



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
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October 26, 2018

Monte Jones, Administrator
Rexburg Care & Rehabilitation Center
660 South Second Street West,
Rexburg, ID 83440-2300

Provider #: 135105

Dear Mr. Jones:

On **October 12, 2018**, a survey was conducted at Rexburg Care & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance 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.

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 5, 2018**. Failure to submit an acceptable PoC by **November 5, 2018**, may result in the imposition of civil monetary penalties by **November 28, 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):

Civil money penalty,

Denial of payment for new admissions effective January 12, 20102

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 5, 2018**. If your request for informal dispute resolution is received after **November 5, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Monte Jones, Administrator
October 26, 2018
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Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive style with a large initial 'D'.

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

dr/
Enclosures

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

PRINTED: 02/06/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/12/2018
NAME OF PROVIDER OR SUPPLIER REXBURG CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 SOUTH SECOND STREET WEST REXBURG, ID 83440		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from October 9, 2018 through October 12, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Cecilia Stockdill, RN Wendi Gonzales, RN Survey Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing I&A= Incidents and Accidents LPM = liters per minute LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment NC = Nasal Cannula O2 = Oxygen PRN = As Needed RN = Registered Nurse TAR = Treatment Administration Record UM = Unit Manager	F 000			
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		11/28/18	

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

TITLE

(X6) DATE

Electronically Signed

11/05/2018

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 584	<p>Continued From page 1</p> <p>use his or her personal belongings to the extent possible.</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, it was determined the facility failed to provide a clean and homelike environment. This was true for 1 of 3 shower rooms in the facility. This deficient practice had the potential for psychosocial and physical harm for those using</p>	F 584	<p>1) The wall will be repaired and painted on both sides of the tub and the doorway, the broken floor tiles will be repaired in the shower stall area, the missing grout in the floor tiles will be replaced in the shower stall on the right, the three hard</p>		

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F 584	<p>Continued From page 2</p> <p>the poorly maintained shower room. Findings include:</p> <p>On 10/11/18 at 10:52 AM, Resident #1 said the shower room was not in good shape.</p> <p>Observation of the 200-hallway shower room on 10/11/18 at 3:32 PM found:</p> <p>*Missing and crumbling wall paint on both sides of the tub and on both sides of the doorway.</p> <p>*Several broken floor tiles in the shower stall area.</p> <p>*Grout missing around floor tiles in the first shower stall on the right.</p> <p>*Three large hard water deposits with a leaking faucet in the bathtub.</p> <p>On 10/11/18 at 3:32 PM and 3:55 PM, the Maintenance Director said he was new to the facility and had just been made aware of some of the conditions in the shower room. He said the room needed to be painted, there were hard water stains in the tub, the tub was leaking, and the floor tiles needed to be repaired or replaced.</p> <p>On 10/11/18 at 3:44 PM, CNA #3 said she assisted residents with showers and she did not use the shower stall on the right because she did not want residents to trip on the tiles with missing grout. CNA #3 said the shower room's condition was "rough."</p> <p>On 10/11/18 at 4:05 PM, the Administrator said he was aware of the shower room conditions and</p>	F 584	<p>water deposits will be removed on the tub and the leaking faucet in the bathtub will be replaced/repared on or before 11-28-18.</p> <p>2) The wall will be repaired and painted on both sides of the tub and the doorway, the broken floor tiles will be repaired in the shower stall area, the missing grout in the floor tiles will be replaced in the shower stall on the right, the three hard water deposits will be removed on the tub and the leaking faucet in the bathtub will be replaced/repared on or before 11-28-18.</p> <p>3) An in-service will be performed to educate staff for communicating needed repairs in the facility. Maintenance staff will be in-serviced by the Administrator or designee on or before 11-28-18 regarding maintaining the facility and having a plan in place for problem areas.</p> <p>4) Beginning the week of December 3rd 2018 Maintenance Director or designee will perform an audit of shower rooms once per week for 4 weeks, then monthly for 2 months. Audit results will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance sustained.</p> <p>5) The Administrator is responsible for monitoring and compliance.</p>		

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F 584	Continued From page 3 staff had been trying to fix issues as they came up.	F 584			
F 656 SS=D	On 10/11/18 at 4:50 PM, Resident #7 said the shower room was "gross." Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized 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.	F 656		11/28/18	

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F 656	<p>Continued From page 4</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, record review, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans. This was true for 1 of 12 (#2) residents whose care plans were reviewed. Resident #2's care plan did not address monitoring the number of hours of uninterrupted sleep and her insomnia. These failures created the potential for harm due to inappropriate or inadequate care. Findings include:</p> <p>The facility's Person-Centered Care Plan Policy and Procedures, dated 3/1/18, documented the facility developed and implemented a person-centered care plan for each patient that included the instructions needed to provide effective and person-centered care that meet professional standards of quality care. The care plan should include measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that were identified in the comprehensive assessments.</p> <p>1. Resident #2 was admitted to the facility on</p>	F 656	<p>1) On or before 11/28/2018 resident #2 was assessed by Center Nurse Executive or designee with no adverse effects noted with insomnia. Care plan was initiated for insomnia to include hours of uninterrupted sleep per shift and interventions for managing resident #2 insomnia.</p> <p>2) Residents currently residing in the facility that receive insomnia medications will have care plan reviewed and updated to include hours of uninterrupted sleep per shift and interventions for managing insomnia by the Center Nurse Executive or designee.</p> <p>3) Social service designee was re-educated by the Center Nurse Executive or designee on or before 11/28/2018 on care planning of insomnia medications. Members of the nurse management team and licensed staff will review all insomnia care plans with the initiation of insomnia medications to ensure hours of uninterrupted sleep per shift and interventions are present on the care plan.</p> <p>4) Beginning the week of 12/3/2018 the</p>		

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F 656	<p>Continued From page 5 6/24/17, with multiple diagnoses including dementia, anxiety, and depression.</p> <p>Resident #2's current care plan did not include directions for staff to monitor the number of hours of uninterrupted sleep per shift and did not include interventions for managing Resident #2's insomnia.</p> <p>Resident #2's physician orders, dated 5/24/18 and 9/18/18, directed staff to monitor the number of hours of uninterrupted sleep per shift, and Ativan 1 mg (milligram) by mouth daily at bedtime for insomnia.</p> <p>Resident #2's care plan, dated 6/6/18, documented she exhibited and was at risk for distress and fluctuating mood symptoms related to sadness and depression, caused by a long history of depression with anxiety as evidenced by some hallucinations and delusions. Interventions directed staff to administer Ativan as ordered.</p> <p>Resident #2's Psychotropic/Therapeutic Medication Use Evaluation, dated 7/30/18 and 9/17/18, documented insomnia behavior trends, and indicated use of Ativan 1.5 mg by mouth at night for psychosis with hallucinations.</p> <p>On 10/11/18 at 3:30 PM, the UM stated insomnia and sleep monitoring were care planned by the Social Worker and documented on the resident's care plan.</p> <p>On 10/12/18 at 9:15 AM, the Licensed Social Worker stated she thought insomnia and monitoring hours of sleep were documented on</p>	F 656	<p>Center Nurse Executive or designee will review 3 care plans per week for residents receiving insomnia medications to ensure care plan is complete for 4 weeks then monthly for 2 months. Results to be discussed at monthly PI for a min of 3 months or until compliance is achieved. 5) The Center Nurse Executive is responsible for monitoring and follow up.</p>		

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F 656	Continued From page 6 the care plan.	F 656			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy and procedure review, and staff and resident family interviews, it was determined the facility failed to ensure professional standards of practice were met related to; a) following physician orders, b) neuro checks after unwitnessed resident falls. This was true for 2 of 12 sampled residents (#4 and #21). This failed practice created the potential for harm should residents experience undetected changes in neurological status after a fall or pain due to poor positioning. Findings include: The facility provided a document from the Agency for Healthcare Research and Quality "Preventing Falls in Hospitals," dated January 2013, which documented the following: * It was adapted from the South Australia Health Fall Prevention Toolkit. * There is higher risk of intracranial hemorrhage (bleeding inside the head) in residents with advanced age, those receiving blood thinners	F 684	1) On or before 11/28/18 resident #4 was assessed by the Center Nurse Executive or designee with no adverse effects noted with neurological assessments or pain. Resident #4 had arm trough replaced by the Center Nurse Executive or designee on or before 11/28/18. On or before 11/28/18 resident #21 was assessed by the Center Nurse Executive or designee with no adverse effects noted with neurological assessments or pain. 2) Residents residing in the facility that use positioning devices will be reviewed by the Center Nurse Executive or designee on or before 11/28/18 to ensure device is in place, physician ordered and care planned. Resident residing in the facility that have had a fall in the last month that required neurological assessments will be reviewed by the Center Nurse Executive or designee on or before 11/28/18 to ensure that neurological assessments were	11/28/18	

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F 684	<p>Continued From page 7 and those with a bleeding disorder.</p> <p>* There may be late signs of head injury after 24 hours.</p> <p>* After an unwitnessed fall or when there is a fall with injury to the head, record vital signs and neurological observations "at least hourly for 4 hours then review."</p> <p>* "Continue observations at least every 4 hours for 24 hours, then as required."</p> <p>The facility's Fall Response Protocol, revised May 2013, directed staff to evaluate and monitor residents for 72 hours after a fall and to perform a neurological assessment for all unwitnessed falls and witnessed falls with a head injury.</p> <p>The facility's policy and procedure for Falls management, dated 3/15/16, directed staff to perform a neurological assessment for all unwitnessed falls and witnessed falls with head injury.</p> <p>1. Resident #4 was admitted to the facility on 5/14/16 with multiple diagnoses, including muscle weakness, unspecified dementia, and hemiplegia (paralysis on one side) and hemiparesis (weakness on one side) following a stroke affecting the right side.</p> <p>a. An I&A Report, dated 4/22/18 at 4:00 PM, documented Resident #4 was found lying on his back by his chair, and he said he fell out of the chair onto the floor.</p> <p>A Neurological Assessment Flow Sheet documented neuro checks were performed for Resident #4 on 4/22/18 at 4:00 PM, 4:30 PM, 5:00 PM, 6:30 PM, 7:30 PM, 8:30 PM, 9:30 PM,</p>	F 684	<p>completed per policy. Follow-up neurological assessments will be completed by the Center Nurse Executive or designee as indicated by the review on or before 11/28/18. Any identified follow-up including physician notification will be completed by the Center Nurse Executive or designee on or before 11/28/18.</p> <p>3) Facility staff were educated on or before 11/28/18 by the Center Nurse Executive or designee that all positioning devices are to have an MD order and be care planned. When placing or removing a device, facility staff are to notify nurse management team. IDT team to review new positioning devices orders in daily clinical review to ensure that device is in place and care planned. Licensed nurses were educated on or before 11/28/18 by the Center Nurse Executive or designee on completion of neurological assessments per policy. Beginning 12/3/18 the center IDT will check for placement of positioning devices during weekly quality of life rounds.</p> <p>4) Beginning the week of 12/3/18 the Center Nurse Executive or designee will review 3 residents per week for 4 weeks with positioning devices for placement, care plan and orders, then monthly for 2 months. Beginning the week of 12/3/18 the Center Nurse Executive or designee will review 3 neurological assessments per week for 4 weeks for completion, then for 2 months. Results to be discussed at monthly PI for a minimum of 3 months or until compliance is achieved.</p>		

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F 684	<p>Continued From page 8</p> <p>and on 4/23/18 at 1:30 AM, 5:30 AM, 9:30 PM, and 1:30 AM. There was no pupil response documented at any time point on the Neurological Assessment Flow Sheet. There was no information documented on 4/22/18 at 5:30 PM and on 4/23/18 at 9:30 AM, 1:30 PM, and 5:30 PM. There was no pain response documented on 4/22/18 at 4:00 PM, 4:30 PM, 5:00 PM, and 5:30 PM. There were no vital signs documented on 4/23/18 at 5:30 AM.</p> <p>b. An I&A Report, dated 6/14/18 at 7:45 PM, documented a CNA found Resident #4 lying on his back between his bed and wheelchair.</p> <p>A Neurological Assessment Flow Sheet documented neuro checks were performed for Resident #4 on 6/14/18 at 8:00 PM, 8:30 PM, 10:00 PM, 11:00 PM, 12:00 AM, 4:00 AM, 8:00 AM, and 12:00 PM. There was no information documented on 6/14/18 at 4:00 AM. There was no neurological assessment information documented on 6/14/18 at 9:00 PM. There was no pupil response information documented at any time point on the Neurological Assessment Flow Sheet. There was no pain response documented on 6/14/18 at 8:00 PM, 8:30 PM, 9:00 PM, 10:00 PM, and 11:00 PM.</p> <p>c. An I&A Report, dated 6/17/18 at 1:45 PM, documented Resident #4 was found on the floor by a CNA. He stated he attempted to stand up from the chair and fell.</p> <p>A Neurological Assessment Flow Sheet documented neuro checks were performed for Resident #4 on 6/17/18 at 2:00 PM, 2:30 PM, 3:00 PM, 3:30 PM, 4:00 PM, and 5:00 PM.</p>	F 684	5) The Center Nurse Executive is responsible for monitoring and follow up.		

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F 684	Continued From page 9 d. An I&A Report, dated 6/17/18 at 5:20 PM, documented Resident #4 had an unwitnessed fall in his room. He was attempting to self-transfer from his wheelchair. Documentation of neuro checks following the second fall on 6/17/18 was not found in Resident #4's clinical record. e. An I&A Report, dated 8/12/18 at 9:30 AM, documented Resident #4 was found on the floor between the bed and wall. He was eating breakfast in bed and rolled out of bed. A Neurological Assessment Flow Sheet documented neuro checks were performed for Resident #4 on 8/12/18 at 9:30 AM, 10:00 AM, 10:30 AM, 11:00 AM, 12:00 PM, 1:00 PM 2:00 PM, 3:00 PM, 4:00 PM, and 8:00 PM, and on 8/13/18 at 12:00 AM, 12:04 AM, 8:00 AM, 12:00 PM, and 4:00 PM. There was no documentation of motor functions on 8/12/18 at 11:00 AM, 12:00 PM, 1:00 PM, and 2:00 PM, and on 8/13/18 at 12:04 AM. There were no vital signs documented on 8/12/18 at 8:00 PM and 8/13/18 at 12:00 AM and 12:04 AM. f. An I&A Report, dated 8/23/18 at 9:35 PM, documented Resident #4 was found lying on his back next to his recliner. He said he did not know what happened. Documentation of additional neuro checks was not found in Resident #4's clinical record. g. An I&A Report, dated 8/29/18 at 7:30 PM, documented the CNA notified the nurse Resident #4 was on the floor. He was found lying on the floor on the right side of his bed, and he said he wanted to sleep on the floor and watch the game.	F 684			

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F 684	<p>Continued From page 10</p> <p>A Neurological Assessment Flow Sheet documented neuro checks were performed for Resident #4 on 8/29/18 at 7:40 PM, 8:10 PM, 9:40 PM, 10:10 PM, 11:10 PM, 12:10 AM, 2:10 AM, 6:10 AM, 10:10 AM, 10:10 PM, 2:10 AM, and 6:10 AM. The level of consciousness was not documented on 8/29/18 at 2:10 PM, 6:10 PM, 10:10 PM, 2:10 AM, and 6:10 AM. There was no information documented on 8/29/18 at 2:10 PM and 6:10 PM.</p> <p>On 10/11/18 at 2:05 PM, the UM said there was missing documentation on Resident #4's Neurological Assessment Flow Sheets and it should have been filled out.</p> <p>h. Resident #4's Physician Orders, dated 10/11/18, documented an arm trough to the right side of wheelchair for positioning due to hemiparesis related to stroke, ordered on 3/14/18.</p> <p>On 10/10/18 at 8:50 AM, 10/10/18 at 10:57 AM, 10/11/18 at 8:42 AM, and 10/11/18 at 1:49 PM, the arm trough was not in place to the wheelchair.</p> <p>On 10/11/18 at 2:05 PM, the UM said Resident #4's arm trough may have been something from Occupational Therapy, he had a custom chair, and the arm trough was always on the wheelchair. The UM said she thought she recently saw the arm trough on his wheelchair. The UM looked for the arm trough in his room and did not locate it.</p> <p>On 10/11/18 at 2:46 PM, the UM said he</p>	F 684			

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F 684	<p>Continued From page 11</p> <p>previously had an arm trough, someone was doing something with the wheelchair, and she was not sure where the arm trough was.</p> <p>2. Resident #21 was re-admitted to the facility on 3/8/17 with multiple diagnoses, including muscle weakness, history of falling, Parkinson's Disease, difficulty in walking, reduced mobility, idiopathic peripheral autonomic neuropathy (nerve damage), and seizures.</p> <p>Resident #21's annual MDS assessment, dated 6/14/18, documented the following:</p> <ul style="list-style-type: none"> * Severe cognitive impairment. * Independent with transfers and walking. * Balance steady at all times. * A walker was used for mobility. * Two or more falls since admission or prior assessment. <p>Resident #21's quarterly MDS assessment, dated 8/21/18, documented the following:</p> <ul style="list-style-type: none"> * Severe cognitive impairment. * Independent with transfers, walking, and toileting. * Balance not steady during transitions and walking, but able to stabilize without human assistance. * A walker was used for mobility. * Two or more falls since admission or prior assessment. <p>a. A Progress Note, dated 6/12/18 at 8:00 PM, documented Resident #21 fell on 6/12/18 at night.</p>	F 684			

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F 684	<p>Continued From page 12</p> <p>A Neurological Assessment Flow Sheet documented neuro checks were performed for Resident #21 on 6/12/18 at 7:50 PM, 8:20 PM, and 11:00 PM, and on 6/13/18 at 12:00 AM, 1:00 AM, 2:00 AM, 6:00 AM, 10:00 AM, and 2:00 PM. There was no information documented on 6/12/18 at 6:00 PM.</p> <p>b. An I&A Report, dated 8/10/18 at 11:50 PM, documented Resident #21 was found sitting on the floor next to the bed, and he said he slipped off the edge of the bed when trying to sit down on the bed. It was noted Resident #21 had increased confusion.</p> <p>A Neurological Assessment Flow Sheet documented neuro checks were performed for Resident #21 on 8/10/18 at 11:50 PM and on 8/11/18 at 12:20 AM, 12:50 AM, 1:20 AM, 1:50 AM, 2:50 AM, 3:50 AM, 4:50 AM, 5:50 AM, 9:50 AM, 1:50 PM, and 5:50 PM.</p> <p>c. An I&A Report, dated 8/12/18 at 5:00 PM, documented Resident #21 slipped and fell in the bathroom.</p> <p>A Neurological Assessment Flow Sheet documented neuro checks were performed for Resident #21 on 8/12/18 at 5:00 PM, 5:30 PM, 6:00 PM, 6:30 PM, 7:00 PM, 8:00 PM, 9:00 PM, and 10:00 PM, and on 8/13/18 at 2:00 AM, 6:00 AM, 12:00 PM, 4:00 PM, 8:00 PM, and at 12:00 AM. No Vital signs were documented on 8/12/18 at 10:00 PM and on 8/13/18 at 2:00 AM and 6:00 AM.</p> <p>d. An I&A Report, dated 8/21/18 at 11:55 PM, documented Resident #21 was found sitting on</p>	F 684			

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F 684	<p>Continued From page 13</p> <p>the floor in the bathroom in front of the toilet. Resident #21 said his feet slipped out from under him.</p> <p>A Neurological Assessment Flow Sheet documented neuro checks were performed for Resident #21 on 8/21/18 at 11:55 PM, on 8/22/18 at 12:25 AM, 1:55 AM, 2:55 AM, 3:55 AM, 4:55 AM, 9:55 AM, and 9:55 PM, and on 8/23/18 at 1:55 AM and 5:55 AM. There was no information documented on 8/22/18 at 5:55 AM and 1:55 PM, and on 8/23/18 at 9:55 AM. There was no neurological assessment information documented on 8/22/18 at 5:55 PM.</p> <p>e. A Progress Note, dated 8/24/18 at 6:40 AM, documented at 9:35 PM the previous night Resident #21 was found lying flat on his back next to the recliner, and he said he did not know what happened.</p> <p>An I&A Report, dated 8/24/18 at 2:30 AM, documented Resident #21 fell again in his room next to the bed.</p> <p>A Neurological Assessment Flow Sheet documented neuro checks were performed for Resident #21 on 8/24/18 at 2:30 AM, 3:00 AM, 3:30 AM, 4:00 AM, 5:30 AM, 7:30 AM, 11:30 AM, 3:30 PM, 7:30 PM, 11:30 PM, and 3:30 AM. On 8/24/18 at 4:30 AM it documented "Sleeping." On 8/24/18 at 6:30 AM the neurological assessment information and vital signs were blank.</p> <p>On 10/10/18 at 11:27 AM, Resident #21's family member said he had fallen recently, the nurse told her he slipped on a wet floor in the bathroom and fell, and he fell a couple of times in</p>	F 684			

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F 684	Continued From page 14 September. On 10/11/18 at 9:37 AM, the UM said if a resident had an unwitnessed fall then neuro checks should be done every 30 minutes times 2, every 1 hour times 4, then every 4 hours times 24 hours. The UM said she was not aware of a standard for how long neuro checks should be performed after an unwitnessed fall. On 10/11/18 at 10:19 AM and 3:12 PM, the DON said neuro checks should be done when a resident may have hit their head and when a fall is unwitnessed. The DON said neuro checks should be done every 30 minutes times 2, every 1 hour times 4, then every 4 hours times 24 hours. The DON said the standard of practice for neuro checks was indicated in the previously provided facility's policy. The DON said there were holes in the documentation of neuro checks for Resident #21 and she did not have an answer for why the information was not documented.	F 684			
F 689 SS=G	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 observation, record review, facility policy and procedure review, and staff, resident, and family interviews, it was determined the	F 689	1) Resident #21 had a head to toe assessment completed by the Center Nurse Executive or designee on or before	11/28/18	

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F 689	<p>Continued From page 15</p> <p>facility failed to provide adequate supervision to meet residents' needs. This was true for 2 of 5 residents (#4 and #21) reviewed for falls and accident hazards. Resident #21 was harmed when he sustained a burn requiring wound treatment, and this failure created the potential for harm when Resident #4 and Resident #21 experienced multiple falls. Findings include:</p> <p>The facility's policy and procedure for Dining Service Standards, revised 6/15/18, documented all staff involved with meal service are trained on general serving tasks, including safe food handling practices, and adaptive devices are provided as indicated on the resident's care plan.</p> <p>The facility's Food and Nutrition Services Guidelines for Hot Beverages, dated 4/1/14, documented the following:</p> <ul style="list-style-type: none"> * Hot beverages such as coffee, tea and hot chocolate are often brewed and held at high temperatures (160-185 degrees.) "...Brief exposures to liquids in this temperature range can cause significant scald burns." * Discourage residents from carrying a cup containing a hot beverage without a lid when walking or moving in a wheelchair. * When serving hot liquids to a resident, place the beverage away from the edge of the table and position the beverage near the dominant hand. * Identify residents at higher risk of spilling hot beverages, such as those with tremors, those with poor hand control from a stroke, arthritis, weakness, etc. <p>1. Resident #21 was re-admitted to the facility on</p>	F 689	<p>11/28/18, resident burn healing without adverse effect, no current pain associated with burn, and no other adverse effect noted. Resident #21 physician was updated on assessment results with no new orders received. Resident #21 was assessed by the Center Nurse Executive or designee for safety with managing hot liquids, and supervision required to provide safety on or before 11/28/18. Resident #21's plan of care will be updated by the Center Nurse Executive or designee based on resident's individualized assessment. Resident #21's fall risk will be reassessed by the Center Nurse Executive or designee on or before 11/28/18. Care plan updates will be implemented including supervision and interventions to reduce falls on or before 11/28/18. Resident #4's fall risk will be reassessed by the Center Nurse Executive or designee on or before 11/28/18. Care plan updates will be implemented including supervision and interventions to reduce falls on or before 11/28/18.</p> <p>2) Center residents were re-assessed for fall risk by the Center Nurse Executive or designee to ensure that there is an adequate plan for supervision to prevent avoidable falls on or before 11/28/18. Resident care plans for falls will be updated by the Center Nurse Executive or designee on or before 11/28/18. Center residents who drink hot liquids will be assessed for the level of supervision and interventions needed to prevent burns on or before 11/28/18. Resident care plans</p>		

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F 689	<p>Continued From page 16</p> <p>3/8/17 with multiple diagnoses, including muscle weakness, history of falling, Parkinson's Disease, difficulty in walking, reduced mobility, idiopathic peripheral autonomic neuropathy (nerve damage), and seizures.</p> <p>Resident #21's annual MDS assessment, dated 6/14/18, documented the following:</p> <ul style="list-style-type: none"> * Severe cognitive impairment. * Independent with transfers and walking. * No setup or physical help from staff with eating. * Balance steady at all times. * A walker was used for mobility. * Two or more falls since admission or prior assessment. * No other ulcers, wounds, and skin problems. <p>Resident #21's quarterly MDS assessment, dated 8/21/18, documented the following:</p> <ul style="list-style-type: none"> * Severe cognitive impairment. * Independent with transfers, walking, and toileting. * No setup or physical help from staff with eating. * Balance not steady during transitions and walking, but able to stabilize without human assistance. * A walker was used for mobility. * Two or more falls since admission or prior assessment. * Burn(s) (second or third degree). * Application of non-surgical dressings and ointments/medications. <p>Resident #21's current care plan documented the following:</p>	F 689	<p>will be updated based on assessment on or before 11/28/18. A facility round will be completed by the Center Nurse Executive or designee on or before 11/28/18 to validate that interventions to prevent falls, and to prevent burns were implemented per the plan of care on or before 11/28/18 any concerns will be immediately addressed. Residents currently residing in the facility that have non-skid strips on the floor were reviewed by the Center Nurse Executive or designee on or before 11/28/18 to ensure that strips are in place and care planned.</p> <p>3) Facility staff were educated on the safe handling of hot beverages on or before 11/28/18 by the Center Nurse Executive or designee. New facility coffee mugs were ordered on or before 11/28/18 with a mug that has a lid. Licensed nurses were educated on or before 11/28/18 by the Center Nurse Executive or designee on assessment and interventions to be placed after a fall. Facility staff were educated on or before 11/28/18 by the Center Nurse Executive or designee on placement of non-skid strips and proper care planning. Beginning 11/28/18 when a resident falls, the assigned nurse will review planned interventions with the center nurse executive or designee to validate that intervention is related to root cause of fall and not already in place.</p> <p>4) Beginning the week of 12/3/18 the Center Nurse Executive or designee will review 3 meal services per week to ensure hot beverage temperatures and proper use of hot beverage mugs for 4</p>		

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F 689	<p>Continued From page 17</p> <ul style="list-style-type: none"> * At risk for falls, initiated on 9/23/16. Staff were directed to assist with mobility and transfers as needed, continue/encourage use of assistive devices, encourage him to sit on the edge of the bed and dangle feet prior to transferring, ensure he has non-skid footwear, ensure the walker is in reach when he is in bed, and offer frequent toileting. * At risk for injuries related to excessive weakness from Parkinson's Disease, initiated on 9/23/16. * At risk for seizure activity, initiated on 9/23/16. <ul style="list-style-type: none"> - Staff were directed to maintain a safe environment, initiated on 9/23/16. * Actual skin breakdown was present related a burn on the left thigh, initiated on 8/2/18. Staff were directed to: <ul style="list-style-type: none"> * Special coffee mugs to prevent spilling, initiated 8/7/18. <p>Resident #21's Change in Condition Evaluation, dated 8/1/18 at 3:41 PM, documented the following:</p> <ul style="list-style-type: none"> * He became agitated after spilling coffee. * His left thigh had a 22 by 24 cm area of "slight redness with mild pain. No blistering noted." * He experienced acute burning pain. * The CNA stated Resident #21 had spilled coffee in the past. <p>An I & A Report, dated 8/1/18 at 5:00 PM, documented Resident #21 was sitting in the recliner near the nurses' station drinking a cup of coffee and he fell asleep. The coffee spilled on him causing a "red, painful area on the upper, inner left thigh." Resident #21 and staff were educated regarding hot drinks. Staff were</p>	F 689	<p>weeks then monthly for 2 months. Beginning the week of 12/3/18 the Center Nurse Executive or designee will review 3 residents with falls per week to review fall assessments and interventions for 4 weeks then monthly for 2 months. Beginning the week of 12/3/18 the Center Nurse Executive or designee will review 3 residents with non-skid strips per week to ensure strips are in place and care planned for 4 weeks then monthly for 2 months. Results to be discussed at monthly PI for a min of 3 months or until compliance is achieved.</p> <p>5) The Center Nurse Executive is responsible for monitoring and follow up.</p>		

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F 689	<p>Continued From page 18</p> <p>educated that he should not be given hot coffee, to make sure the coffee was cooled, and to provide a protective cover on his lap when he drinks.</p> <p>A Progress Note, dated 8/1/18 at 9:00 PM, documented Resident #21 spilled coffee on that evening and had a red area on the upper, inner left thigh. An ice pack was applied and the area was tender to touch.</p> <p>A Progress Note, dated 8/1/18 at 11:41 PM, documented Resident #21 had three blisters on the burn area to the left left upper inner thigh. An ice pack and dressing were applied.</p> <p>A Progress Note, dated 8/2/18 at 1:30 PM, documented the physician examined Resident #21 and was aware of the blisters to the resident's thigh. No new orders were received.</p> <p>A Progress Note, dated 8/2/18 at 5:30 PM, documented Resident #21 was "protective of left upper thigh area. States "it hurts" and will not allow nurse to see it. Assessing facial expression, posture and protectiveness pain level is 5-6 on 0-10 scale."</p> <p>A Physical Therapy Initial Examination, dated 8/21/18, documented Resident #21 spilled a cup of coffee, which resulted in a burn to the left thigh. Resident #21 complained of pain described as sharp and rated as a 7 (on a scale of 0-10 with 10 being the worst imaginable pain.) The goal was to heal the wound and reduce pain. It was recommended to provide sharp debridement (removal of non-viable tissue) and daily dressing changes.</p>	F 689			

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

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F 689	<p>Continued From page 19</p> <p>An untitled facility document, dated 9/20/18, documented Resident #21 drank coffee, had Parkinson's, and could not safely hold a mug.</p> <p>An untitled facility document, dated 9/21/18, documented "IDT (interdisciplinary team) met [and]decided to change all coffee mugs," and was signed by the DON.</p> <p>On 10/10/18 at 10:14 AM, LPN #2 performed a dressing change to Resident #21's left thigh. LPN #2 said Resident #21 spilled coffee on 8/1/18, causing the wound on his left thigh, and he liked coffee very hot. One large, mildly reddened area and one smaller, mildly reddened area were observed on his left upper, inner thigh.</p> <p>On 10/10/18 at 11:24 AM, Resident #21's family member stated he spilled coffee and caused a burn on his leg. Resident #21's family member stated it was an accident when the resident was reaching for something with one hand and spilled the coffee with the other hand.</p> <p>On 10/10/18 at 12:40 PM, Resident #21 was observed in the dining room at the table drinking from a small plastic mug with no lid. The plastic mug contained dark brown liquid that was steaming.</p> <p>On 10/11/18 at 9:32 AM, CNA #2 said staff had to be careful with Resident #21's coffee. CNA #2 said Resident #21 had to have a special mug with a special lid that screws on so it would not spill on him. CNA #2 said Resident #21 liked the coffee very hot.</p>	F 689			

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F 689	<p>Continued From page 20</p> <p>On 10/11/18 at 9:37 AM, the UM said Resident #21 needed only setup assistance with dining, including when drinking coffee in the dining room.</p> <p>On 10/11/18 at 4:47 PM, the UM said Resident #21 spilled coffee and sustained a burn to his leg. The UM said at the time of the burn, an assessment was completed and the physician saw Resident #21. The UM said the DON did a sweep of the building to identify other residents at risk, two residents were identified, and they had spill proof mugs. The UM said Resident #21 did everything by himself except dining and coffee, any staff member could get his mug and screw the lid on.</p> <p>On 10/11/18 at 5:36 PM, Resident #21 was in the dining room sitting at the table with a small plastic mug in front of him that was approximately one-half full of dark brown liquid. Resident #21 said he was drinking coffee. CNA #3 said she set him up for dinner and he did not need any special equipment. CNA #3 said if a resident required special equipment the kitchen would send it. Resident #21's meal ticket did not document any special equipment was needed.</p> <p>On 10/11/18 at 4:54 PM, the DON said all residents who prefer coffee were assessed for safety, and those who were felt to be at a higher risk received a cup with a twist top. The DON said Resident #21 was independent with dining at the time he received the burn from the spilled coffee, and the Resident was still independent.</p> <p>On 10/11/18 at 5:43 PM, the DON said if a resident required special equipment for dining it should be documented on the meal ticket, and</p>	F 689			

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F 689	<p>Continued From page 21</p> <p>the special mug should be on Resident #21's meal ticket. The DON said Resident #21 now had his special mug as they just gave it to him.</p> <p>b. The facility's policy and procedure for Falls management, dated 3/15/16, documented the following:</p> <ul style="list-style-type: none"> * Patients will be assessed for risk of falling as part of the nursing assessment. Residents determined to be at risk will receive appropriate interventions to decrease risk and minimize injury. * Facility staff were directed to identify the resident's fall risk, communicate the fall risk to caregivers, and review and update the care plan regularly. <p>A Progress Note, dated 6/12/18 at 8:00 PM, documented Resident #21 fell on 6/12/18 at night.</p> <p>A Change in Condition assessment, dated 6/13/18 at 10:30 PM, documented Resident #21 fell on 6/12/18. Interventions directed staff to remind him to put shoes or slippers on when getting up.</p> <p>A Progress Note, dated 6/14/18 at 5:30 PM, documented Resident #21 ambulated to meals and in the unit without assistance.</p> <p>A Nursing Assessment, dated 6/14/18 at 6:15 PM, documented Resident #21 had one fall since admission or the prior assessment and was receiving anti-Parkinson's and sedative medications.</p>	F 689			

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F 689	<p>Continued From page 22</p> <p>A Progress Note, dated 6/18/18 at 8:47 AM, documented Resident #21 fell on 6/12/18 when transferring from bed. Resident #21 had socks on and slid to the floor. Resident #21 was able to transfer independently using a front wheel walker, and staff were to encourage the Resident to wear non-skid socks and/or shoes for transfers and mobility.</p> <p>A Progress Note, dated 6/27/18 at 6:50 AM, documented Resident #21 had a "large fading bruise" to the left thigh from a fall during the previous week.</p> <p>An I&A Report, dated 8/10/18 at 11:50 PM, documented the following:</p> <ul style="list-style-type: none"> * Resident #21 was found sitting on the floor next to his bed, and he slipped off the side of the bed. * Preventive measures prior to the fall included call light and personal items within reach, frequent checks, and reminding him to dangle his feet before standing up and to use the walker. * Interventions added after the fall included assess the Resident, Neuro checks, frequent checks when in bed, and walker and personal items within reach. * Corrective actions included frequent checks when Resident #21 was restless/confused, and keep personal items and walker within reach. <p>A Progress Note, dated 8/10/18 at 11:57 PM, documented Resident #21 was found sitting on the floor next to the bed, and he stated he slipped off the bed. There was noted "possible increased confusion."</p> <p>An I&A Report, dated 8/12/18 at 5:00 PM,</p>	F 689			

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F 689	<p>Continued From page 23 documented the following:</p> <ul style="list-style-type: none"> * Resident #21 slipped and fell in the bathroom. * Preventative measures in place prior to the fall included a transfer pole in the bathroom, non-skid shoes, and a walker. * Interventions added after the fall included reminding him to use the call light to request assistance with ambulating and toileting. * Corrective actions included reminding him to request assistance and all safety devices (walker, transfer pole, and bathroom rails) in use. <p>A Progress Note, dated 8/12/18 at 5:37 PM, documented Resident #21 fell on that day in the afternoon.</p> <p>A Progress note, dated 8/14/18 at 2:54 AM, documented Resident #21's door was left "slightly open for frequent room checks" related to risk of falls.</p> <p>A Change in Condition Followup Assessment, dated 8/14/18 at 2:54 AM, documented nursing interventions included close supervision and frequent room checks.</p> <p>An I&A Report, dated 8/21/18 at 11:55 PM, documented the following:</p> <ul style="list-style-type: none"> * Resident #21 fell in the bathroom. * Preventative measures in place prior to the fall included call light within reach, non-skid socks/slippers, and non-skid strips in front of bed. * Interventions added after the fall included non-skid strips in front of the toilet and slippers with a better grip on the bottom. * Corrective actions included non-skid strips in 	F 689			

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F 689	<p>Continued From page 24 front of the toilet and new slippers.</p> <p>A Progress Note, dated 8/21/18 at 11:58 PM, documented Resident #21 was found in the bathroom sitting on the floor in front of the toilet, and he said his feet slipped out from under him. A dark purple bruise, measuring 8 cm by 4 cm, was present on his right sacrum (upper buttock area). Non-skid strips were ordered to be placed in front of the toilet, and "Possible new slippers as [the Resident's] current slippers...has [sic] a bare area to center which could have contributed to fall."</p> <p>An I&A Report, dated 8/24/18 at 2:30 AM, documented the following:</p> <ul style="list-style-type: none"> * Resident #21 fell in his room next to the bed. * Interventions in place prior to the fall included non-skid strips in front of the bed and in the bathroom, and call light and walker within reach. * Interventions added after the fall included new slippers and frequent checks at night. * Corrective actions included requesting new slippers and frequent checks at night due to increased unsteadiness and confusion. <p>A Progress Note, dated 8/24/18 at 4:19 AM, documented Resident #21 had another fall at 2:30 AM as he slipped when attempting to get up out of bed. Action taken included non-skid strips and frequent checks during the night.</p> <p>A Progress Note, dated 8/24/18 at 6:40 AM, documented at 9:35 PM the previous night, Resident #21 was found lying flat on his back next to the recliner, and he said he did not know what happened. Resident #21 had been sitting in</p>	F 689			

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F 689	<p>Continued From page 25</p> <p>the recliner with the feet down. The CNA said she "had just checked on him a few minutes ago and asked if he wanted to go to bed yet and he had stated no." Education was provided to not leave him in the recliner after dinner.</p> <p>A Change in Condition Evaluation, dated 8/24/18 at 6:42 AM, documented Resident #21 fell on 8/24/18 in the morning while attempting to get out of bed to go to the bathroom. Resident #21 slipped and fell next to the bed and landed on his right side.</p> <p>A Progress Note, dated 9/5/18 at 11:41 AM, documented a care team review was performed. Resident #21 fell on 8/21/18 and was found in the bathroom on the floor. A transfer pole was in place in the bathroom. Resident #21's slippers were slick on the bottom, facility slippers were offered and new slippers were requested. Resident #21 fell on 8/24/18 and was found lying on the floor next to the bed. He was unable to provide information about what happened. He was receiving therapy, a transfer pole was placed next to his bed "as resident tends to walk holding onto furniture in [the Resident's] room and transfer pole will allow [the Resident] to stand straight and gain [the Resident's] balance.</p> <p>On 10/10/18 at 11:27 AM, Resident #21's family member said he had fallen recently, and the nurse told her he slipped on a wet floor in the bathroom and fell. Resident #21's family member said he fell a couple of times in September.</p> <p>On 10/11/18 at 9:37 AM the UM said Resident #21 had some falls and was independent with transferring and ambulating. The UM said she did</p>	F 689			

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F 689	<p>Continued From page 26</p> <p>not know what could have been done differently to prevent the falls.</p> <p>On 10/11/18 at 10:19 AM and 3:15 PM, the DON said Resident #21 had falls and he preferred to be independent. The DON said frequent checks were not documented for Resident #21, and frequent checks consisted of staff members walking by his room "all the time." The DON said staff tried to do everything they could to prevent Resident #21's falls.</p> <p>2. Resident #4 was admitted to the facility on 5/14/16 with multiple diagnoses, including muscle weakness, unspecified dementia, and hemiplegia (paralysis on one side) and hemiparesis (weakness on one side) following a stroke affecting the right side.</p> <p>Resident #4's quarterly MDS assessment, dated 7/31/18, documented the following:</p> <ul style="list-style-type: none"> * Severe cognitive impairment. * Extensive assistance of two persons with bed mobility, transfers, and toileting. * Not steady when moving from seated to standing position and only able to stabilize with human assistance. * A wheelchair was used for mobility. * One fall since admission or the last assessment. <p>Resident #4's current care plan documented the following:</p> <ul style="list-style-type: none"> * Resident #4 was at risk for falls due to impaired mobility, history of falls, hemiplegia, resistive to cares, intolerant of close supervision, and 	F 689			

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F 689	Continued From page 27 medications, initiated on 5/14/16. * Assist the Resident with mobility and transfers as he allows, initiated on 5/14/16 and revised on 5/16/17. * Encourage the Resident to express needs and ask for assistance, initiated on 5/14/16. * Encourage the Resident to transfer and change position slowly, initiated on 5/14/16. * Offer toileting frequently, initiated on 5/14/16. * Ensure the use of non-skid footwear, initiated on 5/14/16. * One-person assistance with ambulation with front wheel walker, initiated on 5/14/16. * One-person assistance with transfers, initiated on 5/14/16. * Resident #4 had a self-care deficit related to impaired mobility due to a history of stroke with right-sided weakness, initiated on 5/14/16. * Encourage the Resident to sit on the edge of the bed and dangle feet before transferring, initiated on 5/14/16. * One to two person assistance with toileting, initiated on 5/14/16 and revised on 8/14/18. * Two person assistance with bed mobility, initiated on 5/14/16 and revised on 5/16/17. * Non-skid strips in front of recliner, initiated on 5/16/16. * Non-skid strips in front of the bathroom, initiated on 5/26/16. * Non-skid strips in front of dresser, initiated on 9/6/16. * The Resident removes shoes and will self-transfer to the bathroom, bed, and wheelchair. The Resident refuses non-skid socks. Non-skid strips in place to reduce risk of falls, initiated on 11/14/16. * "gait belt with transfers, resident frequently refuses the gait belt, do not argue with resident	F 689			

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F 689	<p>Continued From page 28</p> <p>as agitation causes increased risk for falls, allow resident to not use gait belt," initiated on 1/26/17 and revised on 2/8/17.</p> <p>* Encourage the Resident to sit in the recliner in between meals, initiated on 10/13/17.</p> <p>* Encourage the Resident to wear shoes when in the wheelchair, initiated on 8/3/18.</p> <p>* If the Resident demonstrates agitation, attempt transfers and mobility with two persons. If agitation worsens, resume with one staff member assistance with transfers, initiated on 9/5/18.</p> <p>Resident #4's I&A Reports, documented Resident #4 fell 9 times in four months. The falls occurred on the following dates and time: 4/22/18 at 4:00 PM, 6/14/18 at 7:45 PM, 6/17/18 at 1:45 PM, 6/17/18 at 5:20 PM, 7/29/18 at 4:10 PM, 8/12/18 at 9:30 AM, 8/19/18 at 12:00 AM, 8/23/18 at 9:35 PM, and 8/29/18 at 7:30 PM, documented Resident #4 fell.</p> <p>An I&A Report, dated 4/22/18 at 4:00 PM, documented Resident #4 was found lying on his back by the chair, and he said he fell out of the chair onto the floor. Preventative measures in place prior to the fall included a self releasing seat belt, increased supervision, and educated him not to self-transfer.</p> <p>An I&A Report, dated 6/14/18 at 7:45 PM, documented a CNA found Resident #4 lying on his back between the bed and wheelchair. Preventative measures in place prior to the fall included call light within reach, shoes on feet, and door positioned so he was visible.</p> <p>An I&A Report, dated 6/17/18 at 1:45 PM, documented Resident #4 was found on the floor</p>	F 689			

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F 689	<p>Continued From page 29</p> <p>by a CNA. Resident #4 stated he attempted to stand up from the chair and fell. He was educated to wait for assistance before transferring. Preventative measures in place prior to the fall included self-releasing seatbelt and supervision. Interventions added after the fall included educating him about self-transferring.</p> <p>An I&A Report, dated 6/17/18 at 5:20 PM, documented Resident #4 had an unwitnessed fall in his room. He was attempting to self-transfer from his wheelchair. Preventative measures in place prior to the fall included shoes on feet and wheelchair seatbelt in place. Interventions added after the fall included placing Resident #4 on 15 minute checks.</p> <p>An I&A Report, dated 7/29/18 at 4:10 PM, documented Resident #4 was changing clothes and slid too far forward in the chair. He was assisted to the floor by an aide. Preventative measures in place prior to the fall included alarm on and functioning, and "assistance." Interventions added after the fall included "assisted to put shoes on. Education."</p> <p>An I&A Report, dated 8/12/18 at 9:30 AM, documented Resident #4 was found on the floor between the bed and wall. He was educated to not self-transfer. He was eating breakfast in bed and rolled out of bed. Preventative measures in place prior to the fall included a transfer pole beside Resident #4's bed, the bed was to be at a certain height when he was in the bed, and wear shoes when getting out of bed. Interventions added after the fall included frequent checks and remind him to request assistance with transfers. Corrective actions included keep the call light</p>	F 689			

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F 689	<p>Continued From page 30</p> <p>and personal items within reach, remind the him to request and wait for assistance, "Medicate and assist with eating as needed."</p> <p>An I&A Report, dated 8/19/18 at 12:00 AM, documented Resident #4 fell when a CNA was transferring him from bed to the chair. He attempted to place his feet on the pedals of the wheelchair, the CNA asked him not to do that and instructed him to pivot and sit in the chair. He bent forward and fell. Preventative measures in place prior to the fall included a transfer pole by the bed, non-skid strips, and restorative therapy. Interventions added after the fall included he was assessed and assisted with cares. Corrective actions included two staff members to assist him if he became combative.</p> <p>An I&A Report, dated 8/23/18 at 9:35 PM, documented Resident #4 was found lying on his back next to the recliner, and he said he did not know what happened. He was sitting in the recliner with the feet down. A CNA said she checked on Resident #4 "a few minutes ago" and asked him if he wanted to go to bed and he said no. Preventative measures in place prior to the fall included frequent checks and make sure the call light is in place. Interventions added after the fall included staff educated to not leave him in the recliner after dinner, re-approach or have another staff member attempt if he refuses care, and notify the nurse immediately if he still refuses.</p> <p>An I&A Report, dated 8/29/18 at 7:30 PM, documented the CNA notified the nurse at 7:30 PM Resident #4 was on the floor, and he was found lying on the floor on the right side of his bed. He said he wanted to sleep on the floor and</p>	F 689			

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

PRINTED: 02/06/2019
FORM APPROVED
OMB NO. 0938-0391

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F 689	<p>Continued From page 31</p> <p>watch the game. Preventative measures in place prior to the fall included bed in low position, call light in place, frequent checks, transfer pole, and non-skid strips. Interventions added after the fall included continue bed in low position, frequent checks, and possible perimeter mattress or larger bed. Corrective actions included frequent checks as he allows and continue therapy evaluation.</p> <p>On 10/10/18 at 8:50 AM, 10/10/18 at 10:57 AM, 10/11/18 at 8:42 AM, and 10/11/18 at 1:49 PM, there were no non-skid strips observed in Resident #4's room.</p> <p>On 10/11/18 at 2:07 PM, the UM said Resident #4 previously had non-skid strips in his room. The UM said the DON and administrator were going through the building and trying to clean up the non-skid strips and she was not sure what happened to the non-skid strips.</p> <p>On 10/11/18 at 2:46 PM, the UM said the non-skid strips were not present in Resident #4's room.</p> <p>On 10/11/18 at 2:05 PM, the UM said Resident #4 had multiple falls, and when asked what could have been done to prevent the falls the UM said she was surprised at the number of falls Resident #4 had.</p> <p>On 10/11/18 at 3:20 PM, the DON said Resident #4 had multiple falls. The DON said when they tried to add more supervision to Resident #4 it could cause more agitation and injury. The DON said after each fall it was discussed in the interdisciplinary team meeting and she would enter a note.</p>	F 689			

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F 689	Continued From page 32	F 689			
F 695 SS=D	<p>On 10/11/18 at 3:30 PM, the DON said they tried really hard to prevent more falls for Resident #4 and she could not think of anything else that could have been done.</p> <p>Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents received respiratory care as ordered by a physician. This was true for 1 of 1 (#16) residents reviewed for oxygen therapy. The deficient practice had the potential for harm if residents did not receive oxygen therapy to maintain adequate oxygen levels. Findings include:</p> <p>Resident #16 was admitted to the facility on 11/18/17 with multiple diagnoses, including shortness of breath.</p> <p>Resident #16's physician's order, dated 11/18/17, documented he was to receive O2 at 2 LPM via NC continuously and to check liter flow four times a day.</p>	F 695	<p>1) Resident #16 was assessed by the Center Nurse Executive or designee on or before 11/28/18 with no adverse effects related to respiratory therapy not given per physician order.</p> <p>2) Residents currently residing in the facility that receive respiratory therapy were reviewed by the Center Nurse Executive or designee on or before 11/28/18 to ensure respiratory therapy in place as ordered.</p> <p>3) Licensed staff were educated on or before 11/28/18 by Center Nurse Executive or designee to ensure that respiratory therapy is in place as ordered.</p> <p>4) Beginning the week of 12/3/18 the Center Nurse Executive or designee will review 3 residents with respiratory therapy per week to ensure respiratory</p>	11/28/18	

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F 695	<p>Continued From page 33</p> <p>Resident #16's October 2018 MAR documented the O2 liter flow checks had been completed as ordered.</p> <p>Resident #16's current care plan directed staff to administer O2 as ordered and observe signs for shortness of breath.</p> <p>On 10/10/18 from 4:10 PM to 4:49 PM, Resident #16 was in his wheelchair in the day room watching a favorite TV show. His portable O2 tank was on, set to 2 LPM, and his NC was in his lap:</p> <p>*At 4:10 PM, Resident #16 said he was hungry. The MDS Coordinator discussed a snack with Resident #16 and she did not attempt to place the NC in his nose.</p> <p>*At 4:13 PM, the MDS Coordinator came back with a sandwich for Resident #16 and then he requested chocolate pudding, and the MDS Coordinator left again and came back 2 minutes later with the pudding and a tray table. An unidentified staff member spoke with the resident while the MDS Coordinator set up the tray table, and neither of staff members did not attempt to place the NC in Resident #16's nose.</p> <p>*At 4:17 PM, the MDS Coordinator asked Resident #16 if there was anything else he needed and he requested a soft drink. The MDS Coordinator left and came back at 4:23 PM with a soft drink.</p> <p>*At 4:25 PM, the Unit Manager came into the room and was a few feet away from Resident #16. The UM looked at Resident #16 and then</p>	F 695	<p>therapy in place as ordered. Results to be discussed at monthly PI for a min of 3 months or until compliance is achieved.</p> <p>5) The Center Nurse Executive is responsible for monitoring and follow up.</p>		

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F 695	<p>Continued From page 34 left the room.</p> <p>*At 4:37 PM, CNA #1 spoke with Resident #16 about his soft drink and food and then left the room without attempting to place the NC in his nose.</p> <p>*At 4:41 PM, the MDS Coordinator came back into the room and did not attempt to place the NC in Resident #16's nose.</p> <p>*From 4:49 PM to 5:10 PM, Resident #16's NC prongs were resting on his right wheelchair wheel.</p> <p>*At 5:02 PM, RN #1 spoke to Resident #16 and took his soft drink mug for a refill and did not attempt to place the NC in his nose.</p> <p>*At 5:05 PM, the Activity Director came into the room. Resident #16 requested a tissue and the Activity Director gave him a few tissues. The Activity Director prepared to assist Resident #16 to the dining room, and the Unit Manager directed her to make sure Resident #16's O2 was on. The Activity Director took the NC off the wheelchair wheel, placed it in his nose, and took him to the dining room.</p> <p>On 10/10/18 at 5:13 PM, the MDS Coordinator said she did not notice anything about Resident #16's O2 and she would have to check the physician orders to see how the O2 was to be administered.</p> <p>On 10/10/18 at 5:17 PM, LPN #1 checked Resident #16's O2 saturation level which was measured at 92%.</p>	F 695			

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F 695	Continued From page 35 On 10/10/18 at 5:21 PM, the Unit Manager said staff should have noticed that the NC was not on Resident #16. Resident #16's Progress Note, dated 10/10/18 at 6:10 PM, documented he went without O2, had no shortness of breath or respiratory distress, and his O2 saturation rate was 92% (desired O2 saturation is greater than 90%).	F 695			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, resident interviews, resident group interview, test tray evaluation and staff interview, it was determined the facility failed to ensure palatable food was served. This affected 5 of 9 (#1, #12, #13, #15, and #32) residents in the group interview and 2 of 12 (#30 and #192) sampled residents and had the potential to affect all 40 residents who dined in the facility. This failed practice created the potential to negatively affect residents' nutritional status and psychosocial well-being related to unpalatable food. Findings include:	F 804	1) Residents #1,12,13,15,32, 30 and 192 will be interviewed by the CDM or designee for food satisfaction survey on or before 11/28/18. 2) All other residents will be interviewed by the CDM or designee using the food satisfaction survey on or before 11/28/18. 3) Dining services staff will be in-serviced on or before 11/28/18. Topics will include steps to insure all equipment is operating properly to maintain acceptable food temperatures throughout meal services; sampling meal prior to service to determine if meal is acceptable to send	11/28/18	

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F 804	<p>Continued From page 36</p> <p>The facility's Food quality policy, dated September 2017, directed staff to prepare and serve palatable food at an appetizing temperature.</p> <p>The facility's Resident Council Minutes, dated 8/14/18, documented resident concerns regarding the quality and temperature of the food. Resident Council Minutes, dated 9/12/18, documented new menus began in October 2018.</p> <p>On 10/9/18 at 3:59 PM, Resident #192 stated the food was not very good. Resident #192's spouse stated there was no spice or flavor in the food.</p> <p>On 10/10/18 at 3:25 PM, Resident #30 stated sometimes the food was not very good, and although the facility provided a menu, the choices seemed to be limited. Resident #30 was on isolation and confined to her room. Resident #30 stated the food was cold a majority of the time when they brought it down to her room. Resident #30 stated she did not have problems with the food being cold when she was eating in the dining room.</p> <p>On 10/11/18 at 10:27 AM, Resident #192 stated the meal was cold the previous evening at dinner time.</p> <p>On 10/11/18 at 10:52 AM, during the Resident group interview, Residents #1, #12, #13, #15, and #32 said the food was terrible and the food was cold half of the time. They said dietary staff had told them the new menus would improve things, but the food had not improved.</p> <p>On 10/11/18 at 12:18 PM, a lunch meal test tray</p>	F 804	<p>out to residents; test trays to monitor temperature and palatability at meal service. Dining services will use the "Food and Nutrition Services Satisfaction Survey" to get feedback from residents and the "Meal Service Log" to test meal quality before food is served. These are ongoing system changes.</p> <p>4) Beginning the week of December 3rd 2018 CDM or designee will perform 5 test trays a week for 4 weeks, and then 3 test trays a week for 2 months to ensure food standards are met. Residents #1,12,13,15,32, 30 and 192 will be interviewed by the CDM or designee monthly for 2 months after initial interview with food satisfaction survey questionnaire. Audit results from test trays, satisfaction surveys and meal service logs will be reported to the Performance Improvement Committee for a minimum of 3 months or until compliance is sustained.</p> <p>5) The Administrator is responsible for monitoring and compliance.</p>		

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F 804	Continued From page 37 was evaluated by two surveyors with the CDM (Certified Dietary Manager) present. The chicken quesadilla had a temperature of 113-degrees F (Fahrenheit). The CDM said the quesadilla was too cool. The CDM and a surveyor said the vegetable barley soup was bland and undercooked with crunchy celery and carrots. On 10/12/18 at 9:39 AM, Resident #192 stated the meals from the previous couple of days were not on the warm side and were cold. On 10/12/18 at 10:00 AM, Resident #30 stated the food from the previous couple of days were not very good. Resident #30 stated the food was cold and did not taste very good.	F 804			
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 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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: §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	F 880		11/28/18	

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F 880	<p>Continued From page 38</p> <p>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 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. <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>	F 880			

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F 880	<p>Continued From page 39</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, record review, policy review, and staff interview, it was determined the facility failed to ensure a resident's O2 NC prongs were disinfected or replaced after they came into contact with a potentially contaminated surface. This was true for 1 of 12 (#16) residents sampled for infection control measures. This failure created the potential for harm by exposing residents to the risk of infection and cross-contamination. Findings include:</p> <p>The facility's cleaning and disinfecting policy, dated 7/24/18, directed staff that objects which came into contact with mucus membranes required a high level of disinfection.</p> <p>Resident #16 was admitted to the facility on 11/18/17 with multiple diagnoses, including shortness of breath.</p> <p>Resident #16's physician's order, dated 11/18/17, documented he was to receive O2 at 2 LPM via NC continuously and to check liter flow four times a day.</p> <p>Resident #16's current care plan directed staff to administer O2 as ordered.</p>	F 880	<p>1) Resident #16 was assessed by the Center Nurse Executive or designee on or before 11/28/18 with no adverse effects related to oxygen prongs not being disinfected prior to placement into resident's nares.</p> <p>2) Residents currently residing in the facility that receive oxygen therapy with the use of nasal cannulas were reviewed by the Center Nurse Executive or designee on or before 11/28/18 to ensure that infection control measures are followed.</p> <p>3) Facility staff were educated on or before 11/28/18 by the Center Nurse Executive or designee on infection control practices for medical equipment that may come into contact with potentially contaminated surfaces.</p> <p>4) Beginning the week of 12/3/18 the Center Nurse Executive or designee will review 3 residents receiving oxygen therapy per nasal cannula per week to ensure infection control practices followed. Results to be discussed at monthly PI for a minimum of 3 months or until compliance is achieved.</p> <p>5) The Center Nurse Executive is</p>		

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F 880	<p>Continued From page 40</p> <p>On 10/10/18 from 4:10 PM to 4:49 PM, Resident #16 was in his wheelchair in the day room watching a favorite TV show. His portable O2 tank was on, set to 2 LPM's, and his NC was in his lap:</p> <p>*From 4:49 PM to 5:10 PM, Resident #16's NC prongs were resting on his right wheelchair wheel.</p> <p>*At 5:05 PM, the Activity Director came into the room. Resident #16 requested a tissue and the Activity Director gave him a few tissues. The Activity Director prepared to assist Resident #16 to the dining room, and the UM directed her to make sure Resident #16's O2 was on. The Activity Director took the NC off the wheelchair wheel, placed it in his nose, and took him to the dining room.</p> <p>On 10/10/18 at 5:10 PM, the Activity Director said the NC was off Resident #16's face prior to placing it back on him and she did not notice where the NC was prior to placing it back in his nose.</p> <p>On 10/10/18 at 5:21 PM, the UM said staff should have noticed that the NC was not on Resident #16 and should have noticed where the NC was prior to placing it back on. She said she would have staff change the O2 tubing.</p>	F 880	responsible for monitoring and follow up.		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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June 10, 2019

Monte Jones, Administrator
Rexburg Care & Rehabilitation Center
660 South Second Street West
Rexburg, ID 83440-2300

Provider #: 135105

Dear Mr. Jones:

On **October 9, 2018** through **October 12, 2018**, an unannounced on-site complaint survey was conducted at Rexburg Care & Rehabilitation Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007914

ALLEGATION #1:

There was not enough staff to meet residents' needs, there was only one nurse on duty in August 2018, and residents had to clean up their own toilets due to lack of staff.

FINDINGS #1:

During the investigation, 14 records were reviewed, 12 residents were observed, the facility nursing schedule was reviewed, facility grievances and resident council minutes were reviewed, and interviews with staff, residents, and family members were conducted.

Call lights were observed throughout the survey and staff were answering call lights and assisting the residents in a timely manner. Several nurses were observed on duty throughout the survey and were assisting residents with their care needs. The bathrooms in 12 residents' rooms were observed for cleanliness and were observed to be clean.

The facility nurse staffing schedule for multiple days from August through October 2018 were reviewed

and it documented the facility had adequate staffing of nurses to meet the resident needs.

Several residents and family members said there were enough nurses and staff to take care of their needs, including enough housekeeping staff to keep their toilets clean. Several nurses and CNAs said they felt there were enough staff to take care of resident needs. The Director of Nursing said the facility had enough nurses and staff to take care of resident needs. A housekeeper and the Housekeeping Manager said residents' bathrooms were cleaned daily.

The allegation was unsubstantiated regarding lack of staffing and residents having to clean their own toilets based on the investigative findings.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The food served at the facility did not taste good.

FINDINGS #2:

During the survey a lunch tray was evaluated, staff were interviewed, residents were interviewed, and resident council minutes were reviewed.

On 10/11/18, a lunch meal test tray was evaluated by two surveyors with the CDM (Certified Dietary Manager) present. The chicken quesadilla had a temperature of 113-degrees Fahrenheit.

The facility's resident council minutes, dated 8/14/18, documented resident concerns regarding the quality and temperature of the food.

Several residents said the food was not very good and was cold. The CDM said the quesadilla was too cool. The CDM and a surveyor said the vegetable barley soup was bland and undercooked with crunchy celery and carrots.

Based on investigative findings the allegation was substantiated and the facility was cited at F804 for unpalatable food.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

Staff told residents to use their incontinent briefs rather than assisting them to the bathroom.

FINDINGS #3:

During the investigation, staff were observed, four resident records were reviewed, facility grievances were reviewed, residents and family members were interviewed, and staff were interviewed.

Staff were observed assisting residents to the toilet and did not tell them to use incontinent briefs instead, including three residents who were observed for incontinence care. CNAs and nurses were observed for staff while interacting with residents and no concerns regarding neglect or abuse were observed.

The records of four residents were reviewed for incontinence care, and potential abuse and neglect and no concerns were identified. The facility grievances from August 2018 to October 2018, did not document a concern for incontinence care, or resident abuse and neglect.

Residents and family members said there were no concerns with toileting or abuse and neglect. Several nurses and CNAs said if residents needed to use the bathroom they assisted them. They said if they heard or saw staff neglect or abuse a resident, they intervened to make sure the resident was safe and reported the incident. The Director of Nursing and the Administrator said staff were trained to report potential abuse and neglect and they had not heard of an incident when staff told residents to use their incontinent briefs rather than assisting them to the bathroom.

The allegation was unsubstantiated regarding incontinent care, or abuse and neglect based on the investigative findings.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents' pain was not adequately managed and administration of requested pain medication was delayed.

FINDINGS #4:

During the investigation, two residents were observed for pain management, three resident records were reviewed, facility grievances were reviewed, residents were interviewed, and staff were interviewed.

Two residents were observed for pain management and they received appropriate pain interventions and medication. Medication administration by a nurse was observed for multiple residents and they received their medications as ordered.

The records of three residents were reviewed for pain management and no concerns were identified. The

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facility grievances from August 2018 to October 2018, did not document a concern for pain management.

Several residents said they received their pain medication when they needed it and within minutes of when they requested it. Several nurses said residents' pain was managed and received pain medication when it was requested. The Director of Nursing said residents' pain was managed appropriately and according to their care plans and physician orders.

The allegation was unsubstantiated regarding inadequate pain management based on the investigative findings.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj