



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
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November 20, 2018

R. Ryan Beckman, Administrator  
Grangeville Health & Rehabilitation Center  
410 East North Second Street  
Grangeville, ID 83530-2258

Provider #: 135080

Dear Mr. Beckman:

On **October 26, 2018**, a survey was conducted at Grangeville Health & 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 immediate jeopardy to resident health or safety, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

On **October 26, 2018**, the facility submitted a credible allegation that the immediate jeopardy was corrected. After review of your Plan of Correction, it was determined that the immediate jeopardy to the residents had been removed. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

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.

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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 30, 2018**. Failure to submit an acceptable PoC by **November 30, 2018**, may result in the imposition of additional civil monetary penalties by December 23, 2018 .

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

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

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

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

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

Based on the immediate jeopardy tags cited during this survey:

- **F0610 -- S/S: J -- 483.12(c)(2)-(4) -- Investigate/prevent/correct Alleged Violation**
- **F0600 -- S/S: J -- 483.12(a)(1) -- Free From Abuse And Neglect**

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional

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Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

- Civil money penalty
- Denial of payment for new admission effective **January 26, 2019**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **April 26, 2019**, if substantial compliance is not achieved by that time.

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

Your facility's noncompliance with the following:

- **F0610 -- S/S: J -- 483.12(c)(2)-(4) -- Investigate/prevent/correct Alleged Violation; F0600 -- S/S: J -- 483.12(a)(1) -- Free From Abuse And Neglect**

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

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

Resident #40 as identified on the enclosed Resident Identifier List.

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

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

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In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

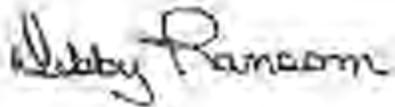
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **November 30, 2018**. If your request for informal dispute resolution is received after **November 30, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

DR/lj

cc: Chairman, Board of Examiners - Nursing Home Administrators

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/26/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GRANGEVILLE HEALTH &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during an unannounced federal recertification survey conducted at the facility from October 22, 2018 to October 26, 2018.</p> <p>Immediate jeopardy to residents' health and safety was cited at 42 CFR 483.12(a)(1) [F600] and 42 CFR 483.12(c)(2)-(4) [F610]. The jeopardy was removed prior to the exit conference.</p> <p>The surveyors conducting the survey were:</p> <p>Linda Kelly, RN, Team Coordinator Lori Griffin, RN</p> <p>Abbreviations used include:</p> <p>DNS = Director of Nursing CNA = Certified Nursing Assistant IM = Intramuscular(ly) LPN = Licensed Practical Nurse NA = Nursing Assistant POST = Physician's Order for Scope of Treatment P&amp;P = Policy &amp; Procedure RN = Registered Nurse SSD = Social Services Director</p>	F 000		
F 578 SS=F	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§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.</p> <p>§483.10(c)(8) Nothing in this paragraph should</p>	F 578		1/25/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/30/2018

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 medical record review, staff interview, and policy review, it was determined the facility failed to ensure residents, and/or their</p>	F 578	<p>F-578</p> <p>Resident Specific:</p>		

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F 578	<p>Continued From page 2</p> <p>representatives, were provided written information about their right to formulate advance directives. This was true for 41 of 41 residents living in the facility, including 16 of 16 residents (#1, #4, #6, #13, #16, #17, #19, #25, #27, #28, #35, #36, #37, #38, #140, and #141) reviewed for advanced directives. The deficient practice increased the risk of residents not having their advance directive decisions documented, honored, and respected when they were unable to make or communicate their health care preferences. Findings include:</p> <p>The facility's Admission Packet identified "Advance Directives - The Patient and/or Legal Representative has been given written materials about the Patient's right to accept or refuse medical treatments as provided by state law and has been informed of the Patient's right to formulate Advance Directives..."</p> <p>This policy was not followed. Examples include:</p> <p>a. Resident #1 was admitted to the facility on 7/16/17, with diagnoses that included major depressive disorder, hypertension, and dyspnea (difficult or labored breathing).</p> <p>The medical record did not contain documented evidence the facility had discussed or provided Resident #1 or her representative with advance directive information, other than a POST.</p> <p>b. Resident #6 was admitted to the facility on 2/11/18, with diagnoses that included cerebral infarction (stroke) and chronic obstructive pulmonary disease.</p>	F 578	<p>Residents 1,6,16,19,35,36,37,38,4,141,13,17,25,27, 28 and or their representatives have been provided written information on their right to formulate advanced directives. Patient #140 has been discharged.</p> <p>Other Residents:</p> <p>All current residents and or their representatives have been provided written information on their right to formulate advanced directives</p> <p>Systemic Changes:</p> <p>Written information on advanced directives has been added to the admission packet.</p> <p>Monitors:</p> <p>Administrator or designee will audit all new admit charts weekly times 4 monthly times 3 to ensure information on advanced directives were provided to resident and or representative.</p> <p>Administrator or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: January 25th 2019</p>		

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F 578	<p>Continued From page 3</p> <p>Resident #6's medical record did not contain documented evidence the facility had discussed or provided him or his representative with advance directive information, other than a POST.</p> <p>c. Resident #16 was admitted to the facility in 2016, with diagnoses that included dementia with behavioral disturbances and glaucoma.</p> <p>The medical record did not contain documented evidence the facility had discussed or provided Resident #16 or her representative with advance directive information other, than a POST.</p> <p>d. Resident #19 was admitted to the facility in 2015, with diagnoses that included kidney failure, diabetes mellitus, and legal blindness.</p> <p>Her medical record did not contain documented evidence that the facility had discussed or provided her or her resident representative with advance directive information, other than a POST.</p> <p>e. Resident #35 was admitted to the facility on 10/13/17, with diagnoses that included anxiety disorder, Parkinson's disease, and macular degeneration.</p> <p>His medical record did not include documented evidence the facility had discussed or provided him or his representative with advance directive information, other a POST.</p> <p>f. Resident #36 was admitted to the facility on 2015, with diagnoses that included major depressive disorder, hypertension, and</p>	F 578			

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F 578	<p>Continued From page 4 Schizophrenia.</p> <p>The medical record did not include documented evidence the facility had discussed or provided Resident #36 or her representative with advance directive information, other than a POST.</p> <p>g. Resident #37 was admitted to the facility in 2015, with diagnoses that included major depressive disorder.</p> <p>Her medical record did not contain documented evidence the facility had discussed or provided her or her representative with advance directive information, other than a POST.</p> <p>h. Resident #38 was admitted to the facility in 2016, with diagnoses that included major depressive disorder and dementia.</p> <p>Her medical record did not contain documented evidence the facility had discussed or provided her or her representative with advance directive information, other than a POST.</p> <p>i. Resident #140 was admitted to the facility on 10/8/18, with diagnoses that included cerebral vascular accident (stroke) with hemiplegia (weakness or paralysis on one side of the body).</p> <p>The medical record did not contain documented evidence the facility had discussed or provided Resident #140 or her representative with advance directive information, other than a POST.</p> <p>j. Resident #4 was admitted to the facility on 4/27/18, with diagnoses that included cancer of</p>	F 578			

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F 578	<p>Continued From page 5</p> <p>the labium and macular degeneration.</p> <p>Her medical record did not contain documented evidence the facility had discussed or provided Resident #140 or her representative with advance directive information, other than a POST.</p> <p>k. Resident #13 was readmitted to the facility on 10/9/18, with diagnoses that included of metatarsal bone fracture, aftercare, and depression.</p> <p>Her medical record did not contain documented evidence the facility had discussed or provided Resident #140 or her representative with advance directive information, other than a POST.</p> <p>l. Resident #17 was readmitted to the facility in 2014, with diagnoses that included cirrhosis of the liver and heart failure.</p> <p>His medical record did not contain documented evidence the facility had discussed or provided him or his representative with advance directive information, other than a POST.</p> <p>m. Resident #25 was admitted to the facility on 6/6/18, with diagnoses that included weakness, hypertension, and osteoarthritis.</p> <p>The medical record did not contain documented evidence the facility had discussed or provided him or his representative with advance directive information, other than a POST.</p> <p>n. Resident #27 was admitted to the facility in</p>	F 578			

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F 578	<p>Continued From page 6</p> <p>2016 with diagnoses that included major depressive disorder, Parkinson's disease, and restless leg syndrome.</p> <p>Her medical record did not contain documented evidence the facility had discussed or provided her or her representative with advance directive information, other than a POST.</p> <p>o. Resident #28 was admitted to the facility on 4/3/17, with diagnoses that included Alzheimer's disease, anxiety disorder, and type 2 diabetes mellitus with diabetic retinopathy.</p> <p>Her medical record did not contain documented evidence the facility had discussed or provided her or her representative with advance directive information, other than a POST.</p> <p>p. Resident #141 was admitted to the facility on 10/15/18, with diagnoses that included aftercare, fractures of the lumbosacral spine and pelvis, and dementia.</p> <p>Her medical record did not contain documented evidence the facility had discussed or provided her or her representative with advance directive information, other than a POST.</p> <p>On 10/24/18 at 9:00 AM, the DNS and SSD were interviewed about advance directives. The DNS stated that advance directive information was discussed when a resident was admitted to the facility and reviewed during quarterly care conferences. The DNS stated the POST was the tool they used to discuss advance directives and that other advance directive written materials were not provided. Further, the DNS stated that</p>	F 578			

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 578	Continued From page 7 discussions about advance directives with residents or their representatives were not documented or maintained in their medical records.	F 578			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)  §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- (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- (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	F 580		1/25/19	

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F 580	<p>Continued From page 8</p> <p>State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically 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 on medical record review, staff interview, and policy review, it was determined the facility failed to ensure the physician was notified of injuries of unknown origin that may require physician involvement. This was true for 1 of 16 residents (#16) reviewed for physician notification. The failed practice placed Resident #16 at risk of harm when the physician was not notified when she was found with bruise and small bump of unknown origin on her chin. Findings include:  The facility's Change in Condition policy, dated 3/12/18, documented, "...The Nurse Supervisor/Charge Nurse will notify the patient's Attending Physician or On-Call Physician when there has been: a discovery of injuries of an unknown source ..."</p> <p>Resident #16 was admitted to the facility in 2016</p>	F 580	<p>F-580</p> <p>Resident Specific:</p> <p>Resident #16 physician and PA notified of previous status. Resident 16 evaluated to ensure they did not suffer ill effect.</p> <p>Other Residents:</p> <p>Please see systemic changes</p> <p>Systemic Changes:</p> <p>All nursing staff have been in-serviced on the correct procedure for reporting change of resident status to the resident, their physician, and resident representative.</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>GRANGEVILLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>		
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F 580	<p>Continued From page 9 with diagnoses that included dementia with behavioral disturbances.</p> <p>Resident #16's 6/1/18 quarterly Minimum Data Set (MDS) assessment documented she had severely impaired cognition and never/rarely made decisions.</p> <p>Resident #16's Care Plan, dated 6/25/18, documented she had cognitive loss and dementia with a the goal "will not sustain serious injury due to cognitive deficits and paranoia". Interventions included: "to conduct behavior monitoring."</p> <p>A Nurses Note, dated 6/24/18 at 9:57 PM, documented, "Bluish-Purple skin discoloration on resident's right jawline noted this shift. Unknown etiology. No recent falls known. Small "pea-sized" bump noted underneath upon assessment of area. Also noted to have brief episode during evening meal of non-responsiveness. Staff reported resident being "less active" this shift. Placing resident on alert charting status for this issue. Will continue to monitor bruising until resolved, and provide ongoing support as needed."</p> <p>On 10/25/18 at 8:30 AM, RN #2 stated she found the new bruise and small lump on Resident #16's chin on 6/24/18. The RN stated it was her responsibility to notify the physician when an injury of unknown origin was found but she "forgot" to do it.</p> <p>On 10/26/18 at 1:00 PM, the DNS stated the physician was not notified of the 6/24/18 injury of unknown origin to Resident #16's chin.</p>	F 580	<p>Monitors:</p> <p>All Accident and Incident reports will be reviewed for change of status during morning meetings. Notification of appropriate parties will be confirmed and status changes discussed.</p> <p>DON or designee will review Accidents and Incident Reports status weekly to confirm proper notifications weekly times 4 and monthly times 3.</p> <p>DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: January 25th 2019</p>		

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F 600 SS=J	<p>Free from Abuse and Neglect CFR(s): 483.12(a)(1)</p> <p>§483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and policy review, it was determined the facility failed to ensure 1 of 3 residents (Resident #40) reviewed for death in the facility was provided CPR per his documented instructions in his POST. The licensed staff neglected to verify Resident #40's code status when he did not have a pulse or respirations and neglected to provide CPR per his documented wishes. The neglect resulted in Resident #40's death, and placed the health and safety of the 3 other residents #37, #140, and #141) in the facility with a code status of Full Code (resuscitate/initiate CPR) in immediate jeopardy. Findings include:</p> <p>Resident #40 was admitted to the facility on 8/20/18, with diagnoses that included cerebral infarction (stroke), hemiplegia and hemiparesis (weakness/paralysis on one side of the body)</p>	F 600	<p>F-600</p> <p>Resident Specific:</p> <p>Resident #40 and #140 have been discharged. Residents #37 &amp; #141 have their code status accurately documented in the medical record. A root cause analysis determined that the individual filling out the resident information sheet stored in the residents closet documented code status in error.</p> <p>Other Residents:</p> <p>The code status has been removed from the information sheet in all closets and all current residents have been reviewed to ensure they accurately reflect patient's</p>	11/30/18	

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F 600	<p>Continued From page 11 following the stroke, chronic obstructive pulmonary disease, and long term and current use of anticoagulant (blood thinner) medication.</p> <p>Resident #40's POST form, located in the front of his paper chart, documented he checked "Resuscitate (Full Code)" for cardiopulmonary resuscitation in the event he did not have a pulse and/or was not breathing. He signed the POST form on 8/20/18 and the physician signed it on 8/27/18.</p> <p>Physician Orders, dated 9/14/18, documented Resident #40's code status was Full Code.</p> <p>A Nurses Note, dated 9/25/18 at 10:50 PM, documented Resident #40 "was talking to CNA, he was on the floor and she had called for help at 2251 [10:51 PM]. She was in room when he started to have petite mal seizure while on the floor. I was called to room and we couldn't get him to respond. 911 [emergency response] called we started O2 [oxygen]and started hitting him on the back and chest compressions. No pulse or respirations noted. Attempted to call wife at 2315 [11:15 PM] but had no good number the one we had was res. [resident's] cell phone. At about 2320 [11:20 PM] called [name of] Hospital to notify MD [physician]. I asked if they had a number for his wife. They gave me the number. I attempted to call it but it just continued to ring. Wife called back about 2330 [11:30 PM]. She was notified about what had happened. DNS [Director of Nursing] and ADM [Administrator] called due to no funeral home in chart. Sheriffs (sic) office called here and asked if we had done everything we could have. I told them we had. They told me to call [name of] funeral home. I</p>	F 600	<p>code status.</p> <p>Staff have been in-serviced in regards to facility policy and procedures regarding CPR as it has been updated to include that CPR is to be continuously administered on full code patients until EMS arrives as well as appropriate response to code situations.</p> <p>Also see systemic changes.</p> <p>Systemic Changes:</p> <p>The code status information has been removed from all resident info sheets in all closets.</p> <p>Licensed staff have been in-serviced in regards to obtaining code status from the patient's chart.</p> <p>Facility P&amp;P regarding CPR has been updated to include that CPR is to be continually administered on Full Code patients until EMS arrives.</p> <p>New P&amp;P has been created instructing staff to locate DNR status only in a patient's paper chart or the EMAR.</p> <p>All facility staff have been in-serviced and given documentation on abuse and neglect P&amp;P (identifying and reporting of abuse and neglect), where to appropriately locate patient code status.</p> <p>Staff have been in-serviced in regards to</p>		

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F 600	<p>Continued From page 12</p> <p>called them, and they stated they would be there shortly. They got here about 0010 [12:10 AM]. Wife got here about 0015 [12:15 AM] and talked to ADM. and [name of] Funeral Home representative. She then went to see resident and left. Funeral home took resident and left about 0030 [12:30 AM]."</p> <p>The "Record of Death" identified on 9/25/18 "Resident was found on floor next to bed, had petite mal seizure and then had no resp [respiration] &amp; no heart rate..."</p> <p>On 10/25/18 at 5:45 PM, the DNS stated the Administrator called her to come to the facility on 9/25/18 because Resident #40 had died when CPR was not provided. The DNS stated when she arrived, LPN # 2, who was the charge nurse on 9/25/18, was at the nurses' station charting. The DNS stated she asked why CPR was not initiated when Resident #40 did not have a pulse or respiration and LPN #2 said she thought his code status was DNR because DNR was on the staff instruction sheet inside his closet door. The DNS said LPN #2 did not check Resident #40's medical record for his code status. The DNS stated the facility's practice at the time of the incident on 9/25/18 was residents' code status was on a resident information sheet located on the inside of their closet doors as well as under the Advance Directive tab in the front of their paper chart. She stated that after the incident, the code status was removed from the resident information sheets and she talked to LPN #2 about where to look for the code status in the paper chart. The DNS stated she did not document the conversation with LPN #2 and the facility did not have a policy about where to</p>	F 600	<p>facility policy and procedures regarding CPR as it has been updated to include that CPR is to be continuously administered on full code patients until EMS arrives as well as appropriate response to code situations.</p> <p>A formal investigation of resident #40 has been conducted and reported to the State.</p> <p>The facility has notified and consulted with the Medical Director and he has agreed with actions taken thus far and to assist with the plan of correction.</p> <p>Nurse identified has watched the American Heart Association's CPR and Heimlich training course and has completed a return demonstration to the DON on proper CPR application.</p> <p>Monitors:</p> <p>Administrator or designee will weekly times 4 and monthly times 3 conduct three random staff interviews regarding abuse and neglect P&amp;P, location of code status, and CPR P&amp;P.</p> <p>Administrator or designee weekly times four monthly times three will interview three staff to ensure proper response to code status situations.</p> <p>DON will review code status of all new admissions weekly times 4 and monthly times 3 to ensure proper code status of all</p>		

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F 600	<p>Continued From page 13</p> <p>locate a resident's code status in an emergency situation.</p> <p>On 10/25/18 at 5:45 PM, the Administrator stated he was informed on 9/25/18 that Resident #40 did not receive CPR, and had died. He said LPN #2 did not perform CPR for Resident #40 because the resident information sheet in his closet incorrectly documented DNR as his code status. The Administrator said another nurse, RN #4, had put the "wrong" code status, DNR rather than Full Code, on Resident #40's resident information sheet.</p> <p>On 10/25/18 at 7:30 PM, LPN #2 said she was called to Resident #40's room by staff who found him on the floor and thought he was having a seizure. LPN #2 said when she got to the room, NA #1 and Staff B were there and Resident #40 was on the floor. LPN #2 said she thought he might have choked, so she provided oxygen and one of the staff hit him on the his back. LPN #2 stated Staff B called 911 (emergency medical system) because "we didn't know what to do" and thought he needed to go to the hospital. She said while Staff B was on the phone with the 911 dispatcher, Resident #40 stopped breathing and did not have a pulse. She said one of the staff gave him "a few compressions to see if he was just choking or something but nothing happened." LPN #2 said they were not sure if he was a code or not so one of the staff checked the paper in his closet which documented DNR. LPN #2 said she heard Staff B tell the 911 dispatcher the ambulance was not needed because he had passed away. LPN #2 said she returned to the Nurses' Station and attempted but was unable to contact his wife, she called the hospital and</p>	F 600	<p>new patients.</p> <p>Administrator and DON or designees will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: Nov 30th 2018</p>		

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F 600	<p>Continued From page 14</p> <p>asked a nurse to notify Resident #40's physician that he had passed away, and she obtained Resident #40's wife's correct phone number. LPN #2 said she called and left a message for Resident #40's wife. LPN #2 said the wife returned the call later and the LPN told her what had happened. After that, LPN #2 tried unsuccessfully to contact the DNS so she called the Administrator. LPN #2 said she was "confused and didn't know what to do" because a funeral home was not listed for Resident #40. LPN #2 said the Administrator arrived within a few minutes and provided the name of a funeral home to call. LPN #2 said the 911 dispatcher called back later and asked if they had done everything they could for Resident #40 and at that time she said they had. When Resident #40's wife arrived, she asked LPN #2 why Resident #40 had not gone to the hospital and said that he should have gone to the hospital. LPN #2 stated that was when she checked Resident #40's chart and saw that his code status was Full Code. She said the Administrator who was still in the facility and she notified him of the situation. LPN #2 stated, "At that time how you identified code status was a paper in the closet and it said no code." The LPN also stated, "I believe it's (code status information) on the face sheet" and that she should have looked at the chart right away."</p> <p>A 10/18/18 "Personnel Action" documented, "... [RN #4's name] created a resident information form that incorrectly identified a resident as DNR when they were in fact full code..."</p> <p>An undated "Write Up Information" sheet documented, "[DNS' name] asked [LPN #2's</p>	F 600			

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F 600	<p>Continued From page 15</p> <p>name] where DNR information was obtained for patient and initial information was pulled from the resident information sheet on the resident's door. [LPN #2's name] was educated that night verbally about her responsibilities of where to find information in the patient chart and about continuation of CPR until EMS arrival. Upon investigation of the information sheet it was noted that the sheet was incorrectly filled out by [RN #4's name]...After speaking to legal counsel, it was determined that [RN #4] should have official corrective action for her mistake. Corrective action has since occurred"</p> <p>The facility's undated policy regarding the POST form documented, "...The licensed nurse places the completed and signed...POST form in the front of the individuals clinical record and under Advanced Directives ..."</p> <p>REMOVAL OF IMMEDIATE JEOPARDY PRIOR TO EXIT CONFERENCE:</p> <p>The IJ was identified on 10/25/18 and determined to first exist on 9/25/18, when Resident #40 was without pulse and respiration and CPR was not initiated by the facility. On 10/25/18 at 9:30 PM, the facility's Administrator, DNS, and Corporate Nurse were informed verbally and in writing of the IJ.</p> <p>On 10/26/18 at 1:50 PM, the Corporate Nurse and Administrator provided an acceptable plan to remove the immediacy of the IJ.</p> <p>The facility's plan to remove the IJ immediacy was:</p>	F 600			

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F 600	<p>Continued From page 16</p> <ol style="list-style-type: none"> <li>1. Revision of the Cardiopulmonary Resuscitation P&amp;P on 10/25/18 to include, "CPR is to continue to be performed by staff until EMS [emergency medical service personnel] arrives."</li> <li>2. Creation of a P&amp;P on 10/25/18 regarding where the staff are to locate a resident's code status in the EHR [electronic health record] and paper chart.</li> <li>3. In-service education for all employees (not just licensed staff), which began on 10/25/18, regarding: <ol style="list-style-type: none"> <li>a. Abuse and neglect P&amp;P (identification and reporting - whom to report to and time frames).</li> <li>b. Where to locate a resident's code status (new P&amp;P), and informed the staff to "always" use the resident's paper chart for identification of code.</li> <li>c. CPR policy for Full Code patients with emphasis on continuing CPR until EMS arrives. This is to be completed by each employee from all departments prior to starting their next scheduled shift. Each in-serviced staff member is given a copy of the P&amp;P [policy and procedure] pertaining to the afore mentioned items in 1, 2, 3, and signs in-service log upon completion).</li> </ol> </li> <li>4. Initiated an investigation of the neglect that resulted in a death in the facility with Idaho Department of Health and Welfare abuse portal, Incident [number] on 10/26/18</li> <li>5. Notified Medical Director of Immediate Jeopardy, steps taken so far, and suggestions for future actions to be taken to prevent further</li> </ol>	F 600			

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F 600	Continued From page 17 incidents of this nature. He agreed with the current steps and to assist with a plan of correction.	F 600			
F 607 SS=D	<p>6. Required the nurse identified in the IJ to watch CPR &amp; Heimlich video by American Heart Association and return demonstrate to the DNS for accuracy and understanding prior to working any further shifts.</p> <p>Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews, and policy review, it was determined the facility failed ensure, in a case of potential neglect, an investigation was initiated, and staff were suspended during the investigation, as stated in its policies. This was true for 1 of 3 residents (Resident #40) whose records were reviewed for death in the facility. This failure resulted in the lack of a thorough investigation when Resident #40 was not provided with cardiopulmonary resuscitation (CPR) consistent with his advanced directive, and subsequently died. Findings</p>	F 607	<p>F-607</p> <p>Resident Specific:</p> <p>Resident #40 has been discharged</p> <p>Other Residents:</p> <p>Please see systemic changes</p> <p>Systemic Changes:</p>	1/25/19	

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F 607	<p>Continued From page 18 include:</p> <p>The facility's Abuse Reporting Policy and Procedure, dated 3/12/18, documented "The following specific possible neglect situations must be reported and investigated: ...Neglect-Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Staff mistakes that result in the resident's need for hospitalization, treatment in a hospital emergency room, fractured bones, IV treatment, dialysis, or death." The policy further stated "A thorough investigation is critical to developing effect prevention strategies..."</p> <p>The facility's Prevention of Mistreatment, Neglect, Abuse &amp; Misappropriation Policy Statement documented "The facility shall investigate all alleged violations and will protect the resident from further potential abuse while the investigation is in progress..."</p> <p>Resident #40 was admitted to the facility on 8/20/18, with diagnoses that included cerebral infarction (stroke), hemiplegia and hemiparesis (weakness/paralysis on one side of the body) following the stroke, chronic obstructive pulmonary disease, and long term and current use of anticoagulant (blood thinner) medication.</p> <p>Resident #40's POST form, located in the front of his paper chart, documented he checked "Resuscitate (Full Code)" for cardiopulmonary resuscitation in the event he did not have a pulse and/or was not breathing. He signed the POST form on 8/20/18 and the physician signed it on 8/27/18.</p>	F 607	<p>Administrator and DON verbally in-serviced by corporate staff in regards to following P&amp;P on the procedure of initiating investigation and suspension of suspected staff for situations of potential neglect on 11/26/18.</p> <p>Monitors:</p> <p>All situations where potential neglect is identified will be reported to corporate staff to ensure proper P&amp;P is being followed.</p> <p>Corporate staff will review findings at QA meetings and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: January 25th 2019</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/26/2018</b>
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F 607	<p>Continued From page 19</p> <p>Physician Orders, dated 9/14/18, documented Resident #40's code status was Full Code.</p> <p>A Nurses Note, dated 9/25/18 at 10:50 PM, documented Resident #40 "was talking to CNA, he was on the floor and she had called for help at 2251 [10:51 PM]. She was in room when he started to have petite mal seizure while on the floor. I was called to room and we couldn't get him to respond. 911 [emergency response] called we started O2 [oxygen] and started hitting him on the back and chest compressions. No pulse or respirations noted." The Nurses Note also documented "Sheriffs (sic) office called here and asked if we had done everything we could have. I told them we had."</p> <p>The "Record of Death" dated 9/25/18 documented "Resident was found on floor next to bed, had petite mal seizure and then had no resp [respiration] &amp; no heart rate..."</p> <p>On 10/25/18 at 5:45 PM, the DNS stated the Administrator called her to come to the facility on 9/25/18 because Resident #40 had died when CPR was not provided. The DNS stated when she arrived, LPN # 2, who was the charge nurse on 9/25/18, was at the nurses' station charting. The DNS stated she asked why CPR was not initiated when Resident #40 did not have a pulse or respiration and LPN #2 said she thought his code status was DNR because DNR was on the staff instruction sheet inside his closet door. The DNS said LPN #2 did not check Resident #40's medical record for his code status. The DNS stated the facility's practice at the time of the incident on 9/25/18 was residents' code status</p>	F 607			

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F 607	<p>Continued From page 20</p> <p>was on a resident information sheet located on the inside of their closet doors as well as under the Advance Directive tab in the front of their paper chart. She stated that after the incident, the code status was removed from the resident information sheets and she talked to LPN #2 about where to look for the code status in the paper chart. The DNS stated she did not document the conversation with LPN #2 and the facility did not have a policy about where to locate a resident's code status in an emergency situation.</p> <p>On 10/25/18 at 7:30 PM, LPN #2 said she was called to Resident #40's room by staff who found him on the floor and thought he was having a seizure. LPN #2 said when she got to the room, NA #1 and Staff B were there and Resident #40 was on the floor. LPN #2 said she thought he might have choked, so she provided oxygen and one of the staff hit him on the back. LPN #2 stated Staff B called 911 (emergency medical system) because "we didn't know what to do" and thought he needed to go to the hospital. She said while Staff B was on the phone with the 911 dispatcher, Resident #40 stopped breathing and did not have a pulse. She said one of the staff gave him "a few compressions to see if he was just choking or something but nothing happened." LPN #2 said they were not sure if he was a code or not so one of the staff checked the paper in his closet which documented DNR. LPN #2 said she heard Staff B tell the 911 dispatcher the ambulance was not needed because he had passed away. LPN #2 said the 911 dispatcher called back later and asked if they had done everything they could for Resident #40 and at that time she said they had. LPN #2 stated when</p>	F 607			

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F 607	<p>Continued From page 21</p> <p>Resident #40's wife arrived, she asked LPN #2 why Resident #40 had not gone to the hospital, as he should have. LPN #2 stated that was when she checked Resident #40's chart and saw his code status was Full Code. She said the Administrator who was still in the facility and she notified him of the situation. LPN #2 stated "At that time how you identified code status was a paper in the closet and it said no code." LPN #2 also stated, "I believe it's (code status information) on the face sheet" and that she should have "looked at the chart right away."</p> <p>A 10/18/18 Personnel Action documented RN #4 created a resident information form that incorrectly identified a resident as DNR when they were in fact full code.</p> <p>An undated "Write Up Information" sheet documented, "[DNS' name] asked [LPN #2's name] where DNR information was obtained for patient and initial information was pulled from the resident information sheet on the resident's door. [LPN #2's name] was educated that night verbally about her responsibilities of where to find information in the patient chart and about continuation of CPR until EMS arrival. Upon investigation of the information sheet it was noted that the sheet was incorrectly filled out by [RN #4's name]...After speaking to legal counsel, it was determined that [RN #4] should have official corrective action for her mistake. Corrective action has since occurred"</p> <p>On 10/26/18 at 12:30 PM, the DNS stated the facility's policy required initiation of an investigation for neglect and the removal of staff involved from the schedule to ensure the</p>	F 607			

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F 607	Continued From page 22 residents were protected during the investigation. The DNS confirmed a thorough investigation of the neglect was not conducted and LPN #2 continued to work at the facility.  On 10/26/18 at 1:00 PM, the Administrator said he was informed on 9/25/18 that Resident #40 who was a Full Code did not receive CPR and died. The Administrator said some actions were taken by the facility but a thorough investigation of the incident of neglect was not initiated per the facility policy.	F 607			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		1/25/19	

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F 609	<p>Continued From page 23</p> <p>designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record reviews, staff interviews, and policy review, it was determined the facility failed ensure potential neglect related to the death of a resident when cardiopulmonary resuscitation (CPR) was not initiated per his advanced directive, and an injury of unknown origin, were immediately reported to the Administrator and reported to the State Survey Agency within 2 to 24 hours. This was true for 2 of 3 residents (#16 and #40) whose death records were reviewed. This deficient practice placed residents at increased risk of undetected abuse/neglect. Findings include:</p> <p>The facility's Abuse Reporting Policy and Procedure, dated 3/12/18, documented "The following specific possible neglect situations must be reported and investigated: ...Neglect-Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Staff mistakes that result in the resident's need for hospitalization, treatment in a hospital emergency room, fractured bones, IV treatment, dialysis, or death." The policy further stated "A thorough investigation is critical to developing effect prevention strategies..."</p> <p>The facility Abuse Policy, dated 3/12/18 stated "The following types of incidents must be reported to the State Survey agency: ...c.</p>	F 609	<p>F-609</p> <p>Resident Specific:</p> <p>Resident #40 has been discharged. Resident #16's situation was identified past required reporting requirements.</p> <p>Other Residents:</p> <p>Any new situations meeting reporting requirements will be submitted in a timely manner.</p> <p>Systemic Changes:</p> <p>All alleged violations of abuse, neglect, and exploitation reported to the administrator will be appropriately reported.</p> <p>All facility staff have been in-serviced and given documentation on abuse and neglect P&amp;P (identifying and reporting of abuse and neglect</p> <p>Monitors:</p> <p>Administrator or designee will review all reportable incidents weekly times 4 monthly times 3 to ensure reporting requirements were met.</p>		

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F 609	<p>Continued From page 24</p> <p>Resident injuries of unknown origin. These injuries whose source was not observed by any person or the source of the injury could not be explained by the resident; and, the injury includes bruising on the head, neck, or trunk, fingerprint bruises anywhere on the body, lacerations, sprains, or fractured bones."</p> <p>These policies were not followed. Examples include:</p> <p>a. Resident #40 was admitted to the facility on 8/20/18, with diagnoses that included cerebral infarction (stroke), hemiplegia and hemiparesis (weakness/paralysis on one side of the body) following the stroke, chronic obstructive pulmonary disease, and long term and current use of anticoagulant (blood thinner) medication.</p> <p>Resident #40's POST form, located in the front of his paper chart, documented he checked "Resuscitate (Full Code)" for cardiopulmonary resuscitation in the event he did not have a pulse and/or was not breathing. He signed the POST form on 8/20/18 and the physician signed it on 8/27/18.</p> <p>Physician Orders, dated 9/14/18, documented Resident 40's code status was Full Code.</p> <p>A Nurses Note, dated 9/25/18 at 10:50 PM, documented Resident #40 "was talking to CNA, he was on the floor and she had called for help at 2251 [10:51 PM]. She was in room when he started to have petite mal seizure while on the floor. I was called to room and we couldn't get him to respond. 911 [emergency response] called we started O2 [oxygen] and started hitting him on</p>	F 609	<p>Administrator or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: January 25th 2019</p>		

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

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OMB NO. 0938-0391

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F 609	<p>Continued From page 25</p> <p>the back and chest compressions. No pulse or respirations noted." The Nurses Note also documented "Sheriffs (sic) office called here and asked if we had done everything we could have. I told them we had."</p> <p>On 10/25/18 at 5:45 PM, the DNS stated the Administrator called her to come to the facility on 9/25/18 because Resident #40 had died when CPR was not provided. The DNS stated when she arrived, LPN # 2, who was the charge nurse on 9/25/18, was at the nurses' station charting. The DNS stated she asked why CPR was not initiated when Resident #40 did not have a pulse or respiration and LPN #2 said she thought his code status was DNR because DNR was on the staff instruction sheet inside his closet door. The DNS said LPN #2 did not check Resident #40's medical record for his code status. The DNS stated the facility's practice at the time of the incident on 9/25/18 was residents' code status was on a resident information sheet located on the inside of their closet doors as well as under the Advance Directive tab in the front of their paper chart. She stated that after the incident, the code status was removed from the resident information sheets and she talked to LPN #2 about where to look for the code status in the paper chart. The DNS stated she did not document the conversation with LPN #2 and the facility did not have a policy about where to locate a resident's code status in an emergency situation.</p> <p>On 10/25/18 at 7:30 PM, LPN #2 said she was called to Resident #40's room by staff who found him on the floor and thought he was having a seizure. LPN #2 said when she got to the room,</p>	F 609			

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F 609	<p>Continued From page 26</p> <p>NA #1 and Staff B were there and Resident #40 was on the floor. LPN #2 said she thought he might have choked, so she provided oxygen and one of the staff hit him on the back. LPN #2 stated Staff B called 911 (emergency medical system) because "we didn't know what to do" and thought he needed to go to the hospital. She said while Staff B was on the phone with the 911 dispatcher, Resident #40 stopped breathing and did not have a pulse. She said one of the staff gave him "a few compressions to see if he was just choking or something but nothing happened." LPN #2 said they were not sure if he was a code or not so one of the staff checked the paper in his closet which documented DNR. LPN #2 said she heard Staff B tell the 911 dispatcher the ambulance was not needed because he had passed away. LPN #2 said the 911 dispatcher called back later and asked if they had done everything they could for Resident #40 and at that time she said they had. LPN #2 stated when Resident #40's wife arrived, she asked LPN #2 why Resident #40 had not gone to the hospital, as he should have. LPN #2 stated that was when she checked Resident #40's chart and saw his code status was Full Code. She said the Administrator who was still in the facility and she notified him of the situation. LPN #2 stated "At that time how you identified code status was a paper in the closet and it said no code." LPN #2 also stated, "I believe it's (code status information) on the face sheet" and that she should have "looked at the chart right away."</p> <p>b. Resident #16 was admitted to the facility in 2016 with diagnoses that included dementia with behavioral disturbances.</p>	F 609			

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F 609	<p>Continued From page 27</p> <p>Resident #16's 6/1/18 quarterly Minimum Data Set (MDS) assessment documented she had severely impaired cognition and never/rarely made decisions.</p> <p>Resident #16's Care Plan, dated 6/25/18, documented she had cognitive loss and dementia with a the goal "will not sustain serious injury due to cognitive deficits and paranoia". Interventions included: "to conduct behavior monitoring."</p> <p>A Nurses Note, dated 6/24/18 at 9:57 PM, documented, "Bluish-Purple skin discoloration on resident's right jawline noted this shift. Unknown etiology. No recent falls known. Small "pea-sized" bump noted underneath upon assessment of area. Also noted to have brief episode during evening meal of non-responsiveness. Staff reported resident being "less active" this shift. Placing resident on alert charting status for this issue. Will continue to monitor bruising until resolved, and provide ongoing support as needed."</p> <p>On 10/25/18 at 8:30 AM, RN #2 stated she did not initiate an investigation when the new bruise and lump were noted on Resident 16's chin on 6/24/18. RN #2 stated, "I am responsible to start the investigation and notify the administration when an injury of unknown origin is found but just forgot to do it."</p> <p>On 10/26/18 at 12:30 PM, the DNS stated the facility policy requires reporting of an allegation of neglect to the Administrator and the State Survey Agency. The DNS confirmed the State Survey Agency was not notified of the incidents with</p>	F 609			

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F 609	Continued From page 28 Resident #16 and Resident #40.	F 609			
F 610 SS=J	<p>On 10/26/18 at 1:00 PM, the Administrator stated he was informed on 9/25/18 that Resident #40 who was a Full Code did not receive CPR and had died. The Administrator confirmed the State Survey Agency was not notified of the allegation of neglect for Resident #40 and the injury of unknown origin for Resident #16.</p> <p>Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)</p> <p>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.</p> <p>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy review, the facility failed to initiate or conduct a thorough investigation of neglect for 1 of 3 residents (#40) whose closed clinical records were reviewed for death in the facility; and, potential abuse for 1 of 16 residents (#16) whose</p>	F 610	<p>F-610</p> <p>Resident Specific:</p> <p>Resident #40 and #16 have been investigated</p>	11/30/18	

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F 610	<p>Continued From page 29</p> <p>records were reviewed. Resident #40, whose clinical record included a POST form documenting his wishes for resuscitation/full code status, did not receive CPR during an emergency situation and subsequently died. Resident #16 was at risk for potential ongoing abuse when a bruise and small bump of unknown origin found on her chin was not investigated as potential abuse. The failure to conduct a thorough investigation of neglect to provide CPR for Resident #40 and to immediately put effective measures in place to ensure further neglect did not occur placed the health and safety of the other 3 residents (#37, #140, and #141) in the facility who chose resuscitation/full code in the event their heart stopped or they stopped breathing, in immediate jeopardy. Findings include:</p> <p>The facility's Abuse Policy, dated 3/12/18, documented, "The following types of incidents must be reported to the State Survey agency: ...c. Resident injuries of unknown origin. These injuries whose source was not observed by any person or the source of the injury could not be explained by the resident; and, the injury includes bruising on the head, neck, or trunk, fingerprint bruises anywhere on the body, lacerations, sprains, or fractured bones. Minor bruising and/or skin tears on the extremities need not be reported, injuries found immediately after a fall need not be reported as unknown origin." And, that injuries of unknown origin "need to be investigated ..."</p> <p>The above policy was not followed. Examples include:</p>	F 610	<p>Other Residents:</p> <p>All incidents of potential neglect or injuries of unknown origin have been thoroughly investigated (if any).</p> <p>See also POC for F-600</p> <p>Systemic Changes:</p> <p>Licensed staff have been in-serviced in regards to performing an investigation of all potential issues of neglect and injuries of unknown origin.</p> <p>See also POC for F-600</p> <p>Monitors:</p> <p>DON or designee will audit all incident reports weekly times 4 and monthly times 3 to confirm all incidents of potential neglect and injuries of unknown origin have been appropriately investigated.</p> <p>DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>See also POC for F-600</p> <p>Date of Compliance: November 30th 2018</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRANGEVILLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>		
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F 610	<p>Continued From page 30</p> <p>1. Resident #40 was admitted to the facility on 8/20/18 with diagnoses that included cerebral infarction (stroke), hemiplegia, and hemiparesis, COPD, and long term (and current) use of anticoagulant medications.</p> <p>His POST located in his paper chart under the Advance Directives tab, documented he checked "Full Code" (cardiopulmonary resuscitation is to be performed by staff in the event the resident is absent of pulse and respiration) on 8/20/18 and his physician signed it on 8/27/18.</p> <p>Resident #40's Physician Orders, dated 9/14/18, documented his code status was Full Code.</p> <p>A Nurses Note, dated 9/25/18 at 10:50 PM, documented, "...resident was talking to CNA, he was on the floor and she had called for help at 2251 [10:51 PM]. She was in room when he started to have petite mal seizure while on the floor. I was called to room and we couldn't get him to respond. 911 [emergency response] called we started O2 [oxygen] and started hitting him on the back and chest compressions. No pulse or respirations noted. Attempted to call wife at 2315 [11:15 PM] but had no good number the one we had was res. [residents] cell phone. At about 2320 [11:20 PM] called [name of] Hospital to notify MD [physician]. I asked if they had a number for his wife. They gave me the number. I attempted to call it but it just continued to ring. Wife called back about 2330 [11:30 PM]. She was notified about what had happened. DNS and ADM [Administrator] called due to no funeral home in chart. Sheriffs [sic] office called here and asked if we had done everything we could have. I told them we had. They told me to call [name]</p>	F 610			

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F 610	<p>Continued From page 31</p> <p>funeral home. I called them and they stated they would be there shortly. They got here about 0010 [12:10 AM]. Wife got here about 0015 [12:15 AM] and talked to ADM. and [name] Funeral Home representative. She then went to see resident and left. Funeral home took resident and left about 0030 [12:30 AM]."</p> <p>Resident #40's Record of Death, dated 9/25/18, documented, "...Resident was found on floor next to bed, had petite mal seizure and then had no resp [respiration] &amp; no heart rate ..."</p> <p>On 10/25/18 at 5:45 PM, the DNS stated she was called to the facility by the Administrator on 9/25/18 because Resident #40 had died and CPR was not initiated. The DNS said when she arrived at the facility, LPN #2, who was the charge nurse on 9/25/18, was at the nurses' station charting. The DNS said she asked LPN #2 why CPR was not initiated when Resident #40 did not have a pulse or respiration and the LPN said because she thought his code status was DNR (do not resuscitate). The DNS said LPN #2 had checked the resident information sheet in Resident 40's closet, rather than his medical record, to find his code status. The DNS stated that on 9/25/18, the facility's practice was to maintain residents' code status on a resident information sheet located inside their closet door, and in the the paper chart under the Advance Directives tab. The DNS said after the 9/25/18 incident they removed residents' code status from the resident information sheets. The DNS said she spoke to LPN #2 about where to look in the chart to identify a resident's code status but that she did not document the conversation. The DNS stated she expected staff to look for a</p>	F 610			

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F 610	<p>Continued From page 32</p> <p>resident's code status in their paper chart (clinical record). The DNS stated the facility was aware LPN #2 failed to obtain Resident #40's code status information from his paper chart and that CPR was not initiated per his POST form directions in his paper chart. The DNS said RN #4 had incorrectly documented Resident #40's code status as DNR on the resident information sheet inside his closet. The DNS said the facility did not initiate a formal investigation into the 9/25/18 incident and they did not provide education/retraining of facility staff, other than to LPN #2 and RN #4. The DNS stated the facility did not have a policy that directed staff where to check a resident's advance directive information in a medical emergency and that she had not developed such a policy to educate staff.</p> <p>On 10/26/18 at 9:20 AM, the Administrator said he was aware Resident #40 did not receive CPR on 9/25/18 because his code status was incorrectly checked as DNR instead of Full Code on the resident information sheet in his closet. He said the DNS addressed the incident with LPN #2 and he provided personnel action with RN #4, who had made the code status error on Resident #40's resident information sheet. The Administrator stated that a thorough investigation was not conducted into the neglect of CPR for Resident #40 and action was not taken and measures were not implemented to ensure other residents were not affected.</p> <p>On 10/25/18 at 7:30 PM, LPN #2 stated that she did not perform CPR when Resident #40 stopped breathing and he did not have a pulse because she thought his code status was DNR. LPN #2 said the resident information sheet on the inside</p>	F 610			

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F 610	<p>Continued From page 33 of the Resident #40's closet door, rather than his medical record, was checked for his code status.</p> <p>The facility did not conduct a thorough investigation or ensure preventive measures were in place after Resident #40 died on 9/25/18 when LPN #2 neglected to accurately verify his code status and provide CPR when he did not have a pulse or respirations.</p> <p>2. Resident #16 was admitted to the facility in 2016 with diagnoses that included dementia with behavioral disturbances.</p> <p>Resident #16's quarterly MDS assessment, dated 6/1/18, documented her cognition was severely impaired and she never/rarely made decisions.</p> <p>Resident #16's Care Plan, dated 6/25/18, documented cognitive loss and dementia with a goal that she would not sustain serious injury. Interventions included behavior monitoring.</p> <p>A 6/24/18 at 9:57 PM Nurses Note documented, "Bluish-Purple skin discoloration on resident's right jawline noted this shift. Unknown etiology. No recent falls known. Small pea-sized bump noted underneath upon assessment of area. Also noted to have brief episode during evening meal of non-responsiveness. Staff reported resident being less active this shift. Placing resident on alert charting status for this issue. Will continue to monitor bruising until resolved, and provide ongoing support as needed."</p> <p>On 10/24/18 at 2:03 PM, the DNS stated she was not aware of an injury of unknown origin for Resident #16 on 6/24/18. She said there was not</p>	F 610			

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F 610	<p>Continued From page 34</p> <p>an incident/accident report regarding the injury and that an investigation was not initiated.</p> <p>On 10/25/18 at 8:30 AM, RN #2 stated she did not initiate an investigation when the new bruise and lump was noted on Resident #16's chin on 6/24/18. The RN stated she reported the new bruise/lump to the nurse who relieved her on 6/24/18. RN #2 said she received training on the company's abuse policy during orientation in March 2018 and she was responsible to start an investigation and notify the administrator when an injury of unknown origin was found. The RN said she "just forgot to do it."</p> <p>REMOVAL OF IMMEDIATE JEOPARDY PRIOR TO EXIT CONFERENCE:</p> <p>The IJ was identified on 10/25/18 and determined to first exist on 9/25/18, when Resident #40 was without pulse and respiration and CPR was not initiated by the facility. On 10/25/18 at 9:30 PM, the facility's Administrator, DNS, and Corporate Nurse were informed verbally and in writing of the IJ.</p> <p>On 10/26/18 at 1:50 PM, the Corporate Nurse and Administrator provided an acceptable plan to remove the immediacy of the IJ.</p> <p>The facility's plan to remove the IJ immediacy was:</p> <p>1. Revision of the Cardiopulmonary Resuscitation P&amp;P on 10/25/18 to include, "CPR is to continue to be performed by staff until EMS [emergency medical service personnel] arrives."</p>	F 610			

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F 610	<p>Continued From page 35</p> <p>2. Creation of a P&amp;P on 10/25/18 regarding where the staff are to locate a resident's code status in the EHR [electronic health record] and paper chart.</p> <p>3. In-service education for all employees (not just licensed staff), which began on 10/25/2018, regarding:</p> <p>a. Abuse and neglect P&amp;P (identification and reporting - whom to report to and time frames).</p> <p>b. Where to locate a resident's code status (new P&amp;P), and informed the staff to "always" use the resident's paper chart for identification of code.</p> <p>c. CPR policy for Full Code patients with emphasis on continuing CPR until EMS arrives. This is to be completed by each employee from all departments prior to starting their next scheduled shift. Each in-serviced staff member is given a copy of the P&amp;P [policy and procedure] pertaining to the afore mentioned items in 1, 2, 3, and signs in-service log upon completion).</p> <p>4. Initiated an investigation of the neglect that resulted in a death in the facility with Idaho Department of Health and Welfare abuse portal, Incident [number] on 10/26/18</p> <p>5. Notified Medical Director of Immediate Jeopardy, steps taken so far, and suggestions for future actions to be taken to prevent further incidents of this nature. He agreed with the current steps and to assist with a plan of correction.</p> <p>6. Required the nurse identified in the IJ to watch</p>	F 610			

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F 610	Continued From page 36 CPR & Heimlich video by American Heart Association and return demonstrate to the DNS for accuracy and understanding prior to working any further shifts.	F 610			
F 684 SS=G	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 observation, staff interview, and policy review, it was determined the facility failed to provide services that met professional standards of quality for blood glucose (BG) testing. This was true for 1 of 2 residents (#28) whose BG testing was observed. The failure to allow the alcohol on Resident #28's finger to dry before testing her BG created the potential for an inaccurate BG reading and harm if she received an inappropriate dose of insulin based on an erroneous BG result. Findings include:  The facility's 12/15/17 policy for Capillary Blood Sampling instructed the staff to wipe the area to be lanced with an alcohol wipe, use a lancet to obtain a blood sample, place the blood sample on the test strip per the manufacturer's recommendations, wipe any visible blood with a cotton ball, gauze or tissue, and ample pressure until the bleeding subsided.	F 684	F-684  Resident Specific:  Resident #28 suffered no ill effects as result of incorrect BG testing as residents subsequent blood sugar tests remained consistent with prior results.  Other Residents:  Blood glucose monitoring is performed per professional standards.  Systemic Changes:  All nursing staff have been in-serviced to properly let alcohol dry before taking sample for blood glucose monitoring equipment.	11/30/18	

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F 684	Continued From page 37  On 10/24/18 at 4:45 PM, LPN #1 was observed as he prepared to check Resident #28's BG. LPN #1 cleaned Resident #28's left middle finger with an alcohol wipe, waited 4 seconds, punctured the side of her fingertip with a lancet, wiped off the first drop of blood with the same wet alcohol wipe, then, without waiting for the alcohol to dry, immediately used the second drop of blood to test her BG level. Her BG reading was 303, for which the LPN administered 10 units of Humalog insulin by subcutaneous injection per the physician's orders for insulin per sliding scale. An Evencare glucometer by Medline was used to test the BG level.  Immediately after LPN #1 administered the insulin to Resident #28, he said he had cleaned her finger with an alcohol wipe to prepare to test her BG and he used the same alcohol wipe to wipe off the first drop of blood. He said the alcohol was not dry when he tested the second drop of her blood.  The Evencare glucometer Healthcare Professional Operator's Manual instructions for BG testing included, "Step 3. Wash the patient's hand thoroughly, and dry well..."  The Lippincott Manual of Nursing Practice, Ninth edition, 2010, documented the Blood Glucose Monitoring Technique included, "Prepare the finger to be lanced by having the patient wash hands in warm water and soap. Dry Thoroughly. For convenience, an alcohol wipe may be used to cleanse the finger. Alcohol must dry thoroughly before finger is lanced."	F 684	Monitors:  DON or designee will observe blood glucose testing by three licensed nursing staff weekly times four and monthly times three.  DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.  Date of Compliance: November 30th 2018		
F 728	Facility Hiring and Use of Nurse Aide	F 728		1/25/19	

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

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F 728 SS=F	Continued From page 38 CFR(s): 483.35(d)(1)-(3)  §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b).  §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section.  §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b).	F 728			

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F 728	<p>Continued From page 39</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and review of staffing schedules, reports, and personnel files, it was determined the facility failed to ensure full-time employees working as NAs were either in a State approved training and competency evaluation program or had recently successfully completed such a program. This was true for 3 of 4 staff (Staff A, Staff B, and Staff C) included on the facility's list of full time CNAs/NAs, whose personnel files were reviewed. The failure had the potential to result in negative outcomes for the 41 residents living in the facility at the time of the survey, including 16 of 16 sample residents (#1, #4, #6, #13, #16, #17, #19, #25, #27, #28, #35, #36, #37, #38, #140, and #141). Findings include:</p> <p>On 10/25/18 at 2:30 PM, the Administrator provided a list of full time CNA/NAs. The list documented "upcoming" in handwriting by the name of Staff A, Staff B, and Staff C. The Administrator said Staff A, Staff B, and Staff C were NAs and "upcoming" meant they were waiting to take the next CNA class. He said that Staff B and Staff C had started a CNA class but both of them dropped out of the class for personal reasons.</p> <p>On 10/25/18, the October 2018 CNA/NA staffing schedule was reviewed. The schedule documented Staff A, Staff B, and Staff C were 3 of 5 full-time CNA/NA staff regularly scheduled to work the night shift (10:00 PM to 6:00 AM). It documented Staff A was scheduled to work on 10/25/18, 10/26/18, and 10/29/18 - 10/31/18; Staff B was crossed off the schedule as of</p>	F 728	<p>F-728</p> <p>Resident Specific: Please see systemic changes</p> <p>Other Residents: Please see systemic changes</p> <p>Systemic Changes: All currently hired nurse's aides are enrolled in an active state approved CNA class and will be licensed by date of compliance. All new hire nurse's aids will be enrolled in a state approved CAN class and will be certified within four months of Hire Date.</p> <p>Monitors: Administrator of designee will review weekly times 4 and monthly time 3 to ensure that all current nurse aids are either in a state approved training and competency evaluation program or have successfully completed such a program.</p> <p>Date of Compliance: January 25th 2019</p>		

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

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F 728	Continued From page 40 10/14/18; and Staff C was scheduled to work on 10/27/18 - 10/29/18.  The personnel files for Staff A, Staff B, and Staff C included the following:  * Staff A was hired on 9/21/17 in the nursing department. The Idaho State Nurse Aide Registry Verification Report, checked 6/4/18, documented her certification status had "Lapsed" and her certification expired on 3/24/09.  * Staff B was hired on 12/22/16 in the nursing department and as of 10/5/18 she was on maternity leave. The Idaho State Nurse Aide Registry Verification Report, checked 7/2/18, documented no record of certification was found.  * Staff C was hired on 5/10/18 in the nursing department. Her file did not contain an Idaho State Nurse Aide Registry Verification Report.  10/25/18 at 8:00 PM, the DNS said Staff A and Staff C were taken off the schedule effective that day and Staff B was on maternity leave and not scheduled to work.  On 10/26/18 at 2:00 PM, the Administrator said he had misunderstood the regulation regarding NAs eligibility to work.	F 728			
F 730 SS=F	Nurse Aide Perform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7)  §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these	F 730		1/25/19	

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F 730	<p>Continued From page 41 reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and review of annual competency evaluations, it was determined the facility failed to ensure every CNA/NA's performance was evaluated at least once every 12 months and annual evaluations were performed. This was true for 9 of 15 CNAs/NAs #2, #3, #4, #5, #6, #11, #12, #13, &amp; #14) and 1 of 3 staff working as an NA who did not meet NA eligibility criteria (Staff B), who worked in the facility for a year or longer. This failure created the potential for incompetent CNAs/NAs providing care and increased the risk for harm for 41 of 41 residents living in the facility, including 16 of 16 sample residents (#1, #4, #6, #13, #16, #17, #19, #25, #27, #28, #35, #36, #37, #38, #140, and #141). Findings include:</p> <p>On 10/26/18 at 2:30 PM, the Corporate Nurse provided CNA Skills/Knowledge Orientation records and Competency Checklists for NAs and said, "This is all we could find." The records did not include annual evaluations for Staff B and CNAs/NAs #2, #3, #4, #5, #6, #11, #12, #13, and #14, each who worked in the facility for a year or longer.</p>	F 730	<p>F-730</p> <p>Resident Specific:</p> <p>Please see systemic changes</p> <p>Other Residents:</p> <p>Please see systemic changes</p> <p>Systemic Changes:</p> <p>All nurse's aides will be in-serviced at minimum 12 hours per year and a performance evaluation will be performed for each aid yearly. Please see F-728 in regards to staff B.</p> <p>Monitors:</p> <p>In-service logs will be created and maintained to include all nurse aid in-service hours and performance reviews will be performed yearly upon hire date to ensure that in-service hours are obtained and competencies performed.</p> <p>DON or designee will review log weekly times 4 and monthly times 3 to ensure performance reviews and in-service hours are on track to meet minimum requirements.</p> <p>DON or designee will report findings at</p>		

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F 730	Continued From page 42	F 730	QA meeting and will make changes to the above plan of correction as needed.		
F 761 SS=D	<p>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure pharmacy labels matched physician orders. This was true for 1 of 26 medications</p>	F 761	<p>Date of Compliance: January 25th 2019</p> <p>F-761 Resident Specific:</p>	1/25/19	

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F 761	<p>Continued From page 43</p> <p>ordered for 1 of 16 residents (#17) observed during medication passes. The failure created the potential for a harmful effect if Resident #17's antibiotic had been administered subcutaneously rather than intramuscularly (IM) as ordered. Findings include:</p> <p>On 10/24/18 at 3:00 PM, LPN #1 was observed as he prepared, then administered Resident #17's ceftriaxone (Rocephin - an antibiotic) by IM injection. The pharmacy label on the ceftriaxone documented it was to be administered subcutaneously rather than IM injection as ordered by the physician on 10/22/18.</p> <p>Immediately after LPN #1 administered Resident #17's Rocephin, he was asked to again read the pharmacy label on the Rocephin, which he did. The LPN said he had not noticed the label documented "subcutaneously" rather than IM, because he knew the medication had to be administered by IM injection. The LPN notified RN #3 about the error on the Rocephin label.</p> <p>On 10/24/18 at 3:12 PM, RN #3 said she notified the pharmacy about the error on Resident #17's ceftriaxone label and they were going to correct the label right away.</p> <p>Regarding ceftriaxone for administration by IM injection, the Nursing 2019 Drug Handbook documented the medication should be injected into a large muscle, such as the gluteus maximus (buttock muscle) or the lateral (outside) aspect of the thigh. Conversely, a subcutaneous injection is an injection beneath the layers of the skin, usually with the needle held at a 45 degree angle to the skin.</p>	F 761	<p>Resident #17 labeling of medications match physician orders.</p> <p>Other Residents:</p> <p>All current resident's medications have been reviewed to ensure they match physician orders</p> <p>Systemic Changes:</p> <p>All nursing staff in-serviced to ensure labeling of medications match physician orders.</p> <p>Monitors:</p> <p>DON or designee will weekly times 4 and monthly time 3 review three patients to ensure medication labels match physician orders.</p> <p>DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: January 25th 2019</p>		

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F 837 SS=F	<p>Governing Body CFR(s): 483.70(d)(1)(2)</p> <p>§483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and</p> <p>§483.70(d)(2) The governing body appoints the administrator who is-</p> <p>(i) Licensed by the State, where licensing is required;</p> <p>(ii) Responsible for management of the facility; and</p> <p>(iii) Reports to and is accountable to the governing body.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, review of Governing Body documents, and interview with staff and a member of the Governing Body, it was determined the Governing Body was not actively engaged and involved in the management of the facility. The failure increased the risk for negative outcomes for 41 of 41 residents living in the facility, including 16 of 16 sample residents (#1, #4, #6, #13, #16, #17, #19, #25, #27, #28, #35, #36, #37, #38, #140, and #141). Findings include:</p> <p>Immediate jeopardy to residents' health and safety was identified during the survey as follows:</p> <p>* Refer to F600 as it relates to the failure of the facility ensure residents were free from neglect. On 9//25/18, the licensed staff neglected to verify Resident #40's code status when he did not have</p>	F 837	<p>F-837</p> <p>Resident Specific:</p> <p>Please see systemic changes</p> <p>Other Residents:</p> <p>Please see systemic changes</p> <p>Systemic Changes:</p> <p>The Governing Body, or member(s) of the Governing Body, will have scheduled monthly meetings with the Administrator of the facility, and at other times as necessary, to address incidents related to potential neglect of residents and to ensure thorough investigations are</p>	1/25/19	

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F 837	<p>Continued From page 45</p> <p>a pulse or respirations and neglected to provide CPR per his wished documented in his POST. Resident #40 subsequently died. This failure placed the health and safety of the 3 other residents in the facility (#37, #140, and #141) with a code status of Full Code (resuscitate/initiate CPR) in immediate jeopardy.</p> <p>* Refer to F610 as it relates to the failure of the facility to initiate and conduct a thorough investigation of neglect to provide CPR for Resident #40, and to immediately put effective measures in place to ensure further neglect did not occur, constituted Immediate Jeopardy (IJ) and was likely to cause serious harm, injury, or death to the 3 other residents in the facility (#37, #140, and #141) who chose resuscitation/full code in the event their heart stopped or they stopped breathing.</p> <p>On 10/26/18 at 2:00 PM, the Administrator said he talked with his direct supervisor who he said was the president of the corporation and the Chief Executive Officer (CEO), who was legal council for the corporation, after the incident regarding Resident #40 on 9/25/18. The Administrator said he followed the CEOs instructions to take action against the nurse who documented the wrong code status on Resident #40's resident information sheet and the DNS verbally counseled the nurse who did not look in the right place to verify Resident #40's code status. The Administrator stated, "But we didn't identify the immediacy" of the incident. Contact information for the Governing Body was requested at that time. At 2:30 PM, the Administrator provided the Chief Operating Officer's (COO) phone number.</p>	F 837	<p>conducted when required. Minutes of the scheduled meetings will be taken by the Governing Body and provided to the facility Administrator.</p> <p>Monitors:</p> <p>The Administrator will review minutes from the scheduled Governing Body meetings in the QAPI meeting held quarterly. He will make changes to the above plan of correction if needed.</p> <p>Date of compliance: January 25th 2019</p>		

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F 837	<p>Continued From page 46</p> <p>On 10/26/18 at 3:04 PM, the COO said he was not involved regarding the 9/25/18 incident and that the CEO had received communication from the facility about the incident. When asked what direction the governing body provided the facility after the 9/25/18 incident, the VP said the CEO was involved. The COO said he would need to look up who was on the governing body for the facility and he would "guess" the CEO was the chairman of the governing body. He said, "We meet frequently, sometimes daily, weekly, monthly" but there were no minutes of those meetings "other than notes." The COO said the governing body wanted to assist with and ensure compliance with regulations. The governing body bylaws and meeting attendance records were requested at the time.</p> <p>On 10/29/18 at 4:03 PM, the Bureau of Facility Standards received an email from the Administrator with an undated document attached regarding the facility's governing body and a log of communication between the governing body and the facility.</p> <p>Per the the undated document the Governing Body included the President, the COO, the CEO, the Chairman, the Chief Financial Officer, and the Vice President of Clinical Services, and other designated individuals as needed. It documented the governing body "shall" institute bylaws and P&amp;P relative to the general operation of all facility services. It documented the facility administrator reports to the governing body and the governing body may communicate with the administrator, both of them "using any commonly accepted means of communication." It documented that "At</p>	F 837			

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F 837	Continued From page 47 least quarterly, the governing body will review and discuss the facility management and operations with the administrator..." Further, it documented that a representative of the governing body, the administrator, the medical director, the DNS, and other designees, would conduct a review and update of the facility-wide assessment as necessary and at least annually.  The Governing Body Communication Log with the facility included the following:  * On 9/17/18 the purpose of the communication was a "Question/Direction" and the communication took 15 minutes. * On 9/26/18 the purpose of the communication was a "Question/Direction" and the communication time was "Unknown." * On 10/2/18 the purpose of the communication was a "Question/Direction" and the communication time was "Unknown."  The facility did not provide the governing body bylaws and the email and the attachment did not include the governing body bylaws. Additionally, there were no notes or minutes of meetings or communications between the facility and the governing body.  There was no evidence the governing body was actively engaged and involved in the management of the facility after Resident #40 died on 9/25/18.	F 837			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an	F 880		1/25/19	

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F 880	<p>Continued From page 48</p> <p>infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation,</p>	F 880			

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F 880	<p>Continued From page 49</p> <p>depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, Infection Control Program review, policy review, and staff interviews the facility failed to implement a comprehensive surveillance plan based on the facility policy and procedure. . Additionally the facility failed to ensure handwashing was performed before and after medication administration and during blood glucose checks, consistent with the facility's policy. This directly impacted 3 of 16 residents (#2, #17, and #28) reviewed for infection control. These failures</p>	F 880	<p>F-880</p> <p>Resident Specific:</p> <p>Residents #2, #17, and #28 have proper handwashing techniques performed and are involved in the comprehensive infection control surveillance plan.</p> <p>Other Residents:</p>		

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F 880	<p>Continued From page 50</p> <p>placed 41 of 41 residents living in the facility at risk of developing infections. Findings include:</p> <p>1. Review of the facility "Infection Control Surveillance Policy and Procedure" documented "The Designated Infection Control Nurse (ICN) will be responsible for conducting routine surveillance of infections within the facility for all patients through observation of patient care, environmental standards as well as data collection and analysis..."</p> <p>On 10/25/18 10:14 AM, RN #3 stated she was the staff responsible for the facility Infection Control Program. RN #3 indicated she rounds in the facility and looks for infection control issues. RN #3 stated she did not have written criteria established for conducting surveillance of the environment or staff. RN #3 stated she did not have documentation that surveillance rounds, or monitoring was conducted in the facility.</p> <p>On 10/25/18 at 11:00 AM, the DON stated she made rounds in the building to check for cleanliness but did not document the rounds and did not have specific criteria for what was being monitored and did not document outcomes or follow up.</p> <p>2. The facility's Handwashing P&amp;P, dated 12/23/17, documented staff were to wash their hands, "...vigorously scrubbing with soap for a minimum of 15 seconds, covering all surfaces of the hands and fingers...The friction of the skin with soap and water is essential in Handwashing; Microorganisms can be harbored unless effectively removed...Rinse hands with water and dry thoroughly..."</p>	F 880	<p>Staff perform proper handwashing techniques and follow the comprehensive infection control surveillance program.</p> <p>Systemic Changes:</p> <p>All licensed staff have been in-serviced on proper hand washing technique and procedures. Infection control nurse or designee will perform physical rounds and record findings.</p> <p>Monitors:</p> <p>DON or designee will observe three licensed staff to ensure proper handwashing P&amp;P being followed weekly times 4 and monthly times 3.</p> <p>DON or designee will monitor infection control surveillance rounds to ensure being properly performed weekly times 4 and monthly times 3.</p> <p>DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: January 25th 2019</p>		

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135080</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/26/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>GRANGEVILLE HEALTH &amp; REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 EAST NORTH SECOND STREET GRANGEVILLE, ID 83530</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	Continued From page 51  LPN #1 was observed performing improper handwashing as follows:  a. On 10/24/18 at 3:00 PM, after he administered an IM injection to Resident #17, LPN #1 removed his gloves then wet his hands, applied liquid soap, rubbed his hands together for 7 seconds, then rinsed and dried his hands.  b. On 10/24/18 at 3:10 PM, after he removed an old transdermal fentanyl patch and administered a new transdermal fentanyl patch to Resident #2, LPN #1 removed his gloves then wet his hands, applied liquid soap, rubbed his hands together for 6-7 seconds, then rinsed and dried his hands.  Immediately afterward, when asked how he washed his hands, LPN #1 said, "Probably not long enough."  c. On 10/24/18 at 4:45 PM, after he checked Resident #28's BG, LPN #1 removed his gloves then wet his hands, applied liquid soap, rubbed his hands together for 5 seconds, then rinsed and dried his hands.  Immediately afterward, LPN #1 said he was not aware of the "specific" length of time to wash his hands.	F 880			
F 947 SS=F	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4)  §483.95(g) Required in-service training for nurse aides. In-service training must-  §483.95(g)(1) Be sufficient to ensure the	F 947		1/25/19	

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F 947	<p>Continued From page 52</p> <p>continuing competence of nurse aides, but must be no less than 12 hours per year.</p> <p>§483.95(g)(2) Include dementia management training and resident abuse prevention training.</p> <p>§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.</p> <p>§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of monthly in-service records, it was determined the facility failed to ensure each NA received no less than twelve hours of in-service education per year. The facility failed to provide 12 hours of in-service education per year for 13 of 14 CNAs/NAs (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, &amp; #13) and 2 of 3 staff working as NAs who did not meet NA eligibility criteria (Staff A and B), who worked in the facility for a year or longer. This failure created the potential for incompetent CNAs/NAs providing care and increased the risk for harm for 41 of the 41 residents living in the facility, including 16 of 16 sample residents (#1, #4, #6, #13, #16, #17, #19, #25, #27, #28, #35, #36, #37, #38, #140, and #141). Findings include:</p> <p>On 10/25/18 at 10:00 AM, the Administrator provided monthly in-service records for November 2017 through October 2018.</p>	F 947	<p>F-947</p> <p>Resident Specific:</p> <p>Please see systemic changes</p> <p>Other Residents:</p> <p>Please see systemic changes</p> <p>Systemic Changes:</p> <p>All nurse's aides will be in-serviced at minimum 12 hours per year and a performance evaluation will be performed for each aid yearly. Please see F-728 in regards to staff B.</p> <p>Monitors:</p> <p>In-service logs will be created and</p>		

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F 947	<p>Continued From page 53</p> <p>On 10/25/18 at 11:30 AM, the DNS said in-services were conducted once a month, the in-services were not repeated, and no other staff education or in-services were offered.</p> <p>The November 2017 through October 2018 monthly in-service records (1 hour a month for a total of 12 hours) contained documented the following:</p> <ul style="list-style-type: none"> <li>* CNAs/NAs #1, #6, #7, #9, and #12 did not attend 1 in-service.</li> <li>* Staff A and CNAs/NAs #10 and #11 did not attend 2 in-services.</li> <li>* CNA/NA #2 did not attend 3 in-services.</li> <li>* CNA/NAs #5 and #13 did not attend 7 in-services.</li> <li>* Staff B did not attend 9 in-services.</li> <li>* CNAs/NAs #3, #4, and #8 did not attend 10 in-services.</li> </ul> <p>On 10/26/18 at 2:30 PM, the Corporate Nurse provided CNA Skills/Knowledge Orientation records and Competency Checklists for NAs and said, "This is all we could find."</p>	F 947	<p>maintained to include all nurse aid in-service hours and performance reviews will be performed yearly upon hire date to ensure that in-service hours are obtained and competencies performed.</p> <p>DON or designee will review log weekly times 4 and monthly times 3 to ensure performance reviews and in-service hours are on track to meet minimum requirements.</p> <p>DON or designee will report findings at QA meeting and will make changes to the above plan of correction as needed.</p> <p>Date of Compliance: January 25th 2019</p>		