758}			

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{F 758}	<p>Continued From page 28</p> <p>documentation how or why Resident #166 was combative, or what was meant when it stated he attempted to touch other residents.</p> <p>The Behavior Monitor Flowsheet documented Resident #166 was physically aggressive 4 times during the evening shift, he was wandering "10+" times during the evening shift and no interventions worked and 4 times during the night shift and all interventions worked, he eloped 2 times on the evening shift and no interventions worked, and he was resistive to cares 5 times on the evening shift and no interventions worked.</p> <p>- On 8/18/18 at 8:54 PM, the nurse stated Resident #166 was combative with staff and was attempting to touch other residents. He also told the nurse he had to stay out of his room all day because his roommate "tells him things all day." The note did not include documentation how or why Resident #166 was combative, or what was meant when it stated he attempted to touch other residents.</p> <p>- On 8/19/18 at 1:03 PM, the nurse stated Resident #166 was confused, delusional, and hallucinating at times. She stated he was combative and sexually inappropriate with female staff and female visitor. The nurse stated Resident #166 was non-directable and attempted to kick her and bite her arm. She stated he did hit a CNA in the stomach and placed a closed fist next to a female resident's head and stated "I'm not gonna hit you."</p> <p>- On 8/19/18 at 2:30 PM, the nurse stated Resident #166 was given an injection of Geodon (an antipsychotic medication) 20 mg per order</p>	{F 758}			

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{F 758}	<p>Continued From page 29</p> <p>after he was verbally and physically aggressive with staff and other residents. She stated other oral PRN medications and verbal redirection were ineffective.</p> <p>- On 8/20/18 at 1:47 PM, the nurse stated Resident #166 was intrusive and going into other female resident's rooms. She stated he was not directable and physically aggressive by "wringing" CNAs hands when they attempted to redirect him.</p> <p>- On 8/20/18 at 2:02 PM, the nurse stated Resident #166 was placed on 15 minute checks for intrusive wandering and invading the space of other residents.</p> <p>- On 8/20/18 at 11:27 PM, the nurse stated Resident #166 was combative with staff and given a PRN medication at 8:00 PM. She stated he was kicking and attempting to punch staff, squeeze staff's hands and pull their fingers back when he was being redirected.</p> <p>- On 8/21/18 at 5:19 AM, the nurse stated Resident #166 was given a PRN Ativan (an antianxiety medication) at 3:00 AM with no effect. She stated he was wandering into other resident's rooms and being intrusive. The nurse stated he had 1:1 staff all night for safety.</p> <p>- On 8/21/18 at 10:22 AM, the nurse stated Resident #166 was physically aggressive when she attempted to redirect him. He made sexually inappropriate comments, grabbed her breast and buttock. Resident #166 attempted to hit and kick staff, and he pushed 2 staff members. The nurse stated she received an order from the psychiatrist</p>	{F 758}			

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{F 758}	<p>Continued From page 30 for Geodon 20 mg injection and it was given with the assistance of 2 CNAs and another nurse. There was no documentation on the Behavior Monitor Flowsheet Resident #166 was sexually inappropriate.</p> <p>- On 8/21/18 at 12:12 PM, Resident #166's psychiatrist ordered Seroquel 200 mg and Clonazepam 0.5 mg 3 times a day. The wife was called, and she was ok with the orders but was worried about an overdose. The note documented the last time he was on multiple medications Resident #166 became weak and was unable to move.</p> <p>- On 8/21/18 at 2:09 PM, the nurse stated Resident #166 was attempting to push another resident down a hall in their wheelchair and became agitated and physically aggressive with staff when asking him to let go of the wheelchair. The nurse stated Resident #166 grabbed and squeezed the arms and hands of staff and punched the resident in the wheelchair in the back. The nurse stated the psychiatrist was called and new orders were given.</p> <p>- On 8/21/18 at 8:55 PM, the nurse documented Resident #166 was given an antianxiety medication at 2:00 PM for increased aggression with anxiety. The nurse stated Resident #166 had no symptoms of anxiety or aggression and was resting quietly in his room.</p> <p>- On 8/22/18 at 2:22 AM, the nurse stated Resident #166 was sleeping with no behaviors and being monitored closely due to his aggressive behaviors on the previous shift and the PRN Haldol (an antipsychotic medication)</p>	{F 758}			

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{F 758}	<p>Continued From page 31 was given.</p> <p>- On 8/22/18 at 3:42 AM, the nurse documented "[Resident #166] is now awake and is mildly displaying s/s [signs and symptoms] of restless behaviors x4. He was calling out several times and was not directable. Staff changed his linen, clothes, toileted him & provided pericare, and re-positions him comfortably in bed. He was also given a glass of water. At the beginning of the shift, he was sleeping with his head resting at the foot of the bed. He has not attempted to get out of bed this noc [night]. [Resident #166] was given prn Haldol IM [intramuscular] to maintain calmness and prevent aggression."</p> <p>There was no documentation on the Behavior Monitor Flowsheet Resident #166 was physically aggressive, was resistive to cares, or sexually inappropriate.</p> <p>- On 8/22/18 at 8:47 PM, the nurse stated Resident #166 remained confused and had aggression. The nurse stated he was given Haldol for the aggression and intrusiveness. There was no description how Resident #166 was aggressive or intrusive.</p> <p>The Behavior Monitor Flowsheet did not include documentation Resident #166 had physical aggression, was resistive to cares, or sexually inappropriate.</p> <p>- On 8/30/18 at 2:31, the nurse stated Resident #166's spouse was upset he was sitting in a chair and not speaking to her. His spouse was upset about the medications, Abilify (an antipsychotic) and Klonopin (a benzodiazepine), prescribed by</p>	{F 758}			

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{F 758}	<p>Continued From page 32</p> <p>the psychiatrist and that she read about the black box warnings related to patients with dementia. The nurse stated an appointment was made for Resident #166's spouse to meet with the psychiatrist on 9/10/18.</p> <p>According to the Food and Drug Administration (FDA), website accessed 9/26/18, a black box warning appears on a prescription drug's label and is designed to call attention to serious or life-threatening risks.</p> <p>- On 8/31/18 at 1:43 PM, the nurse stated Resident #166's spouse was called about a new dietary order. The spouse stated "Well, the problem is that he's not eating. They gave him something over the weekend that almost killed him and turned him into a vegetable."</p> <p>- On 9/3/18 at 10:58 AM, the nurse stated Resident #166's spouse informed the nurse she was taking him to a hospital. The spouse stated "You are killing him. I am taking him to the hospital to see if they can save his life." The nurse stated she could call the physician and arrange for him to go to the hospital, Resident #166's spouse refused. The nurse informed the spouse if she took him without a physician order this was against medical advice. Resident #166's spouse signed a form which stated she took him from the facility against medical advice.</p> <p>Resident #166's MARs for August 2018 and September 2018 documented the following medications:</p> <p>- Seroquel 75 mg 2 times a day for psychosis, ordered 8/13/18 and discontinued on 8/20/18.</p>	{F 758}			

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{F 758}	Continued From page 33 - Seroquel 12.5 mg every 6 hours PRN for psychosis, ordered 8/13/18 and discontinued on 8/27/18. - Celexa 30 mg daily for depression, ordered 8/13/18 and discontinued on 8/20/18. - Geodon 20 mg IM 1 dose for "physically combative with staff and residents," ordered 8/19/18. - Ativan 1 mg every 6 hours PRN for anxiety, ordered 8/20/18. - Geodon 20 mg IM 1 dose for agitation, ordered 8/21/18. - Haldol Decanoate (extended duration medication) 20 mg IM 1 dose for dementia with psychosis, ordered 8/21/18. - Haldol Lactate (short acting duration) 5 mg IM every 6 hours PRN for dementia with psychosis, ordered 8/21/18. - Abilify 5 mg at 7:30 AM and 3:00 PM for dementia with psychosis, ordered 8/21/18. - Depo-Provera 150 mg IM 1 time every 28 days for dementia lewy body with behaviors, ordered 8/21/18. - Klonopin 0.5 mg 3 times a day for anxiety, ordered 8/21/18. - Lexapro 10 mg daily for major depression, ordered 8/21/18.	{F 758}			

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{F 758}	<p>Continued From page 34</p> <p>- Seroquel 200 mg daily for psychosis, ordered 8/21/18 and discontinued on 8/27/18.</p> <p>- Seroquel 100 mg daily for psychosis related to dementia with lewy bodies, ordered 8/27/18.</p> <p>On 8/21/18, Resident #166's psychiatrist ordered 6 new medications for anxiety, dementia with behaviors and/or psychosis, and agitation. Of those 6 medications 3 are classified as antipsychotics. According to Drugs.com a nationally recognized medication information website, accessed 9/26/18, Haldol, Geodon, Seroquel, and Abilify had a black box warning for increased mortality in geriatric patients.</p> <p>The MAR documented Resident #166 received daily doses, according to the psychiatrist orders, of Abilify, Lexapro, Seroquel, and Klonopin on 8/21/18 through 8/31/18. On 8/21/18, Resident #166 also received, in addition to the medications listed above, 1 injection of Depo-Provera, 1 injection of Geodon, 1 injection of Haldol Decanoate 20 mg, and 2 injections of Haldol Lactate 5mg. There was no clinical justification documented for the addition of the Lexapro, Klonopin, Abilify, Seroquel at a higher dose, and the Haldol.</p> <p>On 8/20/18 at 4:25 PM, a progress note documented the psychiatrist examined Resident #166 and changed his medications. Resident #166's spouse was called and she told the nurse she would get the new orders when she came in to visit.</p> <p>On 8/21/18 at 12:12 PM, a progress note</p>	{F 758}			

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{F 758}	<p>Continued From page 35</p> <p>documented the psychiatrist changed Resident #166's medications again and his spouse was called. She told staff " ...ok, but to watch for an overdose. Stated last time he was on a lot of medications he became weak, and could not move."</p> <p>A subsequent note at 2:09 PM, documented the psychiatrist was called and new orders were given, and a message was sent to Resident #166's spouse. There was no documentation his spouse responded to the message regarding the order changes.</p> <p>Resident #166's record did not include written consents for the medications listed above.</p> <p>Resident #166's MAR, from 8/13/18 to 9/3/18, documented he experienced the medication side effect of drowsiness from antipsychotic on the night shifts of 8/21/18 and 8/24/18 - 8/27/18, evening shifts of 8/24/18 - 8/26/18 and 8/28/18, and day shifts of 8/22/18 and 8/24/18 - 8/28/18.</p> <p>On 8/29/18 at 10:07 AM, Resident #166 was documented as losing 9.5 pounds in 1 week with a current weight of 153.5 pounds. The note documented Resident #166 had poor intake and he refused 12 meals the past week. The note documented Resident #166 was spending "more time in bed." The note documented staff were to provide assistance with meals and include enriched food with meals.</p> <p>On 8/29/18 at 9:12 PM, the nurse documented Resident #166 did not urinate throughout the shift. The nurse documented he performed a bladder scan, using ultrasound, and Resident</p>	{F 758}			

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{F 758}	<p>Continued From page 36</p> <p>#166 had greater than 600 ml of urine. The nurse inserted a catheter to release the urine and Resident #166 was noted to have "dark amber" urine with 500 ml of output. The note documented staff were going to push fluids.</p> <p>On 8/31/18 at 1:43 PM, Resident #166 was resting in his chair and would take food and fluids when offered but he would not respond when spoken to.</p> <p>On 9/1/18 at 1:39 PM, Resident #166 was in bed and did not answer questions when asked. The note documented a 3 cm by 3 cm red, blanchable area on his coccyx. The note documented the nurse applied barrier cream and instructed the CNAs to rotate Resident #166 from side to side when repositioning.</p> <p>A Hospital Consultation Note, dated 9/5/18, documented when Resident #166 arrived at the hospital he had developed 2 pressure ulcers and was stiff. The note documented Resident #166 was somnolent, lying in bed, needed assistance with feeding, was incontinent, and difficult to wake. The note documented Resident #166 was non-responsive with most attempts to rouse the resident.</p> <p>A Hospital Progress Note, dated 9/7/18, documented Resident #166 was admitted to the facility for over-sedation and noted to have 2 pressure injuries upon admit, to the sacrum and the left heel. The note documented the sacrum pressure ulcer was unstageable and the left heel was an "intact bullae" (fluid filled blister).</p> <p>On 9/19/18 at 8:24 AM, CNA #6 stated Resident</p>	{F 758}			

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{F 758}	<p>Continued From page 37</p> <p>#166 was pleasant when he first arrived at the facility. She stated she was not sure why he started throwing things, hitting, and kicking staff. CNA #6 stated Resident #166 struck a pregnant CNA in the belly on 8/19/18. She stated he was mostly agitated during the evening shift at first, and then it did not matter. CNA #6 stated Resident #166 calmed down after the shots and remained in bed. CNA #6 stated she had no other issues with him after the shots.</p> <p>On 9/19/18 at 8:40 AM, UM #2 stated Resident #166 was pleasant when he first arrived at the facility, wandering around the building on his own. He stated Resident #166 attempted to "kiss" or "grab" staff members on occasion. UM #2 stated Resident #166's behaviors escalated, and he struck a pregnant CNA in the belly on 8/19/18. UM #2 stated when this occurred the physician ordered Geodon and the medication did not work to decrease his behaviors and Haldol was ordered. UM #2 stated after the Haldol was ordered and the medications were changed Resident #166 did not get up as much. He stated Resident #166 ate with the assistance of staff members and he recalled Resident #166 lost weight. UM #2 stated Resident #166 responded with eye raises if spoken to. He stated Resident #166's spouse had concerns about Resident #166's Abilify and Clonazepam, and he set up an appointment for her to discuss the medications with the psychiatrist. UM #2 stated the spouse placed signs in Resident #166's room to not give the Abilify and the Clonazepam, and the facility complied with the request around 8/30/18. He stated Resident #166's psychiatrist was notified when there were changes in his behaviors and the psychiatrist decreased</p>	{F 758}			

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{F 758}	<p>Continued From page 38</p> <p>Resident #166's Seroquel. UM #2 stated on 8/27/18, a skin assessment was completed, and Resident #166 did not have areas of concern to his coccyx.</p> <p>On 9/19/18 at 8:50 AM, LPN #3 stated Resident #166 was pleasantly confused when he first arrived at the facility and wandered around the building on his own. LPN #3 stated he noticed Resident #166's verbal and physical aggression on 8/19/18, when Resident #166 punched a pregnant CNA in the abdomen. He stated on 8/21/18, Resident #166 was attempting to enter another resident's room and was punching and kicking the CNA. LPN #3 stated Haldol was ordered when Resident #166 struck a resident. He stated Resident #166 was mostly independent with cares before the medication changes and afterwards, he was in bed more often. LPN #3 stated he noticed the skin alteration on 9/1/18, and completed a skin alteration report. LPN #3 stated he applied barrier cream and requested CNAs turn Resident #166 every 2 hours. LPN #3 did not notice if Resident #166 lost weight, and staff assisted Resident #3 with eating in the dining room after Resident #166 became more lethargic and could not assist himself.</p> <p>On 9/19/18 at 9:08 AM, CNA #7 stated Resident #166 was pleasantly confused when he first arrived at the facility and he was easily redirected. CNA #7 stated he was independent with cares. She stated on an evening shift Resident #166 grasped her arm and did not let go. She stated another staff member had to assist her. CNA #7 stated Resident #166 calmed down after the shots and remained in bed. CNA</p>	{F 758}			

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{F 758}	<p>Continued From page 39</p> <p>#7 stated she had no other issues with him after the shots. CNA #7 stated she did not recall if Resident #166 had any concerns with his roommate.</p> <p>On 9/19/18 at 9:13 AM, CNA #8 stated Resident #166 was pleasantly confused when he first arrived at the facility and he was easily redirected. CNA #8 stated during an incident Resident #166 attempted to enter another resident's room and it "took 4 people to hold him down." She stated this occurred 2 days before the Haldol was ordered. CNA #8 stated she tried to redirect him by "telling him this isn't your room let's go this way." CNA #8 stated when she told him this she tried to hold his hand and lead him in a different direction. CNA #8 stated Resident #166 had a 1:1 for about a week. She stated when the 4 staff members held "him down" 1 CNA blocked the door to prevent Resident #166 from entering another resident's room and then another approached and tried to lead him away. CNA #8 stated another CNA assisted the other 2 and tried to lead him away, and finally a nurse came and provided medications. CNA #8 stated after Resident #166's medication changes he was sleepy and stayed in bed. CNA #8 stated she was aware of his skin breakdown on his coccyx, and his urine smelled foul and was dark in color. CNA #8 was provided instructions to offer water with meals and snacks. CNA #8 stated she did not recall if Resident #166 had any concerns with his roommate.</p> <p>On 9/19/18 9:24 AM, CNA #9 stated she was assigned to be Resident #166's 1:1 "not even for 1/2 a day." CNA #9 stated she was told Resident #166 was sexually inappropriate with females</p>	{F 758}			

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{F 758}	<p>Continued From page 40</p> <p>and a male was assigned to watch him. CNA #9 stated when Resident #166 was exhibiting behaviors she held his hand and tried to walk with him when he could walk. She stated when Resident #166 attempted to enter another resident's room, and if the CNAs were unable to lead him away, and he continued to hit, kick, and pinch them, the nurse gave a medication. CNA #9 stated he was independent with cares when he first arrived at the facility and after the "shots" the CNAs had to provide fluids, assist with meals, transfers, and assist with all cares. She stated Resident #166 was a 2 person assist for all cares after the medication changes. CNA #9 stated Resident #166's aggressiveness did decrease and he was sleepier. CNA #9 stated she was aware of his skin breakdown on his coccyx and that his urine smelled foul and was dark in color. CNA #9 was provided instructions to offer water with meals and snacks. CNA #9 stated she did not recall if Resident #166 had any concerns with his roommate.</p> <p>On 9/19/18 at 9:56 AM, UM #1 stated Resident #166 was an inconsistent eater and to her knowledge his skin was intact from admission. She stated Resident #1 would walk about the facility under his own power when he first arrived. UM #1 stated she examined Resident #166's coccyx on 9/3/18, and it appeared to be an unblancheable area about "1/2 the size of my palm" with a long line that looked like a "slit." UM #1 stated she was unable to complete her assessment because Resident #166's spouse removed him from the facility. UM #1 stated she thought Resident #166 was going to harm his roommate which was one of the reasons the Haldol was requested from the psychiatrist. UM</p>	{F 758}			

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{F 758}	<p>Continued From page 41</p> <p>#1 stated the Haldol Lactate was effective for decreasing his behaviors and it made Resident #166 sleepy. UM #1 was unaware if Resident #166 was able to walk after the medications changed. UM #1 stated the spouse did not want Resident #166 to have most antipsychotic medications and told her "you are killing him." UM #1 stated she was on the phone ordering an air mattress for Resident #166 when his spouse arrived to remove the resident.</p> <p>On 9/19/18 at 2:03 PM, the Psychiatrist stated Resident #166 had behaviors from the moment he arrived at the facility. The Psychiatrist stated he ordered 1 dose of Haldol long acting and PRN short acting Haldol to be used sparingly. The Psychiatrist stated he recalled discontinuing the Seroquel, and when Resident #166's behaviors increased he ordered a higher dose of Seroquel to be restarted to try and get the medication in his system. The Psychiatrist stated when the resident displayed signs of over-sedation he decreased the medication on 8/27/18. The Psychiatrist stated he would expect the facility to obtain consents for all psychotropic medications and monitor for their behaviors.</p> <p>On 9/19/18 at 12:58 PM, the IDON stated Resident #166 was on multiple medications in the hospital and the psychiatrist had to "jump" to stabilize the resident. The IDON stated Resident #166 had a history of confusion and delusions. The IDON stated the psychotropic medications should have consents. The IDON stated the spouse placed signs in Resident #166's room to not provide certain medications and she and UM #1 were unaware they were posted. The IDON stated Resident #166 was independent with all</p>	{F 758}			

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{F 758}	<p>Continued From page 42</p> <p>cares when he arrived and by the time he left he was dependent of staff for all cares. The IDON stated the family left the facility too quickly for the medications to be adjusted. The IDON stated sometimes the psychiatrist started at a higher dose to get the level up in the system and then adjusted the medications down from there. The IDON stated sometimes the residents went into a state where they required more assistance like Resident #166 to get their medications controlled. The IDON stated there was no excuse for the pressure ulcer that developed on his coccyx or the weight loss.</p> <p>On 9/19/18 at 3:50 PM, CNA #2 stated Resident #166 should have had a 1:1 from the beginning of his stay at the facility. CNA #2 stated he was up walking around at first and after the medication changes he was in bed. CNA #2 stated Resident #166 never hurt his roommate or attempted to hurt his roommate.</p> <p>On 9/19/18 at 5:15 PM, the IDON stated the psychiatrist was aware of Resident #166's sedation from the medications and examined the HOS documentation on the ADL Flowsheet. The IDON stated she was not aware the ADL Flowsheet did not include all three shifts for the psychiatrist to examine Resident #166's HOS and sedation. The IDON stated she could not locate documentation of notification of when they called the spouse for all the Haldol administrations. The IDON stated she could not locate consents for the medications Resident #166 was provided. The IDON stated the Social Worker received verbal consent for the medications and did not receive written consent for the medications. The IDON stated the Social</p>	{F 758}			

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{F 758}	<p>Continued From page 43</p> <p>Worker thought the verbal consent was good enough. The IDON stated Resident #166's injury to his coccyx was considered a pressure ulcer and she was unaware of a pressure ulcer to his heels.</p> <p>2. Resident #165 was admitted to the facility on 11/28/17, with diagnoses which included schizoaffective disorder, anxiety, dementia, and anoxic brain damage (the brain was deprived of oxygen).</p> <p>A quarterly MDS assessment, dated 8/16/18, documented Resident #165 had severe cognitive impairment and documented she had verbal behaviors 1-3 days a week. The MDS documented Resident #165 was totally dependent on 1-2 staff members for all cares.</p> <p>The care plan area addressing Resident #165's anxiety, initiated 3/5/18, documented Resident #165's anxiety presented as cussing at staff, not using her call light, and yelling out.</p> <p>The care plan area addressing Resident #165's dementia, initiated 3/5/18, documented Resident #165 was physically and verbally aggressive during cares and had delusions people were talking about her.</p> <p>The care plan area addressing Resident #165's schizoaffective disorder, initiated 3/5/18, documented Resident #165 experienced hallucinations, and yelled shut up and "go straight to hell" to people who were not present.</p> <p>Resident #165's Physician's Orders documented the following:</p>	{F 758}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/19/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 758}	Continued From page 44 - Xanax 0.25 mg 2 times a day for generalized anxiety disorder, ordered 12/5/17. - Depakote 500 mg 2 times a day for schizoaffective disorder, ordered 12/4/17. - Abilify 10 mg 2 times a day for schizoaffective disorder, ordered 3/15/18. - Trazadone 100 mg daily for insomnia, ordered 1/8/18. Resident #165's MARs, dated 8/1/18 to 9/18/18, included behavior monitors. The behavior monitors documented on the MARs included the following: - Resident #165 had 8 episodes of verbal aggression- swearing at staff during cares. - Resident #165 had 2 episodes of physical aggression including hitting, kicking, and punching during cares. - There was no documentation Resident #165 had episodes of delusions. - There was no documentation Resident #165 had episodes of yelling out from her bed and not using her call light. Resident #165's MAR did not include monitoring for hallucinations. Resident #165's Behavior Monitor Flowsheets, dated 8/1/18 through 9/1/18, documented she was monitored for physical aggression, verbal	{F 758}			

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{F 758}	<p>Continued From page 45</p> <p>aggression, and delusions. The flowsheets documented she had 6 episodes of physical aggression, 153 episodes of verbal aggression, and 119 episodes of delusions. Resident #165's Behavior Monitor Flowsheets did not include monitoring for hallucinations.</p> <p>Resident #165's Monthly Behavior Summary/GDR Review, dated 9/13/18, was inconsistent with the Behavior Monitor Flowsheets and the MARs. The review documented Resident #165 had no episodes of verbal aggression, no episodes of physical aggression, no repetitive behaviors (yelling out), and she had 60 episodes of delusions. The summary did not evaluate her duplicate therapy she was receiving.</p> <p>On 9/18/18 at 10:41 AM, SW #2 stated the GDR information was based on CNA charting and what the nurses document as well. The SW stated she could see how it was confusing, and the data documented did not match.</p> <p>On 9/19/18 at 12:58 PM, the IDON stated the data provided to the physician should be correct. The IDON stated if the information was not correct the physician was not able to make a correct determination of whether the medication was needed or not. The IDON was trying to find the pharmacy recommendation for Resident #165's duplicate therapy, but it was not provided prior to the end of the survey.</p> <p>3. Resident #164 was admitted to the facility on 5/15/18, with multiple diagnoses including paranoid schizophrenia and anxiety.</p>	{F 758}			

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{F 758}	<p>Continued From page 46</p> <p>Resident #164's physician order included the following medications:</p> <ul style="list-style-type: none"> - Ativan 1 mg 3 times daily for Generalized Anxiety Disorder, ordered 7/3/18. - Haldol 3 mg 3 times daily for schizophrenia, ordered 8/24/18. <p>There was no documentation in Resident #164's medical record of a consent signed by Resident #164 or their representative which informed them of the risks and benefits with the use of Haldol and Ativan</p> <p>On 9/18/18 at 3:40 PM, SW #2 said a nurse should have obtained the consent for Resident #164's medications.</p> <p>On 9/19/18 at 1:15 PM, the IDON said there was no consent for Resident #164's Haldol and Ativan. She said all anti-psychotics and other psychotropic medications should have a consent with the black box warning. The IDON said social work staff thought a verbal consent was enough and have since been educated.</p> <p>4. Resident #7 was admitted to the facility on 10/4/16 with multiple diagnoses, including Alzheimer's Disease, pseudobulbar affect (uncontrollable and inappropriate laughing or crying), and Corticobasal degeneration (a progressive neurological disorder with shrinkage of the brain cerebral cortex).</p> <p>Resident #7's physician orders, dated 5/26/18, documented the resident to receive 2 MG of Abilfy (an anti-psychotic) once a day for</p>	{F 758}			

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

PRINTED: 01/03/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/19/2018
NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
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{F 758}	<p>Continued From page 47</p> <p>psychosis related to dementia, Alzheimer's, and pseudobulbar affect.</p> <p>Resident #7's May through September 2018 MARs, documented the resident received the Abilify.</p> <p>No documentation was found in the medical record for a consent where the resident or resident's representative were informed of the risks and benefits for the use of Abilify, including the risk of death in the elderly. At the time of survey, the resident was 68 years old.</p> <p>On 9/19/18 at 11:30 AM, SW #2 said a nurse should have obtained the consent from Resident #7's spouse.</p> <p>On 9/19/18 at 1:00 PM, the IDON said there was no consent for Resident #7's Abilify and all anti-psychotic and other psychotropic medications should have a consent with the black box warning. She said social work staff had thought a verbal consent was good enough and have since been educated.</p>	{F 758}			

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

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NAME OF PROVIDER OR SUPPLIER CALDWELL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 210 CLEVELAND BOULEVARD CALDWELL, ID 83605		
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F 000	INITIAL COMMENTS Refer to on-site follow-up and complaint survey N6WZ12.	F 000			

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

TITLE

(X6) DATE

Electronically Signed

10/12/2018

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.



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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June 19, 2019

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

Provider #: 135014

Dear Mr. McNeil:

On **September 17, 2019** through **September 19, 2018**, an unannounced on-site complaint survey was conducted at Caldwell Care of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007932

ALLEGATION #1:

The resident was chemically restrained.

FINDINGS #1:

During the investigation six residents were observed and eight residents' records, which included one closed record, were reviewed for Quality of Care and abuse. Multiple interviews were conducted with residents and family members. Multiple staff members were interviewed and observed for evidence of abuse. Facility abuse allegations, grievances, and Resident Council minutes were reviewed.

Facility abuse investigations did not document concerns with over medicating or chemical restraint of residents.

All eight residents' records were reviewed for chemical restraints and potential abuse and neglect concerns, including a resident admitted to the facility in August 2018.

During the review of the records for one resident, admitted August 2018, physician orders and medication administration records documented the resident had nine different psychotropic medications ordered throughout his stay at the facility. Nursing notes documented the resident had dementia with behaviors and was sexually inappropriate towards staff, wandered or eloped from the facility, was aggressive with staff, threatened other residents, and was verbally abusive towards staff during a one week period in August 2018.

Nursing progress notes in the resident's record documented the psychiatrist examined the resident and changed his medications. The notes documented a family member was called regarding the medication changes and was concerned about an overdose. One note documented the last time the resident was on a lot of psychotropic medications he became weak and could not move.

The resident's psychiatrist ordered 6 new medications for anxiety, dementia with behaviors, and/or psychosis, and agitation. Of those 6 medications 3 are classified as antipsychotics. According to Drugs.com a nationally recognized medication information website four of the resident's medications (Haldol, Geodon, Seroquel, Abilify) had a black box warning for increased mortality in geriatric patients.

The medication administration record (MAR) documented the resident received daily doses, according to the psychiatrist orders, of Abilify, Lexapro, Seroquel, and Klonopin for 10 days. On one day, the resident also received, in addition to the medications listed above, 1 injection of Depo-Provera, 1 injection of Geodon, 1 injection of Haldol Decanoate 20 mg, and 2 injections of Haldol Lactate 5 mg. There was no clinical justification documented for the addition of the Lexapro, Klonopin, Abilify, Seroquel at a higher dose, and the Haldol.

The resident's MAR documented he experienced side effects of drowsiness from the antipsychotics.

One progress note documented the resident was spending "more time in bed." Other progress notes documented he continued to not respond when spoken to and remained in bed.

A Hospital Consultation Note documented the resident was somnolent, lying in bed, needed assistance with feeding, was incontinent, and difficult to wake. The note documented the resident was non-responsive with most attempts to rouse the resident. Two days later the resident was admitted to the hospital for over-sedation.

The resident's record did not include documentation of an investigation completed when the resident's condition changed with his increased somnolence, decreased activities of daily living (ADLs), and increased medications.

Several nurses and several residents stated they remembered the resident walking around the facility and eloping when he first arrived to the facility.

Several nursing staff stated the resident was pleasant when he first arrived at the facility. The staff were unsure why he started throwing things, hitting, and kicking staff. Staff members stated the resident struck a staff member and was provided an as-needed (PRN) medication to calm down, and the medication did not work. The staff stated another medication was ordered and it was effective. The staff members stated the resident calmed down after the additional medications were provided and the resident remained in bed. Staff members stated the resident responded with eye raises if spoken to, and a family member of the resident had concerns about his medications.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F605 and F758 as it relates to the failure of the facility to ensure residents were not chemically restrained.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The resident was neglected, and it resulted in the development of two pressure ulcers.

FINDINGS #2:

During the investigation six residents were observed and eight resident records were reviewed, which included one closed record, for Quality of Care and evidence of abuse. Interviews were conducted with residents and family members. Staff members were interviewed and observed regarding abuse and neglect and pressure ulcers. Facility abuse allegations, grievances, and Resident Council minutes were reviewed.

Facility abuse investigations did not document concerns with neglect.

Four residents' records were reviewed for pressure ulcers and potential abuse and neglect concerns, including a resident admitted to the facility in August 2018.

The resident's record, admitted August 2018, documented the resident had nine different psychotropic medications ordered throughout his stay at the facility. Multiple nursing notes documented the resident had dementia with behaviors and was sexually inappropriate towards staff, wandered or eloped from the facility, aggressive with staff, threatened other residents, and verbally abusive towards staff during one week period. Nursing progress notes documented the psychiatrist examined the resident and changed his medications. The notes documented a family member was called regarding the medication changes and was concerned about an overdose. One note documented the last time the resident was on a lot of psychotropic medications he became weak and could not move.

On 8/21/18 the resident's psychiatrist ordered 6 new medications for anxiety, dementia with behaviors, and/or psychosis, and agitation. Of those 6 medications 3 are classified as antipsychotics. According to Drugs.com a nationally recognized medication information website, accessed 4/22/19, Haldol, Geodon, Seroquel, and Abilify had a black box warning for increased mortality in geriatric patients.

The medication administration record (MAR) documented the resident received daily doses, according to the psychiatrist orders, of Abilify, Lexapro, Seroquel, and Klonopin on 8/21/18 through 8/31/18. On 8/21/18, the resident also received, in addition to the medications listed above, 1 injection of Depo-Provera, 1 injection of Geodon, 1 injection of Haldol Decanoate 20 mg, and 2 injections of Haldol Lactate 5 mg. There was no clinical justification documented for the addition of the Lexapro, Klonopin, Abilify, Seroquel at a higher dose, and the Haldol.

The resident's MAR, from 8/13/18 to 9/3/18, documented he experienced the medication side effect of drowsiness from antipsychotic on the night shifts of 8/21/18 and 8/24/18 - 8/27/18, evening shifts of 8/24/18 - 8/26/18 and 8/28/18, and day shifts of 8/22/18 and 8/24/18 - 8/28/18.

A progress note documented the resident was spending "more time in bed." Other progress notes documented he continued to not respond with spoken to and remained in bed.

A Hospital Consultation Note documented when the resident arrived at the hospital he had developed 2 pressure ulcers and was stiff. The note documented the resident was somnolent, lying in bed, needed assistance with feeding, was incontinent, and difficult to wake. The note documented the resident was non-responsive with most attempts to rouse the resident.

A Hospital Progress Note documented the resident was admitted to the facility two days later for over-sedation and was noted to have 2 pressure injuries upon admit, to the sacrum and the left heel. The note documented the sacrum pressure ulcer was unstageable and the left heel was an fluid filled blister.

Bryan McNeil, Administrator
June 19, 2019
Page 5 of 5

The resident's record did not include documentation of an investigation when the resident developed the pressure ulcers and his condition changed with increased somnolence.

Several nursing staff stated the resident was pleasant when he first arrived at the facility. The staff were unsure why he started throwing things, hitting, and kicking staff. The staff members stated the resident calmed down after the additional medication were provided and the resident remained in bed. Staff members stated the resident's skin impairments were first noted to be an open area and the resident was removed by a family member before the facility could complete their assessment of the resident's skin impairment.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F686 as it relates to the failure of the facility to ensures residents did not develop preventable pressure ulcers.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
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June 24, 2019

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

Provider #: 135014

Dear Mr. McNeil:

On **September 19, 2018**, an unannounced on-site complaint survey was conducted at Caldwell Care of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007927

ALLEGATION #1:

The facility chemically restrained a resident.

FINDINGS #1:

Two surveyors conducted an unannounced onsite complaint survey from 9/17/18 to 9/19/18.

During the investigation six residents were observed and eight resident's records, which included one closed record, were reviewed for Quality of Care and abuse. Multiple interviews were conducted with residents and family members. Multiple staff members were interviewed and observed for evidence of abuse. Facility abuse allegations, grievances, and Resident Council minutes were reviewed.

Facility abuse investigations did not document concerns with over medicating residents.

All eight residents' records were reviewed for chemical restraints and potential abuse and neglect concerns, including a resident admitted to the facility in August 2018.

During the review of the records for one resident, admitted August 2018, physician orders and medication administration records documented the resident had nine different psychotropic medications ordered throughout his stay at the facility. Multiple nursing notes documented the resident had dementia with behaviors and was sexually inappropriate towards staff, wandered or eloped from the facility, was aggressive with staff, threatened other residents, and was verbally abusive towards staff from 8/13/18 to 8/20/18. Multiple nursing progress notes documented the psychiatrist examined the resident and changed his medications. The notes documented a family member was called regarding the medication changes and was concerned about an overdose. One note documented the last time the resident was on a lot of psychotropic medications he became weak and could not move.

On 8/21/18 the resident's psychiatrist ordered 6 new medications for anxiety, dementia with behaviors, and/or psychosis, and agitation. Of those 6 medications, 3 are classified as antipsychotics. According to Drugs.com a nationally recognized medication information website, accessed 4/22/19, Haldol, Geodon, Seroquel, and Abilify had a black box warning for increased mortality in geriatric patients.

The medication administration record (MAR) documented the resident received daily doses, according to the psychiatrist orders, of Abilify, Lexapro, Seroquel, and Klonopin on 8/21/18 through 8/31/18. On 8/21/18, the resident also received, in addition to the medications listed above, 1 injection of Depo-Provera, 1 injection of Geodon, 1 injection of Haldol Decanoate 20 mg, and 2 injections of Haldol Lactate 5 mg. There was no clinical justification documented for the addition of the Lexapro, Klonopin, Abilify, Seroquel at a higher dose, and the Haldol.

The resident's MAR, from 8/13/18 to 9/3/18, documented he experienced the medication side effect of drowsiness from antipsychotic on the night shifts of 8/21/18 and 8/24/18 - 8/27/18, evening shifts of 8/24/18 - 8/26/18 and 8/28/18, and day shifts of 8/22/18 and 8/24/18 - 8/28/18.

A progress note on 8/29/18 at 10:07 AM documented the resident was spending "more time in bed." Other progress notes documented he continued to not respond when spoken to and remained in bed.

A Hospital Consultation Note, dated 9/5/18, documented the resident was somnolent, lying in bed, needed assistance with feeding, was incontinent, and difficult to wake. The note documented the resident was non-responsive with most attempts to rouse the resident.

A Hospital Progress Note, dated 9/7/18, documented the resident was admitted to the facility for

over-sedation.

The resident's record did not include documentation of an investigation completed when the resident's condition changed with his increased somnolence, decreased activities of daily living (ADLs), and increased medications.

During interviews with nursing staff, they stated the resident was pleasant when he first arrived at the facility. The staff were unsure why he started throwing things, hitting, and kicking staff. Staff members stated the resident struck a staff member on 8/19/18 and was provided an as-needed medication to calm down, and the medication did not work. The staff stated another medication was ordered and it was effective. The staff members stated the resident calmed down after the additional medication was provided and the resident remained in bed. Staff members stated the resident responded with eye raises if spoken to, and a family member of the resident had concerns about his medications.

CONCLUSIONS:

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F605 and F758 as it relates to the failure of the facility to ensure residents were not chemically restrained.

ALLEGATION #2:

The resident was neglected which resulted in weight loss, dehydration, decline in his activities of daily living (ADLs), and cognitive functioning.

FINDINGS #2:

During the investigation six residents were observed and eight residents' records, which included one closed record, were reviewed for Quality of Care and abuse. Multiple interviews were conducted with residents and family members. Multiple staff members were interviewed and observed for evidence of abuse and neglect. Facility abuse allegations, grievances, and Resident Council minutes were reviewed.

Facility abuse investigations did not document concerns with over medicating residents.

All eight residents' records were reviewed for potential abuse and neglect concerns, including a resident admitted to the facility in August 2018.

During the review of the records for one resident, admitted August 2018, physician orders and medication administration records documented the resident had nine different psychotropic

medications ordered throughout his stay at the facility. Multiple nursing notes documented the resident had dementia with behaviors and was sexually inappropriate towards staff, wandered or eloped from the facility, was aggressive with staff, threatened other residents, and was verbally abusive towards staff from 8/13/18 to 8/20/18. Multiple nursing progress notes documented the psychiatrist examined the resident and changed his medications. The notes documented a family member was called regarding the medication changes and was concerned about an overdose. One note documented the last time the resident was on a lot of psychotropic medications he became weak and could not move.

On 8/21/18 the resident's psychiatrist ordered 6 new medications for anxiety, dementia with behaviors, and/or psychosis, and agitation. Of those 6 medications, 3 are classified as antipsychotics. According to Drugs.com a nationally recognized medication information website, accessed 4/22/19, Haldol, Geodon, Seroquel, and Abilify had a black box warning for increased mortality in geriatric patients.

A progress note on 8/29/18 at 10:07 AM, documented the resident lost 9.5 pounds in 1 week with a current weight of 153.5 pounds. The note documented he had poor oral intake and he refused 12 meals the past week. The note documented the resident was spending "more time in bed." The note documented staff were to provide assistance with meals and include enriched food with meals. Other progress notes documented he continued to not eat or respond when spoken to.

A Hospital Consultation Note, dated 9/5/18, documented the resident was somnolent, lying in bed, needed assistance with feeding, was incontinent, and difficult to wake.

The resident's record did not include documentation of an investigation completed when the resident's condition changed with weight loss, somnolence, decreased ADLs, and increased medications.

Several nurses and several residents stated they remembered the resident walking around the facility and eloping when he first arrived to the facility.

Several nursing staff stated the resident was pleasant when he first arrived at the facility. The staff were unsure why he started throwing things, hitting, and kicking staff. Staff members stated the resident struck a staff member on 8/19/18 and was provided an as-needed (PRN) medication to calm down, and the medication did not work. The staff stated another medication was ordered and it was effective. The staff members stated the resident calmed down after the additional medication was provided and the resident remained in bed. Staff members stated the resident ate with the assistance of staff members and he lost weight. Staff members stated the resident responded with eye raises if spoken to, and a family member of the resident had concerns about his medications.

Bryan McNeil, Administrator
June 24, 2019
Page 5

CONCLUSIONS:

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F605 and F758 as it relates to the failure of the facility to ensure residents were not neglected and resulted in weight loss, decreased ADL, and increased somnolence.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Thank you for the courtesies and assistance extended to us during our visit. Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

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

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day". The signature is written in black ink and is positioned above the typed name of the sender.

BELINDA DAY, RN, Supervisor
Long Term Care Program

BD/slj