



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

November 2, 2018

corrected letter November 9, 2018

Michael Neubauer, Administrator
Good Samaritan Society - Silver Wood Village
405 West Seventh Street
Silverton, ID 83867-0358

Provider #: 135058

Dear Mr. Neubauer:

On **October 12, 2018**, a survey was conducted at Good Samaritan Society - Silver Wood Village by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

Michael Neubauer, Administrator
November 2, 2018
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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 **November 12, 2018**. Failure to submit an acceptable PoC by **November 12, 2018**, may result in the imposition of civil monetary penalties by **December 5, 2018**.

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

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

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

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

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

- **Denial of payment for new admissions effective January 12, 2019**
- **Civil money penalty**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 12, 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.

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

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

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

- BFS Letters (06/30/11)

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

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

Michael Neubauer, Administrator
November 2, 2018
Page 4 of 4

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

Sincerely,

A handwritten signature in cursive script that reads "Debby Ransom". The signature is written in dark ink and is centered below the "Sincerely," text.

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

dr/lj
Enclosures

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|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/12/2018 |
| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST SEVENTH STREET SILVERTON, ID 83867 | | |
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| F 000 | INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted October 9, 2018 to October 12, 2018. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Sharon Whitehead, RN Abbreviations: BP = Blood Pressure cm = centimeter CNA = Certified Nursing Assistant DNS = Director of Nursing Services DTI= Deep Tissue Injury GDR = Gradual Dose Reduction IDNS = Interim Director of Nursing Services LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set mg = Milligram MRR = Medication Regimen Review NOMNC = Notice of Medicare Non-Coverage RN = Registered Nurse PRN = As Needed TAR = Treatment Administration Record | F 000 | | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should | F 578 | | 11/30/18 | |

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

TITLE

(X6) DATE

Electronically Signed

11/10/2018

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

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| F 578 | <p>Continued From page 1</p> <p>be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a) advanced directives were in residents'</p> | F 578 | <p>1. The medical record for resident #3 was reviewed on 11/7/18. The Advance Directive was located in the medical</p> | | |

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| F 578 | <p>Continued From page 2</p> <p>care plans, and b) the residents' medical records or a copy of the residents' advance directives, or documentation of their decision not to formulate advance directives. This was true for 1 of 11 (#3) residents reviewed for advance directives. This failure created the potential for harm if a resident's medical treatment wishes were not honored should the resident be unable to communicate them to a doctor. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 8/7/16, with multiple diagnoses including chronic obstructive pulmonary disease and heart disease.</p> <p>Resident #3's quarterly MDS assessment, dated 7/6/18, documented she was cognitively intact.</p> <p>Resident #3's Idaho Physician Orders for Scope of Treatment (POST), dated 6/22/17, documented she wished to be Do Not Resuscitate (DNR) and comfort measures only.</p> <p>Resident #3's medical record did not include documentation of advance directives, or documentation advance directives were discussed with her.</p> <p>b. Resident #3 did not have a care plan area addressing her POST and or wishes.</p> <p>On 10/11/18 at 8:29 AM, the LSW stated she was unable to locate an advanced directive for Resident #3. The LSW stated the advanced directives were not in the care plans currently. The LSW stated the corporate had made the decision to not place advanced directives in residents' care plans. The LSW stated the facility</p> | F 578 | <p>record. SSD met with resident #3 on 10/25/18 to discuss her Advance Directive and to ensure that the resident's wishes remain current in the medical record. The completed POST is currently in the medical record under Resident Spaces, in the admission record and transfer/discharge record, and also been addressed in the care plan on 11/8/18.</p> <p>2. All residents will have an Advance Directive order listed on the Physician Orders in the medical record. A discharge plan will be listed on the care plan. Resident POST's will be addressed in the care plan. Advance Directives will be discussed and documented with all residents upon admission, also during the quarterly care plan review.</p> <p>3. All nurses, social service staff and the care team will be educated on the need for Advance Directives to be included with admission orders by 11/15/18 by the administrator and the DNS.</p> <p>4. The DNS or designee will audit all charts including new admissions to ensure that an Advance Directive is included in the admission orders. The audit will include ensuring a copy of the POST is scanned into Resident Spaces and addressed in the care plan, and that a current discharge plan is listed on the care plan. This audit will be done weekly X4 and then monthly X3 with the DNS or designee reporting audit findings monthly to the QAPI committee, the committee will determine if further auditing is needed.</p> <p>5. Date certain 11/30/18.</p> | | |

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

PRINTED: 01/11/2019
FORM APPROVED
OMB NO. 0938-0391

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| F 578 | Continued From page 3 | F 578 | | | |
| F 580 SS=G | <p>Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically</p> | F 580 | | 11/30/18 | |

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| F 580 | <p>Continued From page 4 update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based Review of the facility's policy titled, "Notification of Change," dated 11/2016, directed the staff as follows: "A facility must immediately . . . consult with the resident's physician . . . when there is: . . . 2. A significant change in the resident's physical, mental or psychosocial status . . ."</p> <p>1. Resident #30 was admitted to the facility on 7/31/18, and discharged to the hospital on 8/14/18, and re-admitted him on 8/16/18. Resident #30's diagnoses included status-post laminectomy (back surgery) for a ruptured disk, pain, atherosclerotic heart disease (ASHD- also known as coronary artery disease), fractures of thoracic (mid-back) and lumbar (lower back) vertebrae, lumbar spinal stenosis (narrowing of the spinal canal) with neurogenic claudication (pain and cramping in the lower back, buttocks, hips and legs), and nausea with vomiting.</p> | F 580 | <p>1. Resident #30 should have had notification to provider and family as conditions continued to change. Resident #30 is no longer in the facility. 2. All residents experiencing a change in condition will have notification to physician and family by the nursing staff. Daily assessments will be done by nurses to monitor how the resident's condition is improving or declining. 3. Nursing staff were educated on 10/31/18 by the R/S consultant. A review of the Stop and Watch alerts and the use of custom alerts in POC were shared. As soon as either of these alerts are initiated the staff will verbally share this information with the nurse, the nurse will assess the resident and complete a progress note. If the change is significant the Change in Condition Evaluation (CICE) including the SBAR, will be done and the provider notified. Families will also be notified as soon as possible. This</p> | | |

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| F 580 | <p>Continued From page 5</p> <p>Resident #30's Physician Orders for July 2018 through September 2018, documented the resident's medications included:</p> <p>Fentanyl Patch 72-hour, 12 micrograms (mcg)/hour [a narcotic pain medication in a topical patch form that is applied to the skin and delivered in a time-released manner], apply one patch transdermal, one time a day, every three days for pain. (ordered 08/02/18 and discontinued on 09/19/18).</p> <p>Carvedilol 6.25 mg two times a day for hypertension, ordered 7/31/18. Levothyroxine 100 mcg one time a day for hypothyroidism, ordered 08/01/18.</p> <p>Resident #30's History and Physical Evaluation, dated 8/22/18 at 1:20 PM, documented his attending physician saw the resident at the facility and documented the following findings under "Review of Systems": "Constitutional Negative [for] . . . Fatigue, . . . Malaise and Weight Loss . . . GI [gastrointestinal] Negative [for] Abdominal pain, . . . Decreased appetite, . . . Nausea and Vomiting."</p> <p>A quarterly MDS assessment, dated 8/24/18, documented Resident #30 was cognitively intact with mild depression. The MDS documented Resident #30 required extensive assistance of two or more persons for bed mobility, transfer, dressing, and toileting, did not walk in or out of his room, and required extensive assistance of one to two or more persons for wheelchair mobility, but could eat with setup assistance and supervision.</p> | F 580 | <p>education was recorded to be shared with staff unable to attend the meeting on 10/31/18. The DNS and SDC will provide additional education by 11/15/18 to review the CICE and when and how to use this tool.</p> <p>4. The DNS or designee will audit the use of the Stop and Watch and custom alerts. The audit will include steps the nurse takes after receiving the alert or verbal report of a change in a resident. Changes in resident's condition will also be reviewed in the center clinical meeting every morning to assure any changes in residents are noted and assessments completed. The audit will include when provider and families are notified. These audits will be done weekly X4 and then monthly X3 with the DNS or designee reporting the findings to the QAPI committee monthly, the committee will determine if further auditing is needed.</p> <p>5. Date certain 11/30/18</p> | | |

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| F 580 | <p>Continued From page 6</p> <p>Review of Resident 30's care plan indicated the staff developed the following "Focus" areas, all initiated on 08/01/18:</p> <p>a. The care plan area addressing Resident #30's altered cardiovascular status, dated 8/1/18, documented he had a history of coronary artery disease, hypertension, hyperlipidemia [high cholesterol], and Hx [history] of CABG [coronary artery bypass graft surgery]." The "Interventions documented staff were to monitor, document, and report any signs and symptoms of heart related concerns, included nausea and vomiting to the physician.</p> <p>b. The care plan area addressing Resident #30's hypothyroidism, dated 8/1/18, documented the staff were to report signs and symptoms of hypothyroidism such as low blood pressure, decreased breathing, decreased body temp, unresponsiveness; fatigue, impaired memory, and depression.</p> <p>c. The care plan area addressing Resident #30's chronic neuropathy pain [nerve-related pain] and acute back pain, dated 8/1/18, documented he had a T12 [thoracic spine, 12th vertebrae] compression Fx [fracture] with disc retropulsion [herniation] with surgical repair. The interventions documented staff were to observe for signs of nausea or vomiting and report to the physician any occurrences.</p> <p>Resident #30's "Progress Notes" from 09/01/18 through 09/22/18 documented the following:</p> <p>- On 9/1/18 at 11:02 PM, Resident #30 had post-op back surgery and he was to wear a back</p> | F 580 | | | |

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| F 580 | <p>Continued From page 7</p> <p>brace while up in his wheelchair. The note documented Resident #30 denied pain or discomfort and he was alert and oriented.</p> <p>- On 9/2/18 at 8:17 PM, Resident #30 was administered ondansetron HCl (hydrochloride) (Zofran- an anti-nausea medication) 4 milligrams (mg) due to nausea with vomiting.</p> <p>- On 9/2/18 at 11:48 PM, Resident #30 experienced emesis [vomiting] episode this shift, Zofran administered and was effective.</p> <p>- On 9/3/18 at 3:08 AM, Resident #30 was administered Zofran 4 mg due to nausea.</p> <p>- On 9/3/18 at 1:17 PM and at 9:54 PM, and on 09/04/18 at 10:48 PM, the nurses documented Resident #30 was up in his wheelchair with his back brace on, was alert and oriented, participated with PT and OT, and denied pain or discomfort.</p> <p>- On 9/5/18 at 1:09 PM, Resident #30 refused both breakfast and lunch.</p> <p>The "Progress Notes" did not reflect follow up documentation by the nurse or communication with the physician of the resident's change in status.</p> <p>- On 9/5/18 at 1:33 PM, the LSW met with Resident #30 1:1 and discussed his recent lack of activity and not getting out of bed and his lack of desire to get up and use the restroom. The note documented Resident #30 did not "feel up" to it.</p> | F 580 | | | |

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| F 580 | <p>Continued From page 8</p> <p>The "Progress Notes" did not reflect follow up documentation by the LSW or communication with nurses or the physician of the resident's change in status.</p> <p>- On 9/5/18 at 11:02 PM and on 9/6/18 at 11:28 PM, the nurses documented the resident was alert, verbal, oriented x 2, up to his wheelchair with his back brace on, took his medications, and denied pain or discomfort.</p> <p>- Resident #30's MAR documented on 9/14/18, from 4:28 PM through 4:32 PM, Resident #30 was not administered several medication due to nausea and emesis.</p> <p>- On 9/14/18 at 5:44 PM, Resident #30 had a substantial amount of emesis after morning medications. The note documented he did not have much of an appetite for the rest of the day. The note documented his vital signs were obtained and were 88/56 for blood pressure, pulse 59, [and] O2 [oxygen] 94%. The note documented his vital signs were rechecked near dinner time and his [blood] pressure was 102/54, pulse was 70, O2 95%, respirations 16, [and] temp of 96.0. The note documented Resident #30's skin was cold to touch and he was pale.</p> <p>The "Progress Notes" did not reflect follow up documentation by the nurse or communication with the physician of the resident's change in status.</p> <p>- On 9/15/18 at 4:48 PM, Resident #30's carvedilol (a heart medication) was "Held for blood pressure 98/49."</p> | F 580 | | | |

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| F 580 | <p>Continued From page 9</p> <p>- On 9/16/18 at 5:19 PM, Resident #30 experienced episodes of vomited about 5 minutes after evening medications were administered. The note documented he was feeling fine today and his BP was 120/53.</p> <p>- On 9/17/18 at 1:44 PM, Resident #30 remained in bed for most of the day sleeping/resting. The note documented he has not complained of any nausea or had any emesis.</p> <p>- On 9/17/18 at 2:34 PM, Resident #30 was discharged from physical therapy's services. The note documented he did not feel up to participating lately.</p> <p>The Progress Notes from 09/15/18 through 09/17/18 did not reflect follow up documentation with the physician of the resident's change in status.</p> <p>The Progress Notes documented the nursing staff did not document an assessment of Resident #30's medical status from 09/19/18 at 3:34 PM until 09/22/18 at 2:15 AM.</p> <p>- On 09/22/18 at 2:15 AM, Resident #30 experienced an emesis episode at approximately 1:20 AM. The note documented Resident #30 was responsive to verbal and tactile stimuli and continued to vomit while being cleaned up by staff. The note documented his vital signs were taken at this time and his blood pressure was 35/30, pulse 60, temperature 98.3, respirations 10, oxygen saturation 48 percent. The note documented oxygen was applied via nasal cannula while EMR [Emergency Medical Response] were notified. The note documented</p> | F 580 | | | |

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| F 580 | Continued From page 10 the responsible party [name] was notified of Resident #30's decline. The note documented his vitals were obtained again and they were BP 58/32, pulse 63, sats [oxygen saturation] 68. The note documented the EMR arrived and Resident #30's breathing had become shallow and his eyes were glazed and fixed. The note documented the EMR was unable to retrieve a pulse. The note documented at 2:00 AM Resident #30 was pronounced dead by EMR staff and the DNS and physician were notified. On 10/12/18 at 1:46 PM, LPN #1 stated that on 9/14/18, he was in facility orientation with and thought he notified the RN (registered nurse) working with him that day of Resident #30's condition but could not recall the name of the RN. LPN #1 stated he did not notify Resident #30's physician of the change in the resident's condition. On 10/12/18 at approximately 2:00 PM, the DNS stated that Resident #30 had exhibited episodes of nausea and vomiting prior to his back surgery, but none of the staff notified the physician when the resident exhibited additional episodes of nausea and vomiting, decreased appetite and intake, refusal of therapy services, and preference to stay in bed. The DNS stated she expected the staff to notify the physician of any change in a resident's condition. | F 580 | | | |
| F 582 SS=B | Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible | F 582 | | 11/30/18 | |

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| F 582 | <p>Continued From page 11 for Medicaid of-</p> <p>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;</p> <p>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and</p> <p>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.</p> <p>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> | F 582 | | | |

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| F 582 | <p>Continued From page 12</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure the staff provided 2 of 3 sampled residents (#23, #28) discharged from Medicare Part A services, with contact information for their "Quality Improvement Organization (QIO)" in the event either resident wished to file an appeal of the determination. Findings include:</p> <p>1. Review of Resident 23's "Notice of Medicare Non-Coverage (NOMNC)" (a mandatory notice issued by the facility that informs the resident or the resident's representative when all Medicare Part A covered services end for coverage reasons, and provides information on the right to appeal the determination), indicated that Medicare Part A coverage of the resident's "Occupational Therapy/Physical Therapy" services would end on "9/7/18." Under the heading, "How to Ask for an Immediate Appeal," the notice read, "You must make a request to your Quality Improvement Organization (also known as a QIO) . . . Call your QIO at: [blank line] to appeal, or if you have questions." Underneath the blank line, the form instructed the staff to, "Insert QIO name, toll-free number of QIO, and TTY (Teletypewriter- a dialing device used by those who are deaf or very hard of hearing)</p> | F 582 | <p>1. The facility is unable to go back and include the contact information for the Quality Improvement Organization (QIO) on the Notice of Medicare Non-Coverage for residents #23 and #28. The SSD contacted the Medicare Hotline to verify current contact information for the QIO on 11/7/18.</p> <p>2. All residents requiring a Notice of Medicare Non-Coverage will have the QIO contact information included so the resident, if they wish, have the opportunity to file an appeal of the determination. The SSD will bring all completed NOMNC's to Administrator or designee to review them for completion before issuing to residents.</p> <p>3. The SSD was educated on the facilities policy and procedure pertaining to Notice of Medicare Non-Coverage. The SSD was also instructed to bring all completed NOMNC's to Administrator or designee for review before issuing to resident. Education was completed on 11/8/18.</p> | | |

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| F 582 | Continued From page 13 number." The staff failed to provide the resident's QIO contact information in the event the resident wished to appeal the determination. 2. Review of Resident 28's "NOMNC," indicated that Medicare Part A coverage of the resident's "Physical Therapy/Occupational Therapy" services would end on "7/30/18." Under the heading, "How to Ask for an Immediate Appeal," the notice read, "You must make a request to your Quality Improvement Organization (also known as a QIO) . . . Call your QIO at: [blank line] to appeal, or if you have questions." Underneath the blank line, the form instructed the staff to, "Insert QIO name, toll-free number of QIO, and TTY (Teletypewriter- a dialing device used by those who are deaf or very hard of hearing) number." The staff failed to provide the resident's QIO contact information in the event the resident wished to appeal the determination. On 10/11/18 at 8:25 AM, the LSW stated she gave the residents their NOMNC notices, but the facility's Business Office always filled in the QIO information on the forms. The LSW stated since neither Resident #23 nor Resident #28 expressed a desire to appeal the determinations, she did not think the QIO contact information was required. | F 582 | 4. The Administrator will audit that NOMNC's include the QIO contact information so residents have the ability to appeal the determination, if they wish. Audits will be completed weekly x4, monthly x2, and quarterly x2. Audit findings will be reported to the QAPI committee monthly, QAPI committee will determine if further auditing is needed. 5. Date certain 11/30/18 | | |
| F 604 SS=D | Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for | F 604 | | 11/30/18 | |

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| F 604 | <p>Continued From page 14</p> <p>purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents were free from physical restraints, including floor mat alarms and Wanderguards, unless needed to treat the resident's medical symptoms. This was true for 1 of 3 (#27) residents reviewed for restraints. This deficient practice created the potential for harm to residents, including increased the risk of falls, fear movement may set off an alarm, and diminished sense of dignity. Findings include:</p> | F 604 | <ol style="list-style-type: none"> 1. Resident #27 had the Physical Device and Restraint Assessment done on 11/5/18 by the Interim Director of Nursing. Physician was notified that the resident no longer required an alarm mat on 11/6/18. Physician order was received to discountinue alarm mat on 11/6/18. Family was notified and consent was obtained from family on 11/6/18. Care plan was updated on 11/6/18. 2. All residents using a device or | | |

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| F 604 | <p>Continued From page 15</p> <p>1. Resident #27 was admitted to the facility on 6/29/15, with diagnoses which included dementia with behavioral disturbances and Parkinson's disease.</p> <p>A quarterly MDS assessment, dated 9/19/18, documented Resident #27 had a moderate cognitive impairment and required extensive to limited assistance of 1-2 staff members for all cares. The MDS documented she had exhibited no behaviors and she used a restraint daily of a floor mat.</p> <p>The care plan area addressing Resident #27's falls, revised 9/6/18, documented Resident #27 required an alarming mat at the side of her bed which alerted staff when Resident #27 attempted to self-transfer out of bed.</p> <p>On 10/9/18 from 2:19 PM through 2:23 PM, Resident #27 was observed in her recliner chair with a floor mat under the chair. Resident #27 was observed in bed with the floor mat in place on 10/11/18 at 5:50 AM as well.</p> <p>Resident #27's clinical record did not contain an assessment of the medical need for the floor mat or a consent.</p> <p>On 10/10/18 at 4:28 PM, the DNS stated the facility did not know they had to assess floor mats as possible restraints. The DON stated they had not completed assessments for Resident #27's floor mat.</p> | F 604 | <p>equipment that may restrict their freedom of movement or normal access will be assessed prior to the use of the device. A physician order will be obtained and the device or equipment will be care planned after approval from the resident or family. The device or equipment will be re-assessed quarterly to ensure the device is the least restrictive and the need continues.</p> <p>3. The DNS and SDC will provide education to all staff by 11/15/18 regarding the use of restrictive devices or equipment or restraints including the need for assessments, the physician order, and the resident and/or family's education and approval. Education will also include the need for any of these devices to be care planned.</p> <p>4. The DNS or designee will audit all residents using any type of device that restricts their freedom of movement and any potential restraints. The audit will include whether an assessment had been done, if a physician order was obtained, if family and resident were educated and approved the device, and if the device and its use were care planned. The audit will include the quarterly assessment of the device as long as the device is in use. These audits will be done weekly X4 and then monthly X3 with the DNS or designee reporting audit findings monthly to the QAPI committee, the committee will determine if further auditing is needed.</p> | | |

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

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FORM APPROVED
OMB NO. 0938-0391

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| F 604 | Continued From page 16 | F 604 | | | |
| F 636 SS=D | <p>Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)</p> <p>§483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>§483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:</p> <ul style="list-style-type: none"> (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). | F 636 | 5. Date certain 11/30/18. | 11/30/18 | |

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| F 636 | <p>Continued From page 17</p> <p>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p> <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p> <p>(iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure a resident who was no longer at risk for elopement were reassessed for devices to prevent residents from leaving the facility, such as a Wanderguard. This was true for 1 of 1 (#1) residents reviewed for elopement risk. This deficient practice created the potential for harm to residents, including diminished sense of dignity. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 12/1/11, with diagnoses which included dementia</p> | F 636 | <p>1. Resident #1 was assessed for the use of a wanderguard on 11/5/18 using the Physical Device and Restraint Assessment. It was determined that the resident still has continued need for a wanderguard due to elopement risk. Physician order was obtained on 11/6/18. Family was notified and discussed risks vs benefits and consent was obtained on 11/6/18.</p> <p>2. All residents at risk for elopement will be assessed using the Physical Device and Restraint Assessment prior to using a</p> | | |

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| F 636 | Continued From page 18 with behavioral disturbances. A quarterly MDS assessment, dated 7/3/18, documented Resident #1 had a severe cognitive impairment and required extensive assistance of 1-2 staff members for all cares. The MDS documented she had exhibited no behaviors of wandering and she used a restraint daily of a Wanderguard. The care plan area addressing Resident #1's potential for elopement, revised 12/8/16, documented Resident #1 required a personal Wanderguard to her wrist which alerted staff to her movements. On 10/9/18 from 12:33 PM through 3:22 PM, Resident #1 was observed positioned in her wheelchair in the activities room with a Wanderguard clipped on the backside of her wheelchair. Resident #1 was observed positioned in her wheelchair on 10/10/18 at 10:21 AM through 1:55 PM in her wheelchair in the activity room with the Wanderguard in place. Resident #1's clinical record did not contain an assessment of the medical need for the Wanderguard or a consent. On 10/11/18 at 10:42 AM, the DNS stated the facility did not know they had to assess Wanderguards as possible restraints. The DON stated they had not completed assessments for Resident #1's Wanderguard. | F 636 | wanderguard. A physician order will be obtained and the resident and family member will be educated on its use and approval obtained. The use of the wanderguard will be re-assessed quarterly. 3. The DNS and SDC will educate all staff on the use of a wanderguard or similar device for residents at risk for elopement by 11/15/18. The education will include assessing the resident prior to its use, the need for a physician order, and the education to resident and family and their approval of the wanderguard. 4. The DNS or designee will audit all residents with a wanderguard device to assure proper assessment was completed prior to the use and quarterly thereafter. The audit will include a review of a physician order, education and approval from resident and family. This audit will be done weekly X4 and then quarterly X3 with the DNS or designee reporting findings to the QAPI committee monthly, the committee will determine if further auditing is needed. 5. Date certain 11/30/18. | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans | F 656 | | 11/30/18 | |

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| F 656 | Continued From page 19 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this | F 656 | | | |

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| F 656 | <p>Continued From page 20 section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of the facility's policy and procedure, the facility failed to ensure the staff developed person-centered care plans for 2 of 14 residents (#5 and #8), selected for review. The care plans failed to include individualized, non-pharmacological interventions, based on the residents' assessed social history and activity preferences, for the staff to implement to help relieve the residents' expressions of distress and/or to promote their highest practicable physical, mental, and psychosocial well-being. Findings include:</p> <p>The care plans for residents with dementia not utilize information from their "Activity Interest Data Collection Tool" to formulate individualized, non-pharmacological care plan interventions as follows:</p> <p>1. Resident #5 was admitted to the facility on 5/16/17, with diagnoses which included vascular dementia with behavioral disturbance.</p> <p>A quarterly MDS assessment, dated 7/10/18, documented: a) Resident #5 was severely cognitively impaired and exhibited continuous inattention and disorganized thinking. b)Resident #5 exhibited physical and verbal behaviors toward others, and behaviors not directed toward others on one to three days of the assessment's seven-day look-back period. c)Resident #5 required extensive assistance of two or more persons for transfers. d) Resident #5 received antipsychotic medication on all seven days of the</p> | F 656 | <p>1. Resident #5's care plan was updated on 11/8/18 to include specific interventions R/T past experiences and interests. Engaging in specific likes and interests may assist the resident during periods of distress. Resident #8's care plan was updated on 11/8/18 using information from the Activity Interest Tool to assist staff in providing ideas to share when interacting with residents especially when the resident is upset and to promote a sense of physical, emotional, and psychological well-being.</p> <p>2. All residents will have care plans that include information obtained through the Activity Interest Tool and their Social History to assist staff with communication, reminiscing with residents, taking residents to activities that they might enjoy thus promoting a sense of well-being to the residents.</p> <p>3. The SSD and Recreation therapist will provide education by 11/15/18 to all staff on what to look for on a care plan to assist them when dealing with a resident who may have short and long term memory loss, when a resident is upset, or when a resident displays behaviors. Interventions will include ways for staff to promote the optimal well-being for each resident. The education will also include how the activity staff and SS staff can use data from their assessments to implement care plan interventions for staff to utilize with residents.</p> | | |

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| F 656 | <p>Continued From page 21 assessment's seven-day look-back period.</p> <p>The annual MDS assessment, dated 04/16/18, documented Resident #5 preferred activities included: "Reading books, newspapers, and magazines, listening to music, being around animals such as pets, doing things with groups of people, spending time outdoors, and participating in religious activities or practices."</p> <p>Resident #5's Activity Interest Data Collection Tool, dated 05/19/17, documented Resident #5's interests included: crafts, poetry, listening to music, singing, painting, crocheting/knitting/tatting, needlework/quilting/sewing, tending garden/plants, television, movies, checkers, chess, board games, cards, bingo, word games/trivia, books, educational classes, newspaper, magazines, discussion, reminisce, bowling, dancing, walking, humor, talking/conversing, phone use, Bible study, devotions, worship services, animals/pets, traveling, and volunteer activities. The assessment also indicated the resident's favorite color was blue, that she liked to "try things that are different" and "visiting with others," and had worked as a waitress and dishwasher in restaurants in the past.</p> <p>The care plan area addressing Resident #5's impaired cognitive function, dated 2/25/18, documented she had vascular dementia with behavioral disturbances and moderate cognitive impairment, severe short term memory deficits, difficulty understanding others, difficulty expressing needs [and] wandering. The interventions directed the staff to:</p> | F 656 | <p>4. The SSD or designee will audit care plans to assure specific interventions based on resident history are implemented for staff to utilize for residents who may have short and long term memory loss, who may display behaviors, as well as non-pharmacological interventions to utilize prior to using psychoactive medications related to mood and behaviors. These audits will be done weekly X4 and then monthly X3 with the DNS or designee reporting audit findings to the QAPI committee monthly, the committee will determine if further auditing is needed.</p> <p>5. Date certain 11/30/18.</p> | | |

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| F 656 | Continued From page 22 **"Monitor/document/report to heath care provider any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, [and] mental status" (initiated 05/29/17). * "Reminisce with [resident's name] using photos of family and friends" (revised 05/29/17). **"[Resident's name] needs supervision/assistance with all decision making" (revised 05/29/17). * "Ask yes/no questions in order to determine [resident's name] needs" (revised 05/29/17). * "Present just one thought, idea, question or command at a time" (initiated 05/29/17). * "Break tasks into one step at a time" (initiated 05/29/17). * "Cue, reorient and supervise as needed" (initiated 05/29/17). * "Redirect/reassure as needed" (initiated 05/29/17). "Engage resident in simple, structured activities that avoid overly demanding tasks such as coffee time, Bible study, devotions, discussion groups, special events, going outside, and sensory stimulating projects as tolerated" (revised 07/10/18). | F 656 | | | |

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| F 656 | <p>Continued From page 23</p> <p>"Dementia/impaired thoughts: Attempt non-pharmacological interventions: 1:1 visits, cue remind [sic] and reorientate [sic] as needed" (revised 03/13/18).</p> <p>i. The care plan area addressing Resident #5's antipsychotic medication therapy, dated 2/15/18, documented she was on the medication related to vascular dementia with behavioral symptoms, tearfulness, and excessive wandering. The interventions directed the staff to:</p> <p>Behavior #1, Tearfulness: 1 :1 interaction.</p> <p>Behavior #2: Wandering: Offer to take [resident's name] for a walk to divert attention. Assess for toileting, wander guard to left wrist" (revised 07/10/18).</p> <p>"Monitor for a significant decline in function and/or substantial difficulty receiving needed care (e.g., not eating resulting in weight loss, fear, and not bathing leading to skin breakdown or infection)" (initiated 07/19/17).</p> <p>"Monitor for behavioral symptoms that present a danger to the resident or others. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed" (revised 07/19/17).</p> <p>"Monitor for symptoms that are significant enough that the resident is experiencing inconsolable or persistent distress (e.g., fear, continuously yelling, screaming, distress associated with end of life. or crying)" (no date of initiation or revision).</p> | F 656 | | | |

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| F 656 | Continued From page 24 "Document target behavior episodes. side effects, and non-pharmacological interventions used q [every] shift" (revised 08/09/17). The staff did not utilize information from Resident 5's "Activity Interest Data Collection Tool" to formulate individualized, non-pharmacological care plan interventions for the staff to implement in the event Resident 5's expressed distress, or to help promote an optimal state of physical, emotional, and psychological well-being. 2. Resident #8 was admitted to the facility on 8/3/17, with diagnoses which included Alzheimer's disease and a secondary diagnosis of dementia with behavioral disturbance. A quarterly MDS assessment with an ARD, dated 08/02/18, documented Resident #8 was severely cognitively impaired and required extensive assistance of one person for transfers. A significant change in status MDS assessment, dated 02/03/18, documented Resident #8's preferred activities were reading books, newspapers, and magazines, listening to music she likes, keeping up with the news, going outside to get fresh air when the weather is good, and participating in religious services or practices. Resident #8's Activity Interest Data Collection Tool, dated 07/30/18, documented Resident #8 was interested in poetry, listening to music, singing, playing the trumpet, crocheting/knitting/tatting, needlework/quilting/sewing, landscaping and | F 656 | | | |

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| F 656 | <p>Continued From page 25</p> <p>lawn work, tending garden/plants, television, movies, checkers, chess, board games, cards, bingo, word games/trivia, jigsaw puzzles, books, computer, newspaper, magazines, letter writing, discussion, reminisce, bowling, dancing, walking, exercise, humor, talking/conversing, phone use, Bible study, devotions, worship services, communion, animals/pets, traveling, and volunteer activities. The assessment also indicated the resident liked bright colors, sweets, and hand work, enjoyed being with others, and was a teacher for first through eighth grades.</p> <p>Review of Resident 8's care plan, indicated the staff developed the following care plan "Focus" areas:</p> <p>i. The care plan area addressing Resident #8's impaired cognitive function, dated 8/24/17, documented she had dementia without behavioral disturbances, short and long term memory deficits, and poor safety awareness. The interventions directed the staff to:</p> <p>"Monitor/document/report to health care provider any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, [and] mental status" (initiated 08/03/17).</p> <p>"Communication: Reduce any distractions- turn off TV, close door, etc." (revised 08/24/18).</p> <p>"Present just one thought, idea, question or command at a time" (initiated 08/04/17).</p> | F 656 | | | |

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| F 656 | Continued From page 26 "Invite [Resident #8] to Friendship circle, popcorn group, musical events, religious events, and/or other leisure activities of interest" (revised 04/24/18). "Dementia/impaired thoughts: Attempt non-pharmacological interventions: 1:1 visits, assist to activities, reminisce about teaching school, call daughter [name]" revised 08/10/17). ii. The care plan area addressing Resident #8's communication problem, dated 8/16/17, documented she had dementia without behavioral disturbance as evidenced by short and long term memory deficits, needing information repeated, and step by step instructions. The interventions directed the staff to: "Encourage her to continue stating thoughts even if she is having difficulty. Focus on a word or phrase that makes sense or responds to the feeling she is trying to express" (revised 08/16/17). "Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed" (initiated 08/15/17). "Monitor for and document changes in [Resident #8's] ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend" (revised 08/16/17). "Monitor/document/report to health care provider PRN [as needed] changes in: ability to communicate and potential contributing factors | F 656 | | | |

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| F 656 | <p>Continued From page 27 for communication problems" (initiated 08/15/17).</p> <p>"Ensure availability and functioning of adaptive communication equipment: hearing aids; assist to place and remove" (revised 08/22/18).</p> <p>"Use communication techniques which enhance interaction: allow adequate time to respond, repeat as necessary, do not rush; request feedback/clarification from the [sic] [Resident #8] to ensure understanding, face when speaking and make eye contact, turn off TV as needed to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues" (revised 08/24/17).</p> <p>"Be conscious of [Resident #8's] location when in groups, activities, [and the] dining room to promote proper communication with others" (initiated 08/15/17).</p> <p>"Use effective strategies: [Resident's name] has an orange journal in her room for family/friends/staff to write reminders, especially that her daughter has visited in order to enhance communication and assist with remembering events" (revised 08/15/17).</p> <p>"The resident prefers to be called [Resident #8's name]" (revised 08/16/17).</p> <p>The staff did not utilize information from Resident 8's "Activity Interest Data Collection Tool" to formulate individualized, non-pharmacological care plan interventions for the staff to implement to help promote an optimal sense of physical, emotional, and psychological well-being for Resident 8.</p> | F 656 | | | |

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| F 656 | Continued From page 28 During an interview on 10/11/18 at _____, the MDS Coordinator stated the LSW was responsible for the development of the care plans and interventions related to dementia and/or behavioral symptoms but added that she thought the care plans for residents with dementia included person-centered interventions. During an interview on 10/12/18, at _____, the LSW stated she was responsible developing the psychosocial section(s) of the residents' care plans and had begun a process for ensuring the residents' care plans included person-centered interventions. Review of the facility's policy titled, "Care Plan," revised 11/2016, indicated the following: "Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. Through use of departmental assessments, the Resident Assessment Instrument and review of the physician's orders, any problems, needs and concerns identified will be addressed." | F 656 | | | |
| F 684 SS=D | Quality of Care CFR(s): 483.25 § 483.25 Quality of care | F 684 | | 11/30/18 | |

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| F 684 | <p>Continued From page 29</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interview, policy review, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 3 of 14 residents (#1, #6, #14) reviewed for standards of practice. Resident #1 and #14 had the potential for harm when they were not repositioned routinely to prevent potential skin impairments. Resident #6 had the potential for harm when he received blood pressure lowering medications when he was experiencing low blood pressures. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include: The facility's Positioning Policy and Procedure, dated 10/17, documented staff would reposition residents to reduce their risk of developing pressure ulcers.</p> <p>2. Resident #14 was admitted to the facility on 8/1/16, with diagnoses which included bilateral osteoarthritis of the knee, pain, idiopathic peripheral autonomic neuropathy, peripheral vascular disease, and degeneration of the lumbar disc in the back.</p> | F 684 | <p>1. Residents # 1 and #14 have been re-assessed as to their repositioning needs; the care plan for each resident was reviewed for appropriate interventions on 11/8/18. Resident #6 was assessed by the provider to determine if further cardiac medications were needed on 10/25/18 with no new orders. Vital signs will be checked prior to any medication administration, if the medication needs to be held due to vital signs outside of the prescribed parameters that vital sign will be re-checked within 2 hours.</p> <p>2. All residents requiring repositioning assistance from staff will be assessed using the Positioning Assessment and Evaluation UDA upon admission, quarterly, and with changes in condition. If a resident requires repositioning assistance from staff the care plan and kardex will reflect this need and staff will document each time the care is provided. Residents receiving medications that require vital signs or have parameters included in the order will have this included on the e-MAR. Nurses will obtain the ordered</p> | | |

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| NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SILVER WOOD VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST SEVENTH STREET SILVERTON, ID 83867 | | |
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| F 684 | <p>Continued From page 30</p> <p>A quarterly MDS assessment, dated 8/9/18, documented Resident #14 was cognitively intact and she required extensive assistance of one to two staff members with all cares except eating.</p> <p>The care plan area addressing Resident #14's ADL care, revised 6/7/18, documented Resident #14's required 1 staff members assistance with bed mobility and transfers.</p> <p>Resident #14's Positioning Assessment, dated 9/3/18, documented she was incontinent of bladder and required extensive assistance with all transfers and assist with bed mobility. The assessment documented Resident #14 was obese and had frequent recurring rashes to her groin and pannus area. The assessment documented she was at risk for skin breakdown and her skin was fragile.</p> <p>Resident #14 was not repositioned consistently as follows: *On 10/11/18 at 10:44 AM, the DNS stated the staff were instructed to document repositioning of residents in their chair and beds under the bed mobility section of the charting system. The DNS stated the staff were to document each occurrence of repositioning they provided to residents.</p> <p>The September 2018 ADL Bed Mobility record documented the following: - There was no documented evidence she was turned and/or repositioned between 9/1/18 through 9/30/18 day shift, except once on 9/1/18-9/3/18, 9/8/18, 9/9/18, 9/14/18-9/17/18, 9/20/18-9/25/18, and 9/28/18-9/30/18. - There was no documented evidence she was</p> | F 684 | <p>vital signs prior to administering the medication, if the medication is held the vital sign will be checked again within 2 hours. If a medication is held X3 the provider will be notified.</p> <p>3. The DNS and SDC will educate nurses and CNAs by 11/15/18 regarding the need to provide cares per the care plan and kardex and the expectation that documentation occurs after each encounter. The nurses will be educated to follow physician orders on the e-MAR regarding medications with vital sign parameters. If a medication is held related to the ordered parameters that vital sign will be re-checked within 2 hours. If the medication is held 3 times the provider will be updated.</p> <p>4. The DNS or designee audit repositioning needs of residents. The audit will include observation of repositioning to have been completed and will also audit CNA documentation on POC to determine if residents are repositioned per the care plan. The audit will also include the review of the e-MAR and vital signs to assure the medication was either given or held per the parameters ordered by the provider. The audit will include a review of the vital signs taken after a medication is held and that the provider is informed if a medication is held 3 or more time. These audits will be done weekly X4 and then monthly X3 with the DNS or designee reporting audit findings monthly to the QAPI committee, the committee will determine if further auditing is needed.</p> | | |

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| F 684 | <p>Continued From page 31</p> <p>turned and/or repositioned between 9/1/18 through 9/30/18 evening shift, except once one evening shift of 9/5/18, 9/6/18, 9/9/18, 9/19/18, 9/25/18, and 9/30/18.</p> <p>- There was no documented evidence she was turned and/or repositioned between 9/1/18 through 9/30/18 night shift, except once per shift on 9/2/18, 9/6/18-9/14/18, 9/19/18, 9/22/18-9/24/18, and 9/27/18 and twice per shift on 9/1/18, 9/4/18, 9/15/18, 9/17/18, 9/20/18, 9/25/18, and 9/29/18, and three times per shift on 9/28/18.</p> <p>The 10/1/18 through 10/10/18 ADL Bed Mobility record documented the following:</p> <p>- There was no documented evidence she was turned and/or repositioned between 10/1/18 through 10/10/18 day shift, except once on 10/1/18, 10/5/18, 10/7/18, and 10/8/18.</p> <p>- There was no documented evidence she was turned and/or repositioned between 10/1/18 through 10/10/18 evening shift.</p> <p>- There was no documented evidence she was turned and/or repositioned between 10/1/18 through 10/10/18 night shift, except once per shift on 10/1/18, 10/3/18, and 10/4/18 and twice per shift on 10/2/18, 10/5/18-10/9/18.</p> <p>On 10/9/18 at 3:48 PM, Resident #14 was observed positioned in her wheelchair in her room. Resident #14 stated staff did not often reposition her at night or during the day. Resident #14 stated staff would place her in her bed and not move her until she woke in the morning unless she called for assistance to go the restroom. Resident #14 stated she did not want to bother staff with assisting her to reposition and stated she was aware of the risk of skin</p> | F 684 | 5. Date certain 11/30/18. | | |

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| F 684 | <p>Continued From page 32</p> <p>breakdown. Resident #14 was observed positioned in her wheelchair on 10/10/18 at 8:46 AM through 1:55 PM and on 10/11/18 from 5:51 AM through 11:22 AM in her wheelchair in her room.</p> <p>On 10/11/18 at 6:09 AM, Resident #14 was observed positioned close to the edge of the left side of her bed, on her left side with her legs bent at the knees and hanging over the edge of the bed. Resident #14 was observed grasping the hand rail tightly and her face was pressed close the rail. Resident #14 stated to CNA #3, "I have been hanging here like this since 4 in the morning, please help." CNA #3 hurried to Resident #14's aide and assisted her with positioning.</p> <p>On 10/11/18 at 11:22 AM, the DNS stated residents should be assisted with positioning minimally every 2-3 hours. The DNS stated the documented did not show this was being completed.</p> <p>3. Resident #1 was admitted to the facility on 12/1/11, with diagnoses which included dementia with behavioral disturbances, anxiety, depression, borderline personality disorder, and pseudobulbar affect.</p> <p>A quarterly MDS assessment, dated 7/3/18, documented Resident #1 had a severe cognitive impairment and required extensive assistance of 1-2 staff members for all cares.</p> <p>The care plan area addressing Resident #1's ADL care, revised 6/6/16, documented Resident #1 required two staff members assistance with</p> | F 684 | | | |

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| F 684 | <p>Continued From page 33 bed mobility and transfers.</p> <p>Resident #1 was not repositioned consistently as follows:</p> <p>On 10/11/18 at 10:44 AM, the DNS stated the staff were instructed to document repositioning of residents in their chair and beds under the bed mobility section of the charting system. The DNS stated the staff were to document each occurrence of repositioning they provided to residents.</p> <p>The September 2018 ADL Bed Mobility record documented the following:</p> <ul style="list-style-type: none"> - Resident #1 was repositioned/turned once per shift on the day shift between the dates of 9/1/18 and 9/29/18. - Resident #1 was repositioned/turned once per shift on the evening shift between the dates of 9/1/18 and 9/30/18. - There was no documented evidence she was turned and/or repositioned between 9/1/18 through 9/30/18 night shift, except once per shift on 9/1/18, 9/3/18-9/5/18, 9/8/18-9/10/18, 9/13/18, 9/18/18, 9/19/18, 9/22/18-9/24/18, and 9/27/18-9/30/18 and twice per shift on 9/25/18. <p>The 10/1/18 through 10/10/18 ADL Bed Mobility record documented the following:</p> <ul style="list-style-type: none"> - Resident #1 was repositioned/turned once per shift on the day shift between the dates of 10/1/18 and 10/10/18 and twice per shift on 10/2/18, 10/4/18, and 10/5/18. - Resident #1 was repositioned/turned once per shift on the evening shift between the dates of 10/1/18 and 10/10/18. - Resident #1 was repositioned/turned once per | F 684 | | | |

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| F 684 | <p>Continued From page 34 shift on the night shift between the dates of 10/1/18 and 10/10/18.</p> <p>On 10/9/18 from 12:33 PM through 3:22 PM, Resident #1 was observed positioned in her wheelchair in the activities room.</p> <p>Resident #1 was observed positioned in her wheelchair on 10/10/18 at 10:21 AM through 1:55 PM in her wheelchair in the activity room.</p> <p>On 10/11/18 at 11:22 AM, the DNS stated residents should be assisted with positioning minimally every 2-3 hours. The DNS stated the documented did not show this was being completed.</p> <p>4. Resident #6 was admitted to the facility on 9/24/16, with diagnoses which included hypertension.</p> <p>According to the 2018 Nursing Drug Handbook, those receiving Amiodarone HCL, an antiarrhythmic (heart medicine), should have their BP and heart rate monitored "frequently."</p> <p>An annual MDS assessment, dated 7/12/18, documented Resident #6 was cognitively intact.</p> <p>The care plan area addressing Resident #6's hypertension, revised 9/18/18, documented staff were to monitor Resident #6 for signs of low blood pressure.</p> <p>Resident #6's Physician Orders included: - Amiodarone HCL 200 mg in morning for cardiac, ordered 9/25/16 and discontinued 10/9/18.</p> | F 684 | | | |

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| F 684 | <p>Continued From page 35</p> <ul style="list-style-type: none"> - Hold BP medicine and therapy for BP of 90/60 or below after attempting to hydrate with 500 cc of fluids, ordered 1/25/18 and discontinued 10/9/18. - Amiodarone HCL 200 mg in morning, hold BP medicine and therapy for BP of 90/60 or below after attempting to hydrate with 500 cc of fluids, ordered 10/9/18. <p>Resident #6's 9/1/18 through 10/1/18 MAR documented he was administered his Amiodarone HCL 200 daily and the medication was not held on any day.</p> <p>Resident #6's Vital Sign Report 9/1/18 through 10/11/18 documented he experienced multiple BPs below 90/60 and the staff did not hold the BP medication as ordered by the physician. Examples included: - 9/25/18-90/39 - 10/1/18-93/39 - 10/8/18- 88/43</p> <ul style="list-style-type: none"> - Resident #6's BP was not assessed prior to giving the medication on the following mornings 9/3/18, 9/9/18, 9/13/18, 9/15/18, 9/24/18, 9/29/18, and 9/30/18. <p>On 10/11/18 at 12:05 PM, the DNS stated the nursing staff should hold a medication of a residents BP was low from either number the systolic or the diastolic. The DNS stated this was not done on Resident #6's medication. The DNS stated if a CNA obtained the vital for the nurse and the number was low she was expecting the staff to recheck the BP to ensure the BP was indeed low.</p> | F 684 | | | |
| F 686 | Treatment/Svcs to Prevent/Heal Pressure Ulcer | F 686 | | 11/30/18 | |

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| F 686 SS=G | Continued From page 36 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, 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 2 residents (#25) reviewed for pressure ulcers. Resident #25 was harmed when she developed 2 pressure ulcers. Findings include: The facility's Wound and Pressure Ulcer Management Policy and Procedure, dated 1/17, documented the facility followed protocols and procedures consistent with the Agency for Healthcare Research and Quality (AHRQ), the American Medical Director Association (AMDA), and the Society for Post-Acute and Long-Term Care Medicine. The facility's Positioning Policy and Procedure, dated 10/17, documented staff would reposition residents to reduce their risk of developing | F 686 | 1. Resident #25 was re-assessed for proper wound documentation and adequate wound care orders. Facility obtained order from physician on 11/5/18 for resident to be evaluated at wound care clinic. Scheduled appointment for 11/12/18. The positioning assessment was completed on 11/8/18 by the Interim DNS. 2. All residents upon admission will have a skin assessment completed including the Braden scale to determine if the resident is at risk for skin breakdown. Staff will use the Skin Observation Tool to weekly check all resident's skin. If a pressure ulcer or DTI is observed an incident report will be initiated with the family and physician notified immediately and an investigation to determine the cause of injury will be completed. GSS | | |

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| F 686 | <p>Continued From page 37 pressure ulcers.</p> <p>The 2014 guidelines for staging wounds, from the National Pressure Ulcer Advisory Panel, Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, documented a Stage I pressure ulcer was defined as nonblanchable (Skin that remains red in color after pressure was applied.) intact redness to skin over a bony area. The guidelines documented a Stage II wound was partially skin thickness loss (A Wound that affects the top two layers of the skin.) with red and or pink in the wound bed without slough (A mass of dead tissue that separates from a wound bed.). The guidelines documented a Stage III wound was full skin thickness loss (A wound that affected the layers of skin and into the subcutaneous tissue of fat.) with possible slough present in the wound bed, however, the base of wound is visible. The guidelines documented a Stage IV wound was a full thickness tissue loss with exposed muscle, bone, or tendon. The guideline documented slough or eschar could be present in parts of the wound bed. The guideline documented an unstageable wound was of unknown depth due to the base of the wound covered by slough or eschar.</p> <p>Resident #25 was admitted to the facility on 1/31/13, with diagnoses which included difficulty walking, muscle weakness, and pain.</p> <p>The care plan area addressing Resident #25's pressure ulcer, initiated 4/14/17, documented Resident #25 had a stage II pressure injury to her coccyx and a Deep tissue injury (DTI) to her buttock. The care plan documented she was risk related to incontinence, impaired mobility, and a</p> | F 686 | <p>policy and procedure will be followed using the Wound Data Collection Tool daily and the Wound RN Assessment done weekly. The center will assign one staff person to be designated as the Wound Nurse and the DNS and MDS coordinator will do weekly rounds of wounds with the designated wound nurse. The center has contacted their AMT representative to assist with education on identification of a wound, measuring a wound, staging a wound, and information on products specific to wound care.</p> <p>3. The DNS and SDC will educate all nursing staff on identification and care of a pressure ulcer or DTI by 11/15/18. Education will also include using the Braden scale to determine where and when a resident is susceptible for a wound including incontinence, immobility, poor nutritional status, etc. Education will also include the staging of a wound, measuring a wound, and acceptable treatments for specific type ulcers. A review of the Wound Data Collection Tool and the Wound RN assessment will be done including the need for complete data to be entered in these assessments.</p> <p>4. The DNS will audit all residents with a history of pressure ulcers or DTI and other skin issues to assure proper interventions are in place to protect their skin. The audit will include a record review of all resident who currently have a skin injury to assure all interventions are in place including nutritional support, incontinence care, mobility assistance as needed, and that the daily Wound Data</p> | | |

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| F 686 | <p>Continued From page 38</p> <p>history of dermatitis. The care plan documented staff were to encourage Resident #25 to lift her buttock off of her wheelchair seat a minimum of twice per shift. (The facility had two shifts.) The care plan documented Resident #25 was to receive wound care per orders and staff were to encourage her to lay down for pressure relief during the day.</p> <p>Resident #25's clinical record contained Weekly Skin Observation Assessments between the dates of 5/1/18 and 10/10/18. The assessments were completed weekly and PRN.</p> <p>Resident #25's Weekly Skin Observation Assessment, dated 5/8/18, documented her skin was intact.</p> <p>Resident #25 developed and/or re-developed a Stage III pressure ulcer to her coccyx in September 2018, and the facility did not treat, implement interventions, and assess her pressure ulcer when the skin impairment was first discovered in May 2018. Examples include:</p> <p>i. Resident #25's Weekly Skin Observation Assessment, dated 5/15/18, documented Resident #25 had a new area to her coccyx which was red with fragile skin noted. The assessment did not document if the skin was blanchable or provided measurements for the area.</p> <p>Resident #25's clinical records did not contain a Wound Data Collection, dated 5/15/18, describing the skin impairment.</p> <p>Resident #25's May 2018 MAR or TAR and</p> | F 686 | <p>Collection Tool and the Wound RN Assessment is complete and correct. CNA documentation will be audited to assure interventions are being followed. The DNS will also audit by observation to assure that the planned interventions are being followed. The audit will include data from the RD related to nutritional support and review of the physician notifications. These audits will be done weekly X4 and then monthly X3 with the DNS reporting audit findings to the QAPI committee monthly, the committee will determine if further auditing is needed.</p> <p>5. Date certain 11/30/18.</p> | | |

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| F 686 | <p>Continued From page 39</p> <p>physician's orders did not contain treatment orders for the skin impairment found in May on her coccyx.</p> <p>Resident #25's Weekly Skin Observation Assessment, dated 6/9/18 and 6/12/18, documented Resident #25's coccyx had "healing buttocks wound" and was healing. The assessments did not document if the skin was blanchable or provided measurements for the area.</p> <p>Resident #25's clinical records did not contain a Wound Data Collection or a progress note, dated 6/9/18 and 6/12/18, describing the skin impairment.</p> <p>Resident #25's Positioning Assessment, dated 6/25/18, documented her Braden score was a 16 which placed her at risk for skin breakdown and she had no current skin breakdown.</p> <p>A quarterly MDS assessment, dated 9/7/18, documented Resident #25 was cognitively intact and documented she required extensive assistance of one to two staff members with all cares except eating. The MDS documented Resident #25's skin was intact, and she did not have a pressure ulcer.</p> <p>Resident #25's Positioning Assessment, dated 9/18/18, documented she was incontinent of bowel and bladder and required assistance with bed mobility and transfers. The assessment documented her skin was in "good condition." This assessment was not consistent with the 9/18/18 weekly skin observation assessment or progress notes.</p> | F 686 | | | |

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| F 686 | <p>Continued From page 40</p> <p>ii. Resident #25's Weekly Skin Observation Assessment, dated 9/18/18, documented Resident #25's coccyx had a Stage III pressure injury to her coccyx. The assessment documented the facility changed out the cushion on her wheelchair and planned to reposition her every 3 hours.</p> <p>A Progress Note, dated 9/18/18, documented Resident #25 was found to have a Stage III pressure injury to her coccyx after being assisted in the shower.</p> <p>A Progress Note, dated 9/20/18, documented Resident #25's wound was assessed, and the dressing was changed. The note documented Resident #25's wound bed did not have slough, no evidence of subcutaneous fat, or full thickness tissue loss. The note documented the wound was a Stage II.</p> <p>Resident #25's Wound Data Collection, dated 9/20/18, documented Resident #25 had a previously identified "stage II" wound to her coccyx, measuring 1.5 cm by 0.5 cm. The assessment documented the wound was pink and intact.</p> <p>Resident #25's Wound Data Collection assessments for her coccyx were completed between the dates of 9/20/18 and 10/11/18 by 11 different nurses. The documentation of the characteristics of the wound was incomplete and inconsistent as follows: *On 9/27/18 Resident #25's wound worsened in size to 2.5 cm by 1 cm and 0.5 cm in depth. *The 9/27/18 assessment documented the</p> | F 686 | | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 686 | Continued From page 41 wound remained a Stage II wound and the wound bed had 90% slough covering the surface with 5% granulation tissue [pink or beefy red moist tissue]. (The national standards documented slough present would not be a Stage II wound, but an unstageable wound.) * On 9/29/18 Resident #25's wound was documented as worsening in size to 3 cm by 2 cm by 1 cm, no staging documented. * The 9/29/18 assessment documented 5% granulation and no other tissue type documented. * The 9/30/18 assessment documented the wound size remained the same, however there was 5% eschar in the wound bed, no staging documented. *On 10/2/18 the assessment documented the wound was 2.5 cm by 1.5 cm by 0.1 with 100% slough in the wound bed, no staging documented. (The depth of a pressure ulcer cannot be determined when the wound bed is covered by slough 100%.) * The 10/2/18 assessment documented the pressure ulcer was worsening. *On 10/3/18 the assessment documented the wound was a Stage III pressure ulcer, measuring 2.5 cm by 1.5 cm by 4 cm deep, with 85% slough covering the wound bed, 10% epithelialized tissue (new skin tissue), and 5% granulation tissue. (The depth of a pressure ulcer cannot be determined when the wound bed is covered by slough or eschar.) A day later on 10/4/18 the Stage III pressure ulcer was documented as measuring 2.5 cm by 1.5 cm by 0.5 cm deep with 80% slough in the wound bed. (The wound healed 3.5 cm in one day according to the assessment.) | F 686 | | | |

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| F 686 | <p>Continued From page 42</p> <p>Five assessments on 10/6/18, 10/7/18, 10/9/18, 10/10/18, and 10/11/18 following 10/4/18 documented the presence of slough in the wound bed. The 9/28/18, 10/5/18, and 10/8/18 assessments did not document an assessment of the wound bed to include the presence of granulation tissue, slough, eschar, or epithelial tissue. The wound was last measured on 10/10/18 as 2 cm by 1.5 cm by 2 cm deep as a Stage III pressure ulcer.</p> <p>Resident #25's September 2018 MAR documented staff were to cleanse her stage II Pressure Ulcer wound with Kendall sterile saline solution and apply foam border adhesion dressing or alginate hydrocolloid dressing every 3-5 days and PRN, beginning 9/21/18 and discontinued 10/6/18. This was ordered three days after the wound was discovered. The order was not specific to the location of the pressure ulcer. The dressing was changed as ordered with the exception of 9/21/18.</p> <p>b. Resident #25 developed and/or re-developed a skin impairment in September 2018 on her left buttocks, and the facility did not treat and implement interventions to her left buttocks when the skin impairment was first discovered in May 2018. Example includes:</p> <p>i. Resident #25's Weekly Skin Observation Assessment, dated 5/19/18, documented Resident #25 had a recurrent area to her left buttock that was a "stage II." The assessment document the wound was an open area approximately 0.5 cm by 1 cm that was previously scabbed over.</p> | F 686 | | | |

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| F 686 | <p>Continued From page 43</p> <p>Resident #25's Wound Data Collection, dated 5/19/18, documented Resident #25 had new wound to her left buttock, measuring 0.5 by 0.5 cm by 0.25 cm deep. The assessment documented the wound was reopened. The assessment did not document an assessment of the wound bed characteristics.</p> <p>Resident #25's Wound Data Collection, dated 5/26/18, documented Resident #25's wound to her left buttock, measured 0.5 by 0.5 cm. The assessment documented the wound bed had 100% epithelial tissue present in the wound bed.</p> <p>Resident #25's May 2018 MAR or TAR and physician's orders did not contain treatment orders for the skin impairment found in May on her left buttock.</p> <p>ii. Resident #25's Weekly Skin Observation Assessment, dated 9/18/18, documented Resident #25 had a deep tissue injury to her left buttock. The assessment documented the facility changed out the cushion on her wheelchair and planned to reposition her every 3 hours.</p> <p>A Progress Note, dated 9/18/18, documented Resident #25 had a deep tissue injury to her left buttock. The note documented Resident #25 was being assisted into her wheelchair by two staff members when Resident #25's stated her legs were tired and began to sit down. The note documented Resident #25's legs were tired and gave out on her and she was lowered to the floor. The note documented Resident #25's deep tissue injury may have come from this incident as she hit her buttock on the arm rest of the wheelchair.</p> | F 686 | | | |

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| F 686 | Continued From page 44 Resident #25's Wound Data Collection, dated 9/20/18, documented Resident #25 had a previously identified "deep tissue injury" wound to her left buttock, without measurements. The assessment documented Resident #25's left buttocks had a bruised area. Resident #25's Wound Data Collection assessments for her left buttock were completed between the dates of 9/20/18 and 10/4/18 by 3 different nurses. The documentation of the characteristics of the wound and wound size, were inconsistently documented between nurses as follows: * On the 9/20/18, 9/22/18, 9/23/18, and 9/28/18, Resident #25's wound was not documented as measured. *The 9/23/18 assessment documented the wound bed had "3 small areas" open. *The 9/24/18 assessment documented the wound was open and measured 1 cm by 1 cm with 65% granulation and 35% epithelial tissue. * On 9/27/18 Resident #25's wound was documented as worsening in size to 1.5 cm by 3 cm, with 100% granulation tissue. The 9/27/18 assessment documented the area was no longer bruised, but there were "two open areas present." *The 10/4/18 assessment documented the deep tissue injury was 0.5 cm by 0.5 cm with 95% epithelial tissue present. This was the last assessment of the wound. Resident #25's clinical record did not document when her left buttock wound resolved. Resident #25's September 2018 MAR or TAR and physician's orders did not contain treatment | F 686 | | | |

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| F 686 | <p>Continued From page 45 orders for the skin impairment found in September on her left buttock.</p> <p>c. Resident #25 developed new a skin impairment on her left gluteal fold and the facility did not implement interventions or consistently assess the wounds. Example includes:</p> <p>Resident #25's Weekly Skin Observation Assessment, dated 10/2/18, documented Resident #25 had an abrasion to her left gluteal fold. The assessment did not document a size of the wound.</p> <p>Resident #25's Wound Data Collection, dated 10/3/18, documented Resident #25 had previously identified wounds to her left gluteal fold. The assessment documented there were three areas that were connecting with excoriated (rubbed off skin) skin. The assessment documented one area was 1 cm by 0.5 cm by 0.2 cm deep. The assessment documented the biggest wound had slough present in the wound bed and one wound appeared to be a Stage I. The assessment documented there was 85% slough present in the wound bed.</p> <p>A Progress Note, dated 10/3/18, documented Resident #25 had three sores located on her "coccyx, right cheek, and crease of buttock and leg on the right hand side. The 3rd sore is a cluster of satellite open areas with one main area measuring 1 cm x [by] 0.5 cm."</p> <p>Resident #25's Wound Data Collection, dated 10/4/18, documented Resident #25 had previously identified wounds to her left gluteal fold. The assessment documented there were</p> | F 686 | | | |

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| F 686 | <p>Continued From page 46</p> <p>three areas, measuring 1 cm by 1.5 cm with 85% slough present in the wound bed. The assessment documented there was a 3 cm by 3 cm excoriated area surrounding the open area. The assessment documented the other two area "look like potential problem." The assessment documented there was 85% slough present in the wound bed.</p> <p>Resident #25's clinical record did not contain documentation of the progression of the three areas to the left gluteal folds or documentation of further assessments after 10/4/18.</p> <p>Resident #25's October 2018 MAR or TAR and physician's orders did not contain treatment orders for the three areas of skin impairment found in October on her left gluteal fold.</p> <p>d. Resident #25 was not repositioned consistently and every 3 hours as follows:</p> <p>On 10/11/18 at 10:44 AM, the DNS stated the staff were instructed to document repositioning of residents in their chair and beds under the bed mobility section of the charting system. The DNS stated the staff were to document each occurrence of repositioning they provided to residents. The DNS stated the staff were to reposition Resident #25 minimally every 3 hours.</p> <p>The September 2018 ADL Bed Mobility record documented the following:</p> <p>- There was no documented evidence she was turned/repositioned between 9/1/18 through 9/18/18 day shift, except once on 9/7/18 and 9/15/18.</p> | F 686 | | | |

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| F 686 | <p>Continued From page 47</p> <ul style="list-style-type: none"> - There was no documented evidence she was turned/repositioned between 9/1/18 through 9/18/18 evening shift, except once one evening shift on 9/5/18 when she was documented as she was able to do it herself. - There was no documented evidence she was turned/repositioned between 9/1/18 through 9/18/18 night shift, except once per shift on 9/1/18, 9/4/18, 9/5/18, 9/10/18, and 9/18/18 and twice per shift on 9/3/18. The ADL sheet documented Resident #25 was able to provide bed mobility independently once per shift on 9/1/18, 9/6/18, 9/10/18, 9/12/18, 9/13/18-9/15/18 and twice per shift on 9/7/18, 9/8/18, and 9/16/18. <p>* The bed mobility between 9/19/18 through 9/30/18 day shift documented she was repositioned the following hours a day:</p> <ul style="list-style-type: none"> - 9/19/18- Resident #25 was repositioned at 8:28 AM and again at 3:54 PM (7 1/2 hours). - 9/20/18- Resident #25 was repositioned at 1:10 AM and again at 12:20 PM (9 hours). - 9/22/18- Resident #25 was repositioned at 12:51 AM and again at 6:00 AM (5 hours). <p>Resident #25's ADL documentation documented similar findings for the remainder of September 2018.</p> <p>The 10/1/18 through 10/11/18 ADL Bed Mobility record documented the following:</p> <ul style="list-style-type: none"> -10/9/18- Resident #25 was repositioned at 1:33 PM and again at 7:21 PM (6 hours). - 10/10/18- Resident #25 was repositioned at | F 686 | | | |

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| F 686 | <p>Continued From page 48</p> <p>8:02 AM and again at 1:18 PM (5 hours) and at 2:43 PM and again at 7:34 PM (5 hours). - 10/11/18 Resident #25 was repositioned at 6:15 AM and again at 10:01 AM (4 hours).</p> <p>Resident #25's 10/1/18 through 10/8/18 ADL documentation documented similar findings.</p> <p>On 10/9/18 from 2:15 PM through 4:33 PM, Resident #25 was observed positioned in her wheelchair located in the activity room by the window without staff offering to reposition her or staff providing assistance with repositioning. Resident #25 was observed positioned in her wheelchair on 10/10/18 at 8:38 AM through 12:25 PM, on 10/10/18 at 1:58 PM, and on 10/11/18 from 6:54 AM through 10:01 AM, and 10:15 AM through 11:45 AM, and 12:50 PM through 3:25 PM.</p> <p>On 10/11/18 at 6:10 AM, Resident #25's wound care was observed. RN #1 was observed instructing CNA #1 to assist Resident #25 onto her left side from her back while in bed. CNA #1 rolled Resident #25 onto her left side and Resident #25 began to immediately cry out, "Oh, oh! That hurts!" CNA #1 reassured Resident #25 that she would not let her fall and adjusted her legs to try and help ease her pain. CNA #1 unfastened the brief on Resident #25's right hip and pulled it down to reveal an intact foam dressing at the midline of her coccyx. RN #1 began to remove the dressing and Resident #25 again cried out in pain and complained of pain. RN #1 continued to dispose of the old dressing and then used her gloved right hand to hold up Resident #25's right buttock to view the pressure ulcer. The pressure ulcer was observed located</p> | F 686 | | | |

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| F 686 | <p>Continued From page 49</p> <p>in the midline of Resident #25's coccyx at the top of the gluteal fold. The pressure ulcer measured approximately the size of a quarter with a depth of approximately 1.5 cm. The wound bed had a pale-yellow appearance with 30% stingy slough present that was moveable after cleansing. The wound was observed with no signs of infection, exudate, eschar, or tunneling of the pressure ulcer, but also no signs of granulation tissue, or re-epithelization. Wound margins were well-defined, with no undermining noted. The peri-wound skin was observed light pink in color with no signs and symptoms of irritation or infection, and no odors were noted. RN #1 disposed of the old dressing and she picked up a can of saline wound cleanser and sprayed the wound bed with a wound cleanser. RN #1 patted the pressure ulcer dry with a sterile 4 x 4 and removed her gloves, sanitized her hands, and re-gloved. While RN #1 was cleansing the wound Resident #25 continued to complain of pain and cry out, "That hurts." RN #1 covered Resident #25's pressure ulcer with a cut small piece of oil emulsion dressing, and with a self-adhering antimicrobial foam dressing.</p> <p>On 10/11/18 at 10:44 AM, the DNS stated the wounds to Resident #25's coccyx and buttock were both found in September 2018. The DNS stated the September 2018 assessment documented the wounds being previously identified was a mistake. The DNS stated she was unsure where that information came from. The DNS stated she was unsure what the wounds found in May 2018 were and she suspected these wounds healed and resolved without facility staff documenting resolution dates and updating the care plan. The DNS stated the</p> | F 686 | | | |

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| F 686 | Continued From page 50 staff should be completing a Wound Data Collection assessment when they resolve a wound. The DNS stated staff should notify her when new skin areas were found. The DNS stated she could see there was inconsistency with the documentation of the wounds. The DNS stated the facility did not have a wound certified nurse for wound care and all nurses on the floor completed wound assessments. The DNS stated the staff should be repositioning Resident #25 minimally every 3 hours, and she could see this was not documented as completed. | F 686 | | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure mechanical transfer sling was the correct size to reduce potential injuries. This was true for 1 of 5 residents (#25) reviewed for supervision and accidents. These failed practices placed residents at risk of bone fractures and other injuries related inappropriate use of a mechanical lift. Findings include: Resident #25 was admitted to the facility on 1/31/13, with diagnoses which included difficulty walking, muscle weakness, and pain. | F 689 | 1. Resident #25 was re-assessed using the Mobility UDA on 11/7/18. The need for staff assistance for transfer was obtained from the assessment, and the correct sling and sling size was identified. This information was added to the care plan on 11/7/18. Staff were informed when the change was made to the care plan on 11/7/18. 2. All residents upon admission will be assessed using the Mobility UDA to determine what type of assistance needed. The Safe Resident Handling | 11/30/18 | |

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| F 689 | <p>Continued From page 51</p> <p>A quarterly MDS assessment, dated 9/7/18, documented Resident #25 was cognitively intact and documented she required extensive assistance of one to two staff members with all cares except eating. The MDS documented Resident #25's experienced 1 fall since the last assessment.</p> <p>The care plan area addressing Resident #25's risk for falls, revised 6/6/18, documented Resident #25 was at risk of falling related to impaired mobility, a history of falls, weakness, and Alzheimer's.</p> <p>On 10/11/18 at 6:28 AM, Resident #25 was observed sitting in her wheelchair with CNA #1 assisting her with her morning cares. While CNA #1 wheeled Resident #25 into the bathroom, Resident #25 was crying out, "Ow, ow, ow, ow." CNA #1 proceeded to position Resident #25's wheelchair in the bathroom doorway, and asked Resident #25 stand up and reach for the assist bar on the wall by the toilet. Resident #25 was observed trying to stand up and stated, "Nope, I can't stand. Oh, it hurts so bad. It's hurting can you hold my feet. Its hurting so bad. My legs hurt, my whole-body hurts, God, that hurts." Resident #25 asked CNA #1 to "please use the Hoyer lift." CNA #1 left the room to obtain a mechanical lift.</p> <p>On 10/11/18 at 6:32 AM, CNA #1 returned with a sit-to-stand mechanical lift and placed a body sling around Resident #25's torso, just below her breasts. The CNA asked her to place her feet on the machine's foot plate, and hold onto the lift bars, which she did. Then CNA #1 lifted Resident #25 off her wheelchair and asked her to</p> | F 689 | <p>Program (SRHP) will be used to inform staff of specific mobility devices needed, sling sizes, and other assistive support devices needed. Resident will be re-assessed quarterly and with changes in resident condition. The care plan will be updated with any further or additional changes.</p> <p>3. The Interim DNS and the SDC will educate all nursing staff regarding the assessment process by 11/15/18. Staff will provide competency validation on using the SRHP with all the lifts and what type sling is needed for each lift. Staff will be shown on the care plan and kardex how and where to find the correct information. Staff will also be educated to inform the nurse immediately if they feel the current mobility equipment being used is no longer applicable for the resident so the resident can be re-assessed.</p> <p>4. The MDS coordinator will observe and audit transfers, bed mobility, dressing, grooming, and ambulation of residents to assure residents have been assessed and are using the correct assistive devices. If needed the resident will be re-assessed and the care plan and kardex will be updated. The audit will include the communication used to inform staff of changes and understanding by the staff of what each assistive device is and how it is used. These audits will be done weekly X4 and then monthly X3 with the MDS coordinator reporting audit findings to the QAPI committee on a monthly basis, the committee will determine if further auditing is needed.</p> | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 689 | <p>Continued From page 52</p> <p>stand so she could remove her incontinence brief. While Resident #25 was being lifted in the air she said, "Hurry, it hurts, ow, hurry it hurts." CNA #1 removed the soiled brief. Resident #25 stated she needed to sit down, and she was going to fall. CNA #1 stated she was almost done and assisted Resident #25 onto the toilet. Then the CNA removed the sling while Resident #25 used the toilet. After Resident #25 used the toilet and CNA #1 provided pericare, the CNA assisted her with applying a clean brief and clean pants.</p> <p>On 10/11/18 at 6:48 AM, CNA #1 was observed as she applied the sit-to-stand sling around Resident #25's torso, just below her breasts, and asked her to place her hands on the lift bars. The sling was slightly loose. As Resident #25 was raised up she cried out, "Ow, ow, ow, hurry, I'm going to fall, it hurts, it hurts, it hurts." As CNA #1 continued to move Resident #25 from the bathroom toward to her wheelchair, approximately 8 feet away, Resident #25 began to slide down into a sitting position, as the loose sling slid under her underarms, the strap/belt of the sling slid into her mouth gagging her, and the back of the sling curled up over her head. As CNA #1 continued to move Resident #25 towards the wheelchair, her legs were bent at a 45-degree angle and her buttocks was below the seat of the wheelchair. CNA #1 had to raise the sit-to-stand lift high enough in order to place Resident #25's bottom on the front part of her wheelchair seat. Then CNA #1 went around behind Resident #25 and pulled Resident #25's pants as leverage to position her all the way onto her wheelchair seat. Resident #25 appeared frightened, her eyes were opened wide and the sling strap was still in her mouth. When CNA #1</p> | F 689 | 5. Date certain 11/30/18. | | |

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| F 689 | <p>Continued From page 53</p> <p>removed the sling Resident #25 relaxed into her wheelchair and sighed deeply.</p> <p>On 10/11/18 at 6:50 AM, CNA #1 was observed notifying RN #1 that Resident #25 was acting different this morning. CNA #1 stated Resident #25 could not brush her own teeth and was different. RN #1 asked CNA #1 to take Resident #25's vitals and RN #1 would assess Resident #25's blood sugar.</p> <p>On 10/11/8 at 6:54 AM, RN #1 and CNA #1 checked Resident #25's blood sugar and vital signs, Resident #25's results were within normal limits.</p> <p>On 10/11/18 at 7:21 AM, CNA #1 stated Resident #25 was fearful of the sit-to-stand machine and she noticed it about 1 week ago. CNA #1 stated Resident #1 was afraid of falling. CNA #1 stated the facility had two-person Hoyer lifts they could use with a bed side commode for residents. CNA #1 stated Resident #25 started trying to sit down more yesterday and she was close to falling when CNA #1 assisted her on the edge of the bed. CNA #1 stated she had not told anyone about the incident yet. CNA #1 stated she had told RN #1 that Resident #25 was acting differently. CNA #1 stated she had not told the RN about Resident #25's sit-to-stand sling and Resident #25 "biting" the strap or her legs giving out on her or the incident on the previous day. CNA #1 stated she could have given the RN more information and she would. CNA #1 stated she thought Resident #25 was afraid of the sit-to-stand lift and falling because she had more falls recently. CNA #1 stated She could usually talk Resident #25 into using the lift and calm her</p> | F 689 | | | |

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| F 689 | Continued From page 54 down, she stated she was not sure what happened these last couple days. The care plan did not direct staff to use the sit-to-stand lift to transfer the resident between surfaces. On 10/11/18 at 10:44 AM, the DNS and the IDNS stated they would expect staff to report changes in a residents' condition to the nurse as soon as possible. The DNS stated the CNA #1 did talk to the RN after the surveyor spoke with the Aide. The DNS stated Resident #25 would be evaluated by therapy for strength for the most appropriate transfer and she would be placed on the fall committee. The DNS stated if the CNA noticed a change in Resident #25's ability to transfer on 10/10/18 she should have notified nursing. | F 689 | | | |
| F 697 SS=G | Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and review of residents' clinical records, it was determined the facility failed to ensure a method for evaluating the effectiveness of residents' pain management plans was in place. This was true for 1 of 5 residents (#25) reviewed for pain. Resident #25 was harmed | F 697 | 1. Resident #25 was re-assessed for pain on 11/7/18. The provider was notified on 11/8/18 and the following orders were received, Tylenol 650 mg TID for pain management. Family notified of medication change on 11/8/18. 2. All residents will be assessed for pain | 11/30/18 | |

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| F 697 | <p>Continued From page 55</p> <p>when she experienced increased pain during cares and a dressing change and the facility did not identify and treat it. Findings include:</p> <p>The facility's Pain Management Policy and Procedure, dated September 2012, documented when a resident was identified to be in pain a registered nurse would assess the residents current pain level and offer non-pharmacological interventions and provide medication interventions as needed.</p> <p>Resident #25 was admitted to the facility on 1/31/13, with diagnoses which included difficulty walking, muscle weakness, and pain.</p> <p>A quarterly MDS assessment, dated 9/7/18, documented Resident #25 was cognitively intact and documented she required extensive assistance of one to two staff members with all cares except eating. The MDS documented Resident #25's did not have pain.</p> <p>The care plan area addressing Resident #25's chronic pain, revised 6/6/18, documented Resident #25 had generalized pain and could verbalize her pain.</p> <p>The care plan area addressing Resident #25's pressure ulcer, initiated 4/14/17, documented Resident #25 had a Stage II pressure injury to her coccyx and a DTI to her buttock.</p> <p>Resident #25's Physician Orders Included the following: * Staff were to monitor her pain every shift, ordered 5/16/18. * 650 mg of Tylenol by mouth every 6 hours PRN</p> | F 697 | <p>on admission, and on-going daily or more frequently as determined by their condition. CNA staff will report to nursing when a resident is showing signs of pain. Residents will be assessed for the need of analgesic prior to therapy, a potentially painful treatment such as wound care, in early mornings if a resident has difficulty getting up, and in the evening if a resident has trouble sleeping. Residents showing behaviors or mood disorders will also be assessed for pain as needed/indicated. Providers will be informed of assessment findings and pharmacological and non-pharmacological interventions will be implemented.</p> <p>3. The DNS and SDC will educate all staff by 11/15/18 regarding pain and how residents may express or exhibit pain through verbalization, non-verbal signs and mood and/or behaviors. Education will include the use of non-pharmacological interventions that may be effective to relieve pain. The PAINAD will be shared with staff as an example of what non-verbal residents may display when in pain. Staff will be educated on using the Stop and Watch tool, and to verbally share with a nurse when they see signs and symptoms of a resident in pain.</p> <p>4. The MDS coordinator will audit all residents who trigger for pain. The audit will include if pain was assessed and the follow-up that occurred. A review of physician orders will be included in this audit to identify what analgesic has been ordered and if it is effective. The audit will</p> | | |

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| F 697 | <p>Continued From page 56 for pain, ordered 7/27/17.</p> <p>Resident #25 did not have orders for scheduled pain medications.</p> <p>The Wound Data Collection Assessments from 9/20/18, 9/24/18, 9/30/18, 10/3/18, 10/4/18, 10/6/18, 10/7/18, and 10/11/18 documented Resident #25 complained of pain during the dressing changes.</p> <p>Resident #25's Weekly Skin Observation Assessment, dated 9/18/18, documented Resident #25 had a deep tissue injury to her left buttock. The assessment documented the facility changed out the cushion on her wheelchair and planned to reposition her every 3 hours.</p> <p>On 10/11/18 at 6:10 AM, Resident #25's wound care was observed. RN #1 was observed instructing CNA #1 to assist Resident #25 onto her left side from her back while in bed. CNA #1 rolled Resident #25 onto her left side and Resident #25 began to immediately cry out, "Oh, oh! That hurts!" CNA #1 reassured Resident #25 that she would not let her fall and adjusted her legs to try and help ease her pain. CNA #1 unfastened the brief on Resident #25's right hip and pulled it down to reveal an intact foam dressing at the midline of her coccyx. RN #1 began to remove the dressing and Resident #25 again cried out in pain and complained of pain. RN #1 continued to dispose of the old dressing and then used her gloved right hand to hold up Resident #25's right buttock to view the pressure ulcer. RN #1 disposed of the old dressing and she picked up a can of saline wound cleanser and sprayed the wound bed with a wound</p> | F 697 | <p>also include the use of the Stop and Watch and verbal reports of resident pain to the nursing staff. The care plans will be audited to assure non-pharmacological interventions have been added. These audits will be done weekly X4 and then monthly X3 with the MDS coordinator reporting the findings to the QAPI committee monthly, the committee will determine if further auditing is needed.</p> <p>5. Date certain 11/30/18.</p> | | |

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| F 697 | <p>Continued From page 57</p> <p>cleanser. RN #1 patted the pressure ulcer dry with a sterile 4 x 4 and removed her gloves, sanitized her hands, and re-gloved. While RN #1 was cleansing the wound Resident #25 continued to complain of pain and cry out, "That hurts."</p> <p>While the wound care was being provided, Resident #25 stated the pain was located in, "My back, and from the wound when they clean it." Resident #25 stated staff had not provided pain medication prior to wound care nor offered. Resident #25 stated, "No, but that would probably help."</p> <p>On 10/11/18 at 6:27 AM, RN #1 was observed leaving Resident #25's room. RN #1 stated she had just given Resident #25 Tylenol for pain.</p> <p>On 10/11/18 at 6:28 AM, Resident #25 was observed sitting in her wheelchair with CNA #1 assisting her with her morning cares. While CNA #1 wheeled Resident #25 into the bathroom, Resident #25 was crying out, "Ow, ow, ow, ow." CNA #1 proceeded to position Resident #25's wheelchair in the bathroom doorway, and asked Resident #25 stand up and reach for the assist bar on the wall by the toilet. Resident #25 was observed trying to stand up and stated, "Nope, I can't stand. Oh, it hurts so bad. It's hurting can you hold my feet. Its hurting so bad. My legs hurt, my whole body hurts, God, that hurts." Resident #25 asked CNA #1 to "please use the Hoyer lift." CNA #1 left the room to obtain a mechanical lift.</p> <p>On 10/11/18 at 6:32 AM, CNA #1 returned with a sit-to-stand mechanical lift and placed a body sling around Resident #25's torso, just below her</p> | F 697 | | | |

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| F 697 | <p>Continued From page 58</p> <p>breasts. The CNA asked her to place her feet on the machine's foot plate, and hold onto the lift bars, which she did. Then CNA #1 lifted Resident #25 off her wheelchair and asked her to stand so she could remove her incontinence brief. While Resident #25 was being lifted in the air she said, "Hurry, it hurts, ow, hurry it hurts." CNA #1 removed the soiled brief. Resident #25 stated she needed to sit down, and she was going to fall. CNA #1 stated she was almost done and assisted Resident #25 onto the toilet. Then the CNA removed the sling while Resident #25 used the toilet. After Resident #25 used the toilet and CNA #1 provided pericare, the CNA assisted her with applying a clean brief and clean pants.</p> <p>On 10/11/18 at 6:48 AM, CNA #1 was observed as she applied the sit-to-stand sling around Resident #25's torso, just below her breasts, and asked her to place her hands on the lift bars. The sling was slightly loose. As Resident #25 was raised up she cried out, "Ow, ow, ow, hurry, I'm going to fall, it hurts, it hurts, it hurts."</p> <p>On 10/11/18 at 6:35 AM, RN #1 stated she had not administered pain medications prior to Resident #25's wound dressing change. RN #1 stated she had not spoken with Resident #25's physician about obtaining a pre-treatment pain medication order. RN #1 stated, "Giving her [the resident] pain medication at about 5:00 AM every morning would probably work well."</p> <p>On 10/11/18 at 10:45 AM, the DNS stated she would expect the staff to pre-medicate Resident #25 prior to the dressing change. The DNS stated the nurse told her about the resident's complaint of pain during the dressing change and</p> | F 697 | | | |

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| F 697 | Continued From page 59 that Resident #25 had not complained of pain during dressing changes in the past. The DNS stated she would expect staff to wait for pain medications to be effective before providing cares and if a resident verbalized pain during the dressing change or cares the staff should stop and try and address the situation. | F 697 | | | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending | F 756 | | 11/30/18 | |

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| F 756 | <p>Continued From page 60</p> <p>physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. 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 pharmacy recommendations were followed or addressed by the attending physician. This was true for 1 of 5 residents (#14) reviewed for pharmacy recommendations and had the potential for harm if residents' medications were administered without a clinical rationale. Findings include:</p> <p>Resident #14 was admitted to the facility on 8/1/16, with diagnoses which included dementia with behavioral disturbances and depression.</p> <p>A quarterly MDS assessment, dated 8/9/18, documented Resident #14 was cognitively intact and she had minimal signs and symptoms of depression. The MDS documented she had no behaviors.</p> <p>The care plan area addressing Resident #14's depression, revised 9/13/17 documented Resident #14's depression presented by tearfulness, self-isolation, statements of loss of home and possessions, and independence.</p> | F 756 | <ol style="list-style-type: none"> 1. Resident # 14 was re-assessed by the SSD and nursing for signs and symptoms of depression on 11/7/18. The physician was notified 11/7/18 of the pharmacy recommendation for a dose reduction and the medication dose is now reduced to 5 mg PO daily from 10mg. 2. All residents will be reviewed by the consulting pharmacist monthly including a medical record review. When a pharmacy recommendation is written it will be given to the DNS who will inform the provider as soon as possible. The DNS will monitor for a response from the provider and implement ordered changes. The center will also hold monthly reviews of all psychoactive medications and inform the providers if changes are noted. Families will also be informed with these changes. 3. The pharmacy consultant will provide education to all nursing and SS staff, explaining the use of psychoactive medications, potential side-effects, how the pharmacist will communicate changes to nursing and SS, and how nursing will provide these recommendation to the | | |

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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 756 | Continued From page 61 A Physician's Order, dated 9/13/17, documented Resident #14 received Lexapro 10 mg once daily for depression. Resident #14's 9/1/18 through 10/10/18 MAR documented she was administered her Lexapro as ordered. A pharmacy recommendation form, unsigned by the physician, dated 4/30/18, documented Resident #14's Lexapro was currently at 10 mg daily and Resident #14 had not displayed any signs and symptoms of depression for several months. The form documented the GDR team recommended a trial dose reduction to 5 mg of Lexapro. On 10/11/18 at 11:26 AM, the DNS stated if a resident did not exhibit behaviors for a few months then the committee would make a recommendation to attempt a GDR of the medication. On 10/11/18 at 1:55 PM, the LSW stated she could not find evidence the GDR was attempted for Resident #14's Lexapro. The LSW stated she was not sure why it was not completed. The LSW stated Resident #14 would be reviewed in the next GDR committee meeting. | F 756 | provider. This education will occur by 11/15/18. 4. The DNS and SS will audit all residents currently receiving psychoactive medications to determine when the last dose reduction was completed. The pharmacist and provider will be informed if a dose reduction has not been attempted within the past 6 months and efforts will be made to reduce the medication safely. The audit will also include monitoring of potential side effects. This audit will be done weekly X4 and them monthly X3 with the DNS or SS reporting audit findings to the QAPI committee monthly, the committee will determine if further auditing is needed. 5. Date certain 11/30/18. | | |
| 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: | F 758 | | 11/30/18 | |

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| F 758 | <p>Continued From page 62</p> <p>(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 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</p> | F 758 | | | |

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| F 758 | <p>Continued From page 63</p> <p>prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and facility policy review, it was determined the facility failed to a) attempt GDR of psychotropic medications b) monitor behavioral symptoms , obtain informed consents for the medications. This was true for 3 of 5 residents (#1, #5, and #25) reviewed for unnecessary medications. This deficient practice had the potential for harm should residents receive unnecessary psychotropic medications which were not adequately monitored. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 12/1/11, with diagnoses which included dementia with behavioral disturbances, anxiety, depression, borderline personality disorder, and pseudobulbar affect (sudden crying/laughing).</p> <p>A quarterly MDS assessment, dated 7/3/18, documented Resident #1 had a severe cognitive impairment and she displayed inattentive and disorganized thinking. The MDS documented she had minimal signs and symptoms of depression and no behaviors such as wandering.</p> <p>The care plan area addressing Resident #1's antipsychotic medication, revised 12/8/16, documented Resident #1 required the medication due to dementia with behavioral disturbances, anxiety disorder, and borderline personality disorder as evidenced by angry out-burst, agitation, crying, and threatening behavior.</p> <p>The care plan area addressing Resident #1's</p> | F 758 | <p>1. Resident #1's Seroquel dose was reviewed by pharmacy, nursing, and social services on 11/7/18. The provider was notified on 11/8/18. Physician recommends no change to medication at this time. Specific behavior monitors were added to the care plan for CNA documentation completed on 11/8/18. Resident #25 has consent for the use of Trazodone by family placed in her medical record on 11/8/18. Resident #5's medical records were reviewed on 11/8/18 by nursing and social services and pharmacy. GDR committee met on 11/8/18 to review resident #5 for a possible GDR. Upon review resident has displayed increased wandering, Pharmacist does not recommend a GDR at this time. The provider was notified of Pharmacist recommendation on 11/8/18. The care plan was updated with new interventions.</p> <p>2. All residents admitted to the center with psychoactive medications will be assessed carefully with the care plan interventions in place to monitor for side-effects, a consent signed with educations given to residents and family members regarding the medication, and interventions to assist residents when behaviors are seen. The pharmacy consultant will review each resident monthly and work with the center team to determine when Gradual Dose</p> | | |

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| F 758 | <p>Continued From page 64</p> <p>dementia, revised 10/26/17, documented Resident #1 had poor safety awareness, wandered into other residents' personal spaces, and had a history of negative resident to resident interactions.</p> <p>a. A GDR was not attempted for Resident #1's Seroquel as follows:</p> <p>A Physician's Order, dated 8/26/16, documented Resident #1 received Seroquel 25 mg twice daily for anxiety related to borderline personality disorder.</p> <p>Resident #1's Physician Orders included Seroquel 25 mg twice daily for anxiety related to dementia with behavioral disturbances and borderline personality disorder, ordered 8/3/17.</p> <p>Resident #1's 3/1/18 through 10/10/18 MAR documented she was administered her Seroquel as ordered.</p> <p>Resident #1's GDR Review, dated 5/1/18, documented her Seroquel was at 25 mg twice daily and the team discussed the recommendations of a hospice and psych evaluation. The note documented Resident #1 was not appropriate for either evaluation at this time. The note documented the GDR committee would continue to monitor and make recommendations for Resident #1's care. Resident #1's GDR evaluation did not review specific behavior or identify she had been on the Seroquel dose 25 mg twice daily for two years without an attempt at reducing the medication.</p> <p>The review did not evaluate Resident #1 for how</p> | F 758 | <p>Reductions (GDR) are appropriate.</p> <p>3. The pharmacy consultant will provide education to nursing and social service staff by 11/15/18 explaining the use of psychoactive medications, potential side-effects, the need provide education to family members and residents regarding these medications and the need to obtain informed consent. Education will also include the need for specific interventions for staff to attempt when residents are dealing with mood and behavior problems.</p> <p>4. SS and the DNS will audit all residents receiving psychoactive medications to assure education has been given and a signed consent is in the record. The audit will also include a review of the care plan to assure proper and specific interventions are in place for staff to assist residents if mood or behavior problems are seen. The audit will include a review of the most recent GDR and with assistance from the pharmacy consultant the center team will determine if a safe dose reduction is indicated. Side-effect monitoring will also be audited. These audits will be done weekly X4 and then monthly X3 with the SS reporting audit findings to the QAPI committee monthly, the committee will determine if further audits are needed.</p> <p>5. Date certain 11/30/18.</p> | | |

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| F 758 | <p>Continued From page 65</p> <p>many episodes/behaviors of anxiety, wandering, physical or verbal aggression she had experienced during the look back period.</p> <p>On 10/11/18 at 9:07 AM, the LSW stated she was not sure why Resident #1 was on Seroquel for anxiety with a diagnosis of dementia. The LSW stated Resident #1 cried often, was paranoid of the color red, scared to be alone, could not sleep well at night, and would take a hold of staff members arms and not want to let go. The LSW stated the facility practice was to start residents on Melatonin if they could not sleep to try that first before starting residents on antipsychotic medications. The LSW stated there was no documentation that a GDR trial of Resident #1's Seroquel had been completed. The LSW stated she would discuss Resident #1 in the next committee meeting.</p> <p>On 10/11/18 at 9:57 AM, the LSW stated the medication should be provided for borderline personality disorder and was monitored for other behaviors a few years ago. The LSW stated she added Resident #1 to the GDR review list for next month. The LSW stated she was unsure why Resident #1's diagnosis for the medication had changed to dementia with behaviors. The LSW stated she did not know why Resident #1's Seroquel had not been adjusted since 2016. The LSW stated the GDR committee consisted of the LSW, the pharmacist, the DNS, and the MD as needed. The LSW stated the committee reviewed each resident in the facility on antipsychotic medications each month. The LSW stated she could see the GDR reviews were not specific with identifying and reviewing behaviors a resident was experiencing in order to inform the physician</p> | F 758 | | | |

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| F 758 | <p>Continued From page 66 on whether to keep a medication or not.</p> <p>On 10/11/18 at 11:26 AM, the DNS stated residents' psychotropic medications should be start low and go slow to find the appropriate dose after non-pharmacological options have been exhausted. The DNS stated residents require medications when they have psych diagnoses and or were harmful to self or others. The DNS stated the facility could send residents out and could provide some behavioral counseling for residents. The DNS stated the GDR process involved the DNS, SW, Pharmacy, and the MD was involved as needed. The DNS stated they reviewed all psychotropic medications in the building for issues. The DNS stated if a resident did not exhibit behaviors for a few months then the committee would make a recommendation to attempt an GDR of the medication.</p> <p>b. Resident #1's behavior monitors did not match as follows:</p> <p>Resident #1's 3/1/18 through 10/10/18 MAR documented staff monitored Resident #1 for verbal and physical aggression, inconsolable distress/crying, and wandering into other residents' spaces. The MAR documented she experienced the following behaviors.</p> <ul style="list-style-type: none"> - Verbal or physical aggression directed at others- 9/30/18 - Inconsolable distress/crying- 10/4/18 - Wandering- 7/8/18 <p>Resident #1's 9/1/18 through 10/10/18 ADL Flowsheets documented behaviors witnessed by CNA staff. The CNA staff documented different</p> | F 758 | | | |

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| F 758 | <p>Continued From page 67</p> <p>behaviors from the nursing staff. The following behaviors were monitored by the CNAs.</p> <ul style="list-style-type: none"> - Physical directed towards other- hitting, kicking, pushing, scratching, grabbing, sexual abuse, biting, and no behavior. Resident #1 was documented to have hit towards others on 9/5/18, 9/8/18, 9/22/18, 9/29/18, 10/3/18, 10/8/18, and 10/9/18. Resident #1 was documented to push others twice on 9/4/18. Resident #1 was documented to scratch at other on 9/4/18. Resident #1 was documented to grab at others once on 9/6/18 and 9/7/18 and twice on 9/9/18. - Verbal directed towards others- threatening others, screaming at others, cursing at others, sexual comments, and no verbal behaviors. Resident #1 was documented as threatening others on 9/20/18. Resident #1 was documented as cursing at others on 9/5/18, 9/8/18, 9/9/18, 9/12/18, 9/22/18, 9/29/18, and 10/3/18. - Behaviors not directed at others- hitting self, scratching self, pacing, rummaging, public sexual act, disrobing in public, throwing or smearing food or bodily waste, screaming, disruptive sounds, exit seeking, and no behaviors. Resident #1 was documented as exit seeking on 9/5/18. - Did the residents reject care- yes or no. Resident #1 was documented to have rejected cares once on 9/4/18, 9/8/18, 9/22/18, 10/3/18, and 10/9/18, and twice on 9/5/18 and 9/9/18. - Had the resident wandered- yes or no. Resident was documented to have wandered on 9/5/18. - Was this the first-time the behavior occurred- | F 758 | | | |

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| F 758 | <p>Continued From page 68</p> <p>yes or no. There were no first-time behaviors documents.</p> <p>The CNAs were not monitoring Resident #1 for crying.</p> <p>On 10/11/18 at 9:07 AM, the LSW stated the CNAs documented residents' behaviors in their system and the system behaviors could not be changed. The LSW stated the CNA behavior monitors were identical facility wide and she would figure out to match the residents' behaviors with the nurses behavior monitors.</p> <p>2. Resident #25 was admitted to the facility on 1/31/13, with diagnoses which included depression.</p> <p>A quarterly MDS assessment, dated 9/7/18, documented Resident #25 was cognitively intact and documented she required extensive assistance of one to two staff members with all cares except eating.</p> <p>The care plan area addressing Resident #25's depression, revised 7/11/18, documented Resident #25's depression presented as withdrawing from activities of choice and accusing others of taking her things.</p> <p>Resident #25's Physician Orders included Trazodone 50 mg every evening for depression, ordered 4/24/17.</p> <p>Resident #25's 5/1/18 through 10/10/18 MAR documented she was administered her Trazodone as ordered.</p> | F 758 | | | |

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| F 758 | <p>Continued From page 69</p> <p>Resident #25's clinical record did not contain a consent for the Trazodone.</p> <p>On 10/11/18 at 2:21 PM, the LSW stated she could not locate Resident #25's consent for the Trazodone. The LSW stated the facility noticed a few months ago that consents were not completed and they tried to complete them all. The LSW stated Resident #25 had a care conference planned in a few weeks and she would obtain a consent for the medication at that time.</p> <p>3. Review of Resident 5's undated "Admission Record" and undated "Medical Diagnosis" form indicated the facility admitted the resident on 05/16/17 with a primary diagnosis of vascular dementia with behavioral disturbance.</p> <p>Review of Resident 5's quarterly "Minimum Data Set (MDS)," an assessment tool completed by the facility staff used to identify resident care problems and assist with care planning, with an "Assessment Reference Date (ARD)," the end-point of the evaluation period, of 07/10/18, specified under "Section C: Cognitive Patterns," Resident 5 had "severely impaired" cognitive skills and exhibited continuous inattention and disorganized thinking. "Section E: Behavior," indicated the resident exhibited physical and verbal behaviors toward others, and behaviors not directed toward others on one to three days of the assessment's seven-day look-back period. "Section N: Medications," indicated the resident received antipsychotic medication on all seven days of the assessment's seven-day look-back period.</p> | F 758 | | | |

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| F 758 | Continued From page 70 Review of Resident 5's September 2018 "Physician Orders" indicated Resident 5 received, Zyprexa (an antipsychotic medication) 10 milligrams (mg) daily at bedtime "related to dementia . . . with behavioral disturbance" (ordered on 04/06/18). Further review of the orders indicated the physician decreased the resident's Zyprexa dose to 5 mg daily at bedtime on 09/05/18 for "dementia . . . with behavioral disturbance." The orders also directed the staff to, "Monitor the following behaviors: T = tearfulness, P = pacing up and down the hallways, I = physically intrusive in others' personal space every shift for behavioral monitoring" (ordered 05/16/18). A review of Resident 5's "Medication Administration Records (MARs)" from 09/05/18 through 10/11/18 indicated the nursing staff documented Resident 5 exhibited no signs or symptoms of tearfulness, pacing up and down the hallways, or of being physically intrusive on others' personal space. During an interview on 10/12/18, the Social Services Director (SSD) stated Resident 5 used to walk and wander in and out of other residents' rooms, then became too unsteady when walking and began using a wheelchair for locomotion. The SSD stated Resident 5 no longer goes in other residents' rooms, but continues to receive antipsychotic medication. | F 758 | | | |
| F 812 SS=F | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - | F 812 | | 11/30/18 | |

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| F 812 | <p>Continued From page 71</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions when a staff member was observed in the kitchen without a hair restraint. This affected 12 of 12 residents (#1, #2, #3, #4, #5, #6, #8, #14, #18, #23, #25, and #27) and had the potential to affect the remaining 15 residents who dined in the facility. This failure created the potential for contamination of food and exposed residents to potential disease-causing pathogens. Findings include:</p> <p>The 2013 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, documented, "(A) Except as provided in (B) of this section, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing</p> | F 812 | <ol style="list-style-type: none"> Staff #1 was educated immediately by the CDM about the use of hair restraints. All dietary staff was educated on the GSS policy/procedure and food code that pertains to hair restraints, including the use of facial hair restraints by the CDM on 10/17/18. All residents have the potential to be affected. Hair restraints, including facial hair restraints, have been placed outside of the kitchen. Location of the hair restraints is clearly marked for all individuals to use before entering the kitchen. All staff will be educated by 11/15/18 by the CDM on the requirement to wear hair restraints in the kitchen and the location of the hair restraints. Auditing the use of hair restraints | | |

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| F 812 | Continued From page 72 that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food..." On 10/10/18 at 1:30 PM, Cook #1 was observed entering the kitchen, without a hair restraint to cover his hair. On 10/10/18 at 1:35 PM, Cook #1 was observed leaving the kitchen, without a hair restraint to cover his hair, and he was holding a pie. On 10/10/18 at 1:45 PM, the Certified Dietary Manager (CDM) stated she would ensure hair restraints were worn. | F 812 | while in the kitchen will be completed by the CDM or designee weekly x4, monthly x3. Audit findings will be reported to the QAPI committee monthly, the QAPI committee will determine if further auditing is needed. 5. Date certain 11/30/18. | | |
| F 842 SS=E | 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 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized | F 842 | | 11/30/18 | |

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| F 842 | <p>Continued From page 73</p> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <ul style="list-style-type: none"> (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. <p>§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"> (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. <p>§483.70(i)(5) The medical record must contain-</p> <ul style="list-style-type: none"> (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; | F 842 | | | |

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| F 842 | <p>Continued From page 74</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure accurate and complete clinical records were maintained for each resident. This was true for 5 of 5 residents (#7, #9, #18, #26, and #27) whose immunization records were reviewed. This created the potential for harm should inappropriate care and/or treatment be provided based on inaccurate information in the resident's clinical record. Findings include:</p> <p>1. Resident #27 was admitted to the facility on 6/29/15, with diagnoses which included dementia with behavioral disturbances and Parkinson's disease.</p> <p>Resident #27's Immunization Record documented she received the Pneumococcal Polysacchriade (PPSV23) historically and the Pneumococcal Conjugated (PCV13) on 6/26/18. The immunization record documented consent was obtained for the shots, however, Resident #27's clinical record did not contain evidenced of a signed or verbal consent for the vaccines. There was no record of when the consent was obtained, who obtained the consent, if it was verbal, or if the risk verses benefits were discussed with the resident.</p> | F 842 | <ol style="list-style-type: none"> 1. Facility is unable to go back and obtain consents, either written or verbal for immunizations given previous to survey for residents #7, 9, 18, 26, and 27. Families were notified by the RN on 11/8/18 about the vaccinations that were administered for residents #7, 9, 18, 26, and 27. 2. All residents or their designee will provide informed consents prior to any future vaccinations. 3. The DNS will educate all licensed nurses by 11/15/18. Education will include LN responsibility for discussing risk vs benefits with responsible parties and obtaining informed consents prior to vaccination. 4. The DNS or designee will audit all new vaccination orders and ensure the informed consent is provided. Audits will be done weekly x4, monthly x3. Audit findings will be reported to the QAPI committee monthly, the QAPI committee will determine if further auditing is needed. 5. Date certain 11/30/18 | | |

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

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| F 842 | <p>Continued From page 75</p> <p>2. Resident #9 was admitted to the facility on 5/20/05, with diagnoses which included multiple sclerosis.</p> <p>Resident #9's Immunization Record documented she received the Pneumovax Dose 1 (PCV13) historically and the Pneumococcal 13-valent Conjugated (Prevnar 13) on 6/27/18. The immunization record documented consent was obtained for the shot, however, Resident #9's clinical record did not contain evidenced of a signed or verbal consent was obtained for the vaccine. There was no record of when the consent was obtained, who obtained the consent, if it was verbal, or if the risk verses benefits were discussed with the resident.</p> <p>3. Resident #7 was admitted to the facility on 8/10/17, with diagnoses which included weakness and Raynaud's syndrome.</p> <p>Resident #7's Immunization Record documented he received the Pneumococcal Conjugated (PCV13) historically and Pneumococcal Polysacchriade (PPSV23) on the 10/9/18. The immunization record documented consent was obtained for the shots, however, Resident #7's clinical record did not contain evidenced of a signed or verbal consent for the vaccines. There was no record of when the consent was obtained, who obtained the consent, if it was verbal, or if the risk verses benefits were discussed with the resident.</p> <p>4. Resident #18 was admitted to the facility on 6/7/16, with diagnoses which included acute respiratory disease, heart failure, and pain.</p> | F 842 | | | |

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| F 842 | Continued From page 76 Resident #18's Immunization Record documented she received the Pneumococcal Polysacchriade (PPSV23) historically and the Pneumococcal Conjugated (PCV13) on 6/26/18. The immunization record documented consent was obtained for the shots, however, Resident #18's clinical record did not contain evidenced of a signed or verbal consent for the vaccines. There was no record of when the consent was obtained, who obtained the consent, if it was verbal, or if the risk verses benefits were discussed with the resident. 5. Resident #26 was admitted to the facility on 11/7/11, with diagnoses which included chronic kidney disease and pain. Resident #26's Immunization Record documented she received the Pneumococcal Conjugated (PCV13) on 6/26/18. The immunization record documented consent was obtained for the shots, however, Resident #26's clinical record did not contain evidenced of a signed or verbal consent for the vaccines. There was no record of when the consent was obtained, who obtained the consent, if it was verbal, or if the risk verses benefits were discussed with the resident. On 10/12/18 at 10:15 AM, the DNS stated she did not have the consent forms for the Pneumococcal immunizations. | F 842 | | | |
| F 880 SS=D | Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program | F 880 | | 11/30/18 | |

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| F 880 | <p>Continued From page 77</p> <p>designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> (A) The type and duration of the isolation, depending upon the infectious agent or organism | F 880 | | | |

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| F 880 | <p>Continued From page 78 involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 2 of 12 (#25 and #27) residents reviewed for infection control when staff failed to adequately perform effective hand hygiene during residents' cares and dressing changes. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include</p> | F 880 | <ol style="list-style-type: none"> 1. Careful observation of provision of care for residents #25 and 27 is in progress, including wound care and ADL's. 2. All residents will be randomly observed during provision of care for adequate infection prevention practices by the DNS or designee. 3. All staff will be educated on adequate infection prevention practices by 11/15/18. Education will include the importance of proper hand hygiene during | | |

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| F 880 | <p>Continued From page 79</p> <p>1. During observation of pressure ulcer wound care for Resident #25 on 10/11/18 at 6:10 AM, RN #1 checked the resident's wound care orders and retrieved wound care supplies from the medication cart. RN1 then entered the resident's room and setup a clean field for the wound care supplies. RN #1 sanitized her hands and donned gloves. After CNA #1 positioned the resident to the left side and unfastened the resident's brief, RN #1 removed a dressing from the resident's coccyx (lower back) and discarded the old dressing. Then without first removing her contaminated gloves, sanitizing her hands, and re-gloving, RN #1 picked up a can of saline wound cleanser and sprayed Resident 25's pressure ulcer with the wound cleanser, cleansed the ulcer with a sterile gauze pad, and then patted the ulcer with a clean gauze pad to dry the area. RN #1 then removed her gloves, sanitized her hands, re-gloved, and continued with the application of a new dressing.</p> <p>During an interview on 10/11/18 at 10:45 AM, the DNS stated she expected the nursing staff to remove their gloves, sanitize their hands, and re-glove after removing the old dressing and before cleaning and re-dressing a wound. Upon conclusion of the interview with the DNS, a request was made for the facility's policy and procedure for infection control, hand hygiene/sanitization, and glove use during wound care; however, the policy was not provided prior to the survey's exit conference on 10/12/18.</p> <p>2. On 10/9/18 at 2:32 PM, CNA #2 was observed assisting Resident #27 to the bathroom. Resident #27 was sitting in a recliner chair and was assisted into her wheelchair to assist with</p> | F 880 | <p>wound care and ADL's, and nursing staff will provide return demonstration. Education will also will include the importance of offering residents hand hygiene during cares.</p> <p>4. The DNS or designee will audit hand washing during provision of cares randomly weekly x4, monthly x3. Audit findings will be reported to the QAPI committee mothly, the QAPI committee will determine if further auditing is needed</p> <p>5. Date certain 11/30/18.</p> | | |

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| F 880 | <p>Continued From page 80</p> <p>wheeled Resident #27 into the bathroom. CNA #2 asked Resident #27 to please stand and use the grab bar on the wall. Resident #27 stood, and CNA #2 removed Resident #27's pants and briefs to finish assisting her onto the toilet. CNA #2 left the bathroom for Resident #27 to complete her task, and when Resident #27 was finished, CNA #2 entered the bathroom, assisted with pericare, and pulled up Resident #27's drawers. CNA #2 assisted Resident #27 into the wheelchair and wheeled her out of the bathroom. CNA #2 removed her gloves and wheeled Resident #27 out into the activity room. Resident #27 was not offered to wash her hands after she finished using the restroom.</p> <p>On 10/12/18 at 11:36 AM, the DNS stated staff should wash their hands before starting cares, apply gloves, then provide pericare, then remove their gloves, sanitize, re-glove, assist with clothing, and then assist the resident with washing their hands.</p> | F 880 | | | |



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LICENSING & CERTIFICATION
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June 24, 2019

Michael Neubauer, Administrator
Good Samaritan Society - Silver Wood Village
405 West Seventh Street, Po Box 358
Silverton, ID 83867-0358

Provider #: 135058

Dear Mr. Neubauer:

On **October 12, 2018**, an unannounced on-site complaint survey was conducted at Good Samaritan Society - Silver Wood Village. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007950

ALLEGATION #1:

The facility failed to ensure residents were provided with appropriate oxygen therapy and assistance to get into bed.

FINDINGS #1:

An unannounced onsite complaint and recertification survey was conducted from 10/9/18 - 10/12/18. During the survey six resident records were reviewed, observations were conducted, residents were interviewed, and staff were interviewed.

During the observations the residents who required oxygen did not exhibit signs of oxygen deficits and staff were observed checking and refilling residents' oxygen regularly throughout

observations.

Two residents were interviewed regarding their oxygen therapy. The residents stated they had not experienced their oxygen running out for extended periods of time, and when it was low the staff replaced or refilled their tanks.

The residents observed at night were in their beds or were observed to watch television in the day room. The residents observed in the day room at night stated if they wanted to get up in the middle of the night the facility staff accommodated their requests. Two residents, who could speak for themselves, stated the facility had never left them up in their wheelchair for extended periods of time at night and Certified Nursing Assistants (CNAs) said if they noticed a resident sleeping in a chair, they offered to move the resident to a bed.

Six out of six resident records reviewed did not document any concern regarding a lack of appropriate oxygen therapy or assistance to get into bed. For example, the record for one resident, admitted August 2017, included a discharge summary from the facility, dated 4/27/18. The discharge summary documented the resident had a terminal diagnosis of chronic obstructive pulmonary disease (COPD) and was on hospice. The summary and multiple nursing notes documented the resident preferred to stay up in his wheelchair or to sit in a recliner chair in the day room for extended periods of time due to his issues with breathing. The notes documented the resident received 5 liters of oxygen continuously and used a bi-pap at night. Multiple progress notes dated between 1/1/18 and 4/27/18 documented the resident had increased shortness of breath, an overall decline in status, and had more complaints of air hunger. The progress notes documented the family was notified of the changes to the resident's condition. No documentation related to the resident running out of oxygen was present in progress notes.

When asked about the resident, several CNAs stated the resident preferred to be up in his wheelchair or a recliner because of his breathing issues. The CNAs said they did not recall an instance when the resident was left up in his wheelchair against his will. The CNAs stated the resident would ask staff to leave him alone and let him sleep in his chair at times. The CNAs stated the resident wore oxygen continuously and the staff would change out his oxygen canister a couple of times a day. The staff stated they checked the oxygen level at the beginning of their shifts, at meal times, when vitals were completed, and if the resident was flushed. The nurse stated the resident had a decline in his overall health towards the end of his stay at the facility, which was why he was placed on hospice. The nurse stated his COPD was advanced and he sometimes had a difficult time maintaining his oxygen saturation level. The nurses stated for those instances he was provided breathing treatments, an inhaler, and he preferred to remain upright. One nurse stated the night before he discharged from the facility, the resident stayed up in the day room at night and watched the television. The nurse stated the resident voiced concerns of being unable to breathe and was provided breathing treatments. The nurse stated the resident increased his oxygen level to 12 liters per minute and she had to turn it down and refill

Michael Neubauer, Administrator
June 24, 2019
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his oxygen more often. The nurse stated the resident refused to go to his room when he started to drift off to sleep.

CONCLUSIONS:

It could not be determined that the facility failed to ensure residents were provided with appropriate oxygen therapy and assistance to get into bed. Therefore, the allegation was unsubstantiated and no deficiencies were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson".

LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/slj