



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
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P.O. Box 83720  
Boise, Idaho 83720-0009  
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October 12, 2018

Joseph Rudd, Administrator  
Riverview Rehabilitation  
3550 West Americana Terrace  
Boise, ID 83706-4728

Provider #: 135139

Dear Mr. Rudd:

On **September 27, 2018**, a survey was conducted at Riverview Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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 22, 2018**. Failure to submit an acceptable PoC by **October 22, 2018**, may result in the imposition of penalties by **November 14, 2018**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **November 1, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 27, 2018**. A change in the seriousness of the deficiencies on **November 11, 2018**,

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may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 27, 2018** includes the following:

Denial of payment for new admissions effective **December 27, 2018**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 27, 2019**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 27, 2018** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

Joseph Rudd, Administrator  
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<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)

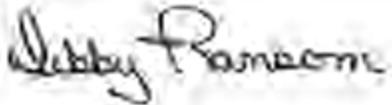
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **October 22, 2018**. If your request for informal dispute resolution is received after **October 22, 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/

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

PRINTED: 01/10/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135139</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/27/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>RIVERVIEW REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3550 WEST AMERICANA TERRACE BOISE, ID 83706</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification survey conducted September 24, 2018 to September 27, 2018.  The surveyors conducting the survey were:  Edith Cecil, RN, Team Coordinator Brad Perry, LSW  Abbreviations:  DON = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set MG/mg = Milligram NP = Nurse Practitioner PRN = As Needed RD = Registered Dietician UM = Unit Manager	F 000			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)  §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		10/22/18	

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

TITLE

(X6) DATE

Electronically Signed

10/19/2018

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 755	<p>Continued From page 1 biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, review of physician orders, and staff interview, it was determined the facility failed to ensure the pharmacy label matched the physician's order for a nasal spray used to treat allergies. This was true for 1 of 4 residents (#124) whose medication administration was observed. This failed practice created the potential for sub-therapeutic dosing of the nasal spray and subsequent increase in Resident #124's allergy symptoms. Findings include:  On 9/26/18 at 7:50 AM, LPN #2 was observed as he provided Resident #124 with a bottle of Fluticasone Propionate Nasal Spray. The pharmacy label documented, "Instill 1 spray in each nostril two times a day." Resident #124 was observed as she delivered 2 sprays into each</p>	F 755	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverview Rehabilitation does not admit that the deficiencies listed on the CMS 2567 exists, nor does the facility admit to any statements, finding, facts or conclusion that form the basis for the alleged deficiencies.</p> <p>F755 Srvcs/Procedures/Pharmacist/Records</p> <p>1. Resident #124 no longer resides in this facility.</p> <p>The pharmacy label was fixed as soon as</p>		

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F 755	Continued From page 2 nostril and handed the bottle back to the LPN. LPN #2 provided documentation of a physician order, dated 9/11/18, that directed 2 sprays to each nostril in the morning for allergies.  On 9/26/18 at 8:30 AM, the DNS and Unit Manager (UM) LPN #3, agreed the pharmacy label did not match the physician order.	F 755	it was brought to the attention of facility staff, with appropriate sticker as per policy and procedure.  2. Medication labels for other residents have been audited by licensed nurses on or before 10/19/18. No other pharmacy labels were found to be in variance with the Medication Administration Record.  3. Licensed staff have been educated by the Director of Nursing, on or before 10/19/18, to validate medication labels against the Medication Administration Record during each medication pass to ensure they are consistent; and to follow the facility policy and procedure regarding inconsistent labels if any are found.  4. Beginning the week of 10/21/18, medication labels will be reviewed by Unit Managers or designee weekly for one month and then monthly for two months to ensure consistency between the MAR and the label; or in the event that the labels and MAR are inconsistent, the Policy regarding inconsistency has been followed.  The results of these audits will be presented to the facility Quality Assessment and Assurance (QAA) Committee by the Director of Nursing or designee, monthly for three months. The QAA Committee will follow the facility's QAPI policy to address any negative findings.		
F 757	Drug Regimen is Free from Unnecessary Drugs	F 757		10/22/18	

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F 757 SS=D	Continued From page 3 CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(2) For excessive duration; or  §483.45(d)(3) Without adequate monitoring; or  §483.45(d)(4) Without adequate indications for its use; or  §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or  §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interview, it was determined the facility failed to ensure residents did not receive excessive doses of acetaminophen (APAP/Tylenol). This was true for 1 of 5 (#2) residents reviewed for unnecessary medications. This failed practice created the potential for harm if residents experienced liver damage or other adverse outcomes from excessive doses of acetaminophen. Findings include:  Resident #2 was readmitted to the facility on	F 757	F757 Drug Regimen is Free from Unnecessary Drugs.  1. Resident #2 was evaluated by a physician on or before 10/19/18 for negative effects of the use of APAP during his stay here. None were noted.  2. Other resident's medication regimens were evaluated by the consultant pharmacist, on or before 10/19/2018, for excessive APAP use. None were		

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F 757	<p>Continued From page 4 9/11/18 with multiple diagnoses, including laminectomy (back disc surgery), fusion of the spine and chronic pain.</p> <p>Resident #2's admission physician orders, dated 9/11/18, documented the following:</p> <ul style="list-style-type: none"> <li>* APAP 325 mg 1 tablet by mouth every 6 hours PRN for pain and elevated temperature greater than 100.4. Not to exceed 3 grams (3,000 mg) of APAP in 24 hours.</li> <li>* A second order for APAP 325 mg 2 tablets by mouth every 6 hours PRN for pain and elevated temperature greater than 100.4. Not to exceed 3 grams of APAP in 24 hours.</li> <li>* Percocet 10-325 mg (Oxycodone-APAP) 1 tablet by mouth every 4 hours PRN for moderate pain. Not to exceed 3 grams of APAP in 24 hours.</li> <li>* Percocet 10-325 mg (Oxycodone-APAP) 2 tablets by mouth every 4 hours PRN for severe pain. Not to exceed 3 grams of APAP in 24 hours.</li> </ul> <p>The website for the U.S. Food and Drug Administration, announced new measures to reduce the risk of severe liver injury with the use of APAP on 1/13/11. On 7/28/11, the maker of Tylenol announced new instructions to lower the maximum daily dose from 4000 mg to 3000 mg.</p> <p>Resident #2's September 2018 MAR documented on 9/20/18, he received:</p> <ul style="list-style-type: none"> <li>* Percocet 10-325 mg (Oxycodone-APAP) 2 tablets at 2:31 AM, 10:21 AM, 5:40 PM, and 9:13 PM. This was a total of 2,600 mg of APAP.</li> </ul>	F 757	<p>identified.</p> <p>3. On or before 10/19/2018 licensed nurses have been educated by the Director of Nursing on how and why to monitor residents for excessive APAP use when administering multiple different medications which contain APAP The facility standing orders have been modified to allow short-term acute APAP use of up to levels that are in accordance with FDA guidelines.</p> <p>4. Beginning the week of 10/21/18, APAP use by residents will be reviewed by Unit Managers or designee weekly for one month and then monthly for two months to ensure that the dosage prescribed and used by the resident does not exceed the established FDA guidelines referenced above.</p> <p>The results of these audits will be presented to the facility Quality Assessment and Assurance (QAA) Committee by the Director of Nursing or designee, monthly for three months. The QAA Committee will follow the facility's QAPI policy to address any negative findings.</p>		

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F 757	Continued From page 5  * APAP 325 mg 2 tablets at 8:56 PM. This was a total of 650 mg of APAP and a combined total of 3,250 of APAP in a 24 hour period.  On 9/26/18 at 1:51 PM, LPN #1 said based on Resident #2's orders he had the potential to receive 6,500 mg in a 24 hour period. She said she could review the electronic MAR before administering the medication to make sure it would not exceed the 3 gram limit. LPN #1 said the electronic MAR would show how many times the medication was given, but the system would not add up the dosage amount given.  On 9/26/18 at 2:17 PM, Resident #2 said he took pain medications to help control his chronic back and neck pain.  On 9/26/18 at 2:21 PM and 9/27/18 at 8:53 AM, UM #1 said the way Resident #2's Physician orders were written, there was the potential for him to receive up to 6,500 mg in a 24 hour period which was excessive. UM #1 said the orders should have been clarified with the physician. She said the 3 gram limit was exceeded on 9/20/18 when Resident #2 received 3,250 mg of APAP.	F 757			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		10/22/18	

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F 758	<p>Continued From page 6</p> <p>(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 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</p>	F 758			

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F 758	<p>Continued From page 7</p> <p>the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure there was a clear indication for use of a psychotropic medication, and a consent was obtained prior to administration of psychoactive medications. This was true for 1 of 5 (#132) residents reviewed for unnecessary medications. This created the potential for harm if residents received psychotropic medications that were unwarranted and/or were administered psychotropic medications without their full knowledge of the risks and benefits of the medications. Findings include:</p> <p>Resident #132 was admitted to the facility on 9/21/18 with multiple diagnoses, including right femur (thigh bone) fracture, major depression, and anxiety.</p> <p>Resident #132's admission physician orders, dated 9/21/18, documented she was to receive:</p> <p>* Quetiapine fumarate (antipsychotic) 100 mg, 1 tablet at bedtime. The order did not document an indication for its use.</p> <p>* Buspirone hydrochloride (anti-anxiety)10 mg, 1 tablet two times a day for anxiety.</p> <p>* Lamotrigine (anticonvulsant) 25 mg, 1 tablet two times a day for depression.</p> <p>Resident #132's current care plan documented she received psychotropic medications, including</p>	F 758	<p>F758 Free from Unnecessary Psychotropic Meds/PRN use</p> <ol style="list-style-type: none"> <li>1. Resident #132 no longer resides in this facility.</li> <li>2. Other residents with psychotropic medications were audited by the Director of Nursing or designee, on or before 10/19/18, for appropriate and timely consents, black box warnings, and diagnoses. No issues were identified.</li> <li>3. On or before 10/19/18 licensed nurses were educated by the Director of Nursing, or designee, regarding the policy and procedure for obtaining proper diagnoses and consents for psychotropic medications prior to administration of the medication; as well as for the need to validate resident/representative understanding when these consents are obtained.</li> <li>4. Beginning the week of 10/21/18, residents who receive psychotropic medications will be reviewed by Unit Managers or designee weekly for one month and then monthly for two months to ensure that the resident has an appropriate diagnosis, the consents are signed, and black box warnings are given prior to administration for all required medications.</li> </ol>		

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F 758	<p>Continued From page 8</p> <p>Quetiapine related to depression, Lamotrigine for depression, and Buspirone for anxiety.</p> <p>Resident #132's September 2018 MAR, documented that from 9/21/18 to 9/26/18 she received Quetiapine, Buspirone, and Lamotrigine as ordered.</p> <p>a. On 9/26/18 at 10:32 AM, Resident #132 said her doctor in the community had ordered several new medications for her prior to her fall at home and she did not know what the medications were. She said some of the medications were for depression, but was not sure which ones.</p> <p>On 9/26/18 at 1:47 PM, LPN #1 said she was not sure what the Quetiapine was used for and said Resident #132 was not able to tell her. LPN #1 said the admitting nurse should have clarified the order with the physician.</p> <p>On 9/26/18 at 2:30 PM, UM #1 said the Quetiapine was for Resident #132's depression and the order was not clear and should have been clarified to include an indication for use.</p> <p>b. The facility's psychoactive medication informed consent policy, dated June 2017, directed staff to obtain informed consents from the resident or responsible party for each psychotropic medication class including antipsychotic, antidepressant, and anxiolytic (anti-anxiety). The resident or responsible party were to be informed of potential side effects associated with psychoactive medication use.</p> <p>On 9/26/18 at 10:32 AM, Resident #132 said she did not remember signing consent paperwork or</p>	F 758	The results of these audits will be presented to the facility Quality Assessment and Assurance (QAA) Committee by the Director of Nursing or designee, monthly for three months. The QAA Committee will follow the facility's QAPI policy to address any negative findings.		

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F 758	<p>Continued From page 9 receiving a black box warning for the psychotropic medications.</p> <p>On 9/26/18 at 11:05 AM, Resident #132's medical record was reviewed and it did not contain consents or black box warnings for the psychotropic medications Quetiapine fumarate or Buspirone hydrochloride.</p> <p>On 9/26/18 at 12:15 PM, the facility provided psychotropic consents for Resident #132 that had been signed and dated 9/21/18 by the admitting nurse. The consent forms and black box warning pages documented the resident's signature without a date.</p> <p>On 9/26/18 at 1:15 PM, Resident #132 was shown the consent and black box warnings, signed by her. Resident #132 said LPN #1 had brought those papers to her shortly after 10:30 AM that morning and had her sign them. Resident #132 said that was the first time she saw the documents.</p> <p>On 9/26/18 at 1:47 PM, LPN #1 said the admitting nurse should have had Resident #132 sign the consent forms upon admission.</p> <p>On 9/26/18 at 3:12 PM, the DON said the original consents and black box warnings paperwork had been signed on 9/21/18, the day of admission, but the paperwork had been lost before Medical Records had the opportunity to scan them into Resident #132's medical record. The DON said the consents were again signed that day (9/26/18) by the admitting nurse and Resident #132.</p>	F 758			

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F 758	Continued From page 10 On 9/26/18 at 3:20 PM, UM #1 said she had the admitting nurse again sign and date the consents for 9/21/18, because that was the original date the lost consents were signed as witnessed by Resident #132's daughter.  Resident #132's progress note dated 9/26/18 at 3:54 PM by UM #1, documented the original consent forms were not found. Resident #132's daughter was contacted again regarding the consents and the daughter was not sure what paperwork had been signed on 9/21/18. The note stated Resident #132's daughter said she did not see all the paperwork her mother had signed on 9/21/18.  On 9/27/18 at 2:42 PM, Medical Records Representative #1 said nurses were to place all consents and documents in an accordion file at the nurse's station and then she scanned them into the medical records.	F 758			
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)  §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.  §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		10/22/18	

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F 842	<p>Continued From page 11 that are-</p> <ul style="list-style-type: none"> <li>(i) Complete;</li> <li>(ii) Accurately documented;</li> <li>(iii) Readily accessible; and</li> <li>(iv) Systematically organized</li> </ul> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <ul style="list-style-type: none"> <li>(i) To the individual, or their resident representative where permitted by applicable law;</li> <li>(ii) Required by Law;</li> <li>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</li> <li>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</li> </ul> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <ul style="list-style-type: none"> <li>(i) The period of time required by State law; or</li> <li>(ii) Five years from the date of discharge when there is no requirement in State law; or</li> <li>(iii) For a minor, 3 years after a resident reaches legal age under State law.</li> </ul>	F 842			

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F 842	<p>Continued From page 12</p> <p>§483.70(i)(5) The medical record must contain-</p> <ul style="list-style-type: none"> <li>(i) Sufficient information to identify the resident;</li> <li>(ii) A record of the resident's assessments;</li> <li>(iii) The comprehensive plan of care and services provided;</li> <li>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</li> <li>(v) Physician's, nurse's, and other licensed professional's progress notes; and</li> <li>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</li> </ul> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure a) each resident's resuscitation code status of Do Not Resuscitate (DNR) or Full Code (resuscitate using all lifesaving measures) was consistently and accurately documented in their medical records and, b) consents for psychotropic medications accurately reflected signature dates. This was true for 3 of 12 (#21, #78, and #132) residents whose records were reviewed. This deficient practice created the potential for harm should inappropriate care and/or treatment be provided based on inaccurate information. Findings include:</p> <p>1. The facility's code status policy, dated 2017, documented the code status of each resident should be available in the electronic medical record for quick retrieval by facility staff. This policy was not followed. Examples include:</p> <p>a. Resident #21 was admitted to the facility on</p>	F 842	<p>F 842 Resident Records</p> <p>1. Resident #21 No longer resides in this facility. Resident #78's Care Plan, Physician Order, and POST were reconciled and reviewed by the Director of Nursing, on or before 10/19/18, to ensure consistency. Resident 132 no longer resides in this facility.</p> <p>2. On or before 10/19/18 current facility resident records have been audited by the facility Interdisciplinary Team to ensure that are maintained in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are</p> <ul style="list-style-type: none"> <li>(i) Complete;</li> <li>(ii) Accurately documented;</li> <li>(iii) Readily accessible; and</li> <li>(iv) Systematically organized</li> </ul>		

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F 842	<p>Continued From page 13</p> <p>9/6/18 with multiple diagnoses, including septic arthritis to the right knee (joint infection).</p> <p>Resident #21's Physician Orders for Scope of Treatment (POST), dated 12/12/16, documented her code status was to be DNR.</p> <p>Resident #21's admission physician orders, dated 9/6/18, documented she was a "Full code per hospital records."</p> <p>Resident #21's current care plan, directed staff that her code status was DNR.</p> <p>On 9/26/18 at 8:00 AM, Resident #21's electronic medical record (EMR) was reviewed. Full Code was documented on the facesheet.</p> <p>On 9/26/18 at 8:25 AM, Resident #21 said she had an advanced directive that she did not bring to the facility and was unsure of what her code status was at that time.</p> <p>On 9/27/18 at 9:51 AM, LPN #4 said Resident #21's code status was Full Code per her facesheet, orders, MAR, and care plan.</p> <p>On 9/27/18 at 10:00 AM, the DON reviewed Resident #21's EMR and said the POST showed DNR and the facesheet and physician order documented Full Code.</p> <p>b. Resident #78 was readmitted to the facility on 9/22/18 with multiple diagnoses, including an intracranial injury (head injury).</p> <p>Resident #78's POST, dated 9/22/18, documented her code status was to be DNR.</p>	F 842	<p>Any deficient areas noted were corrected at the time of the audit.</p> <p>3. On or before 10/19/18 the facility Interdisciplinary Team including Licensed Nurses and Administrative Medical Records staff were educated by the Director of Nursing or designee regarding the facility policy on ensuring all medical records are <input type="checkbox"/></p> <p>(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>4. Beginning the week of 10/21/18, five (5) resident records will be reviewed by Unit Managers or designee weekly for one month and then five (5) monthly for two months to ensure that they are <input type="checkbox"/></p> <p>(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>The results of these audits will be presented to the facility Quality Assessment and Assurance (QAA) Committee by the Director of Nursing or designee, monthly for three months. The QAA Committee will follow the facility's QAPI policy to address any negative findings.</p>		

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F 842	<p>Continued From page 14</p> <p>Resident #78's admission physician orders, dated 9/22/18, documented she was a "Full code per hospital records."</p> <p>Resident #78's facesheet documented her code status was Full Code.</p> <p>Resident #78's current care plan directed staff that her code status was undetermined and gave an option for either DNR or Full Code.</p> <p>On 9/27/18 at 9:57 AM, LPN #2 said residents' code status would be found on their MAR, orders, facesheet, and care plan. LPN #2 said nurses would usually check the MAR first to find the code status.</p> <p>On 9/27/18 at 10:00 AM, the DON said if there was a code called, then nurses should check the POST first and then verify that with the order and care plan. The DON said Resident #78's POST did not match the facesheet.</p> <p>2. The facility's Medical Record policy, dated August 2017, documented prompt entries will be made in residents' medical records and consents for medications will be signed and entered into the medical record.</p> <p>Resident #132 was admitted to the facility on 9/21/18 with multiple diagnoses, including right femur (thigh bone) fracture, major depression, and anxiety.</p> <p>Resident #132's admission physician orders, dated 9/21/18, documented she was to receive:</p>	F 842			

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F 842	<p>Continued From page 15</p> <p>* Quetiapine fumarate (antipsychotic) 100 mg, 1 tablet at bedtime.</p> <p>* Buspirone hydrochloride (anti-anxiety) 10 mg, 1 tablet two times a day for anxiety.</p> <p>* Lamotrigine (anticonvulsant) 25 mg, 1 tablet two times a day for depression.</p> <p>Resident #132's current care plan documented she received psychotropic medications, including Quetiapine related to depression, Lamotrigine for depression, and Buspirone for anxiety.</p> <p>Resident #132's September 2018 MAR, documented that from 9/21/18 to 9/26/18 she received Quetiapine, Buspirone, and Lamotrigine as ordered.</p> <p>On 9/26/18 at 10:32 AM, Resident #132 said she did not remember signing consent paperwork or receiving a black box warning for the psychotropic medications.</p> <p>On 9/26/18 at 11:05 AM, Resident #132's medical record was reviewed and it did not contain consents or black box warnings for the psychotropic medications Quetiapine fumarate or Buspirone hydrochloride.</p> <p>On 9/26/18 at 12:15 PM, the facility provided psychotropic consents for Resident #132 signed and dated 9/21/18, by the admitting nurse. The consent forms and black box warning pages documented Resident #132's signature without a date.</p> <p>On 9/26/18 at 1:15 PM, Resident #132 was</p>	F 842			

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F 842	<p>Continued From page 16</p> <p>shown the consent and black box warnings, signed by her. Resident #132 said LPN #1 had brought those papers to her shortly after 10:30 AM that morning and had her sign them. Resident #132 said that was the first time she saw the documents.</p> <p>On 9/26/18 at 1:47 PM, LPN #1 said the admitting nurse should have had Resident #132 sign the consent forms upon admission.</p> <p>On 9/26/18 at 3:12 PM, the DON said the original consents and black box warnings paperwork had been signed on 9/21/18, the day of admission, but the paperwork had been lost before Medical Records had the opportunity to scan them into Resident #132's medical record. The DON said the consents were again signed that day (9/26/18) by the admitting nurse and Resident #132.</p> <p>On 9/26/18 at 3:20 PM, UM #1 said she had the admitting nurse again sign and date the consents for 9/21/18, because that was the original date the lost consents were signed as witnessed by Resident #132's daughter.</p> <p>Resident #132's progress note dated 9/26/18 at 3:54 PM by UM #1, documented the original consent forms were not found. Resident #132's daughter was contacted again regarding the consents and the daughter was not sure what paperwork had been signed on 9/21/18. The note stated Resident #132's daughter said she did not see all the paperwork her mother signed on 9/21/18.</p> <p>On 9/27/18 at 2:42 PM, Medical Records</p>	F 842			

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

PRINTED: 01/10/2019  
FORM APPROVED  
OMB NO. 0938-0391

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F 842	Continued From page 17 Representative #1 said nurses were to place all consents and documents in an accordion file at the nurse's station and then she scanned them into the medical records.	F 842			