



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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November 23, 2018

Joe Rudd, Jr., Administrator
Life Care Center of Boise
808 North Curtis Road
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Rudd Jr:

On **October 26, 2018**, a survey was conducted at Life Care Center of Boise by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 3, 2018**. Failure to submit an acceptable PoC by **December 3, 2018**, may result in the imposition of civil monetary penalties by **December 26, 2018**.

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

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

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

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

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

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

- **Civil Monetary Penalty**
- **Denial of payment for new admissions 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 & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

Joe Rudd, Jr., Administrator
November 23, 2018
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If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **December 3, 2018**. If your request for informal dispute resolution is received after **December 3, 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/26/2018
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF BOISE	STREET ADDRESS, CITY, STATE, ZIP CODE 808 NORTH CURTIS ROAD BOISE, ID 83706
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey and complaint survey conducted at the facility from October 22, 2018 to October 26, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Presie Billington, RN Cecilia Stockdill, RN Kathi Davis, RN</p> <p>Abbreviations include:</p> <p>ADM = Administrator ADON = Assistant Director of Nursing BID = twice a day CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DON = Director of Nursing FDA = U.S. Food and Drug Administration FNP = Family Nurse Practitioner GDR = Gradual Dose Reduction LPN = Licensed Practical Nurse LN = Licensed Nurse LMSW = Licensed Medical Social Worker MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set mg = milligrams ml = milliliter POST = Physician Orders for Scope of Treatment (a form which documents whether or not a resident chooses to be resuscitated should the situation arise) PRN = as needed RN = Registered Nurse</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 12/03/2018
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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 000	Continued From page 1 RSS = Resident Support Services (LMSW Assistant) SDC = Staff Development Coordinator UM = Unit Manager	F 000			
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		12/21/18	

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F 550	<p>Continued From page 2 from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure meals were served as scheduled and residents seated together were served meals at the same time. This was true for 4 of 20 random residents observed dining in the main dining room and created the potential for harm should residents experience decreased self-worth and psychosocial well being. Findings include:</p> <p>The facility's policy for Resident Dining Services, revised 11/28/17, documented: * A process is in place to ensure residents receive a pleasant dining experience in a timely manner. * Residents seated together are served in consecutive order so they can eat at the same time. * A process is developed indicating which order the residents are to be served in the dining areas and room.</p> <p>On 10/22/18 at 7:56 AM through 8:33 AM, 11 residents were seated in the main dining room. The meal was scheduled to be served at 8:00 AM. There was no music, conversation, or activity provided to the residents as they awaited their meal service. The first meal was served at</p>	F 550	<p>This Plan of Correction required under Federal and State Regulations and statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</p> <p>Additional Abbreviations: Daily = Monday through Friday (with regard to audits) DX = Diagnosis CDM = Certified Dietary Manager UM = Unit Manager SDC = Staff Development Coordinator QA = Quality Assurance DNS = Director of Nursing Services IDT = Interdisciplinary Team LMSW = Licensed Master Social Work</p>		

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F 550	<p>Continued From page 3</p> <p>8:07 AM, when a resident entered the dining room and seated herself at a table with 2 other residents. The resident who entered the dining room last was served breakfast immediately, while the other 2 residents at the same table waited for their food. The resident who entered the dining room last finished her meal and exited the dining room. The 2 residents at her table still had not received their breakfast. The next 2 trays were served to 2 other residents seated alone at 2 separate tables at 8:16 AM. The 2 residents who were seated at the first table served were served breakfast 21 minutes later at 8:28 AM.</p> <p>On 10/22/18 at 8:28 AM, there were 2 CNAs present in the dining room serving the residents breakfast. When asked, CNA #1 stated "we just serve them as they come up on the line."</p> <p>On 10/26/18 from 11:56 AM through 12:31 PM, the noon meal was scheduled to be served at 12:00 PM in the main dining room. Thirteen residents were seated at 7 tables with no meal service until 12:16 PM. At 12:16 PM, CNA #1 served the first meal tray to a resident seated at a table with 2 other residents. The other 2 residents waited for their food for 6 minutes while their tablemate ate, and while 2 residents seated alone at other tables were served.</p> <p>On 12:25 PM on 10/26/18, CNA #1 confirmed the meal was scheduled at 12:00 PM and the first trays were served at 12:16 PM.</p>	F 550	<p>SATS = Oxygen Saturation Level</p> <p>F 550</p> <p>Corrective Action: Nursing staff will continue to coordinate the resident's tray cards with Dietary Staff at each meal to ensure that residents seated together are served at the same time, and to ensure that meals are served timely with respect to posted meal delivery times.</p> <p>Identification: All residents that eat their meals in the facility's Main Dining Room are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1.Education to be provided to Nursing and Dietary staff regarding the facility policy and procedure concerning serving residents seated together at a table at the same time. 2.Education provided to Nursing and Dietary Staff regarding timely service of each meal with respect to posted meal delivery times.</p> <p>Monitor: 1.DNS or Designee to audit meal service in the dining room to ensure compliance. 2.Audits to be conducted at the following frequencies: a.Daily for two (2) weeks b.Weekly for four (4) weeks</p>		

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F 550	Continued From page 4	F 550	c.Monthly for three (3) months 3.Findings to be reviewed by Administrator and reported to QA Committee		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (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. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (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. (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	F 578		12/21/18	

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F 578	<p>Continued From page 5</p> <p>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:</p> <p>Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents received assistance to exercise their right to formulate Advance Directives. This was true for 10 of 18 residents (#10, #12, #21, #23, #33, #41, #44, #50, #56, and #61) whose records reviewed for Advance Directives. This deficient practice created the potential for harm should residents wishes regarding Advance Directives not be followed or they were denied the opportunity to formulate Advance Directives. Findings include:</p> <p>The State Operations Manual defined an ""Advance directive" is "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." "Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form" is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm</p>	F 578	<p>Corrective Action:</p> <ol style="list-style-type: none"> 1.A facility-wide audit will be conducted of all residents for advanced directives and / or documentation of education provided regarding advanced directives. 2.Resident #10 was discharged from hospice services and the resident's code status was changed to Full Code as per resident and family wishes. Resident and family educated regarding advanced directives. 3.Residents #12, #21, #23, #33, #41, #44, #50, #56, and #61 and / or family representatives have received education regarding advanced directives. <p>Identification:</p> <p>All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> 1.Education provided to staff regarding resident's right to formulate advanced directives. 2.Admission staff educated regarding requesting a copy of an advanced directive, upon admission, from the resident and/or resident's responsible 		

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F 578	<p>Continued From page 6 form is not an advance directive."</p> <p>Review of the facility policy for Advanced Directives, revised in February 2018, documented:</p> <p>* An advance directive is defined as a written instruction regarding care and treatment, such as a living will (a document that specifies a resident's preferences about measures used to sustain life) or a durable power of attorney for health care, recognized under state law in relation to the provision of such care when the resident is incapacitated.</p> <p>* Each time the resident is admitted to the facility, quarterly, after a significant change, and as needed, Social Services should review the advance directive information for accuracy with the resident or representative, and document these findings in the progress notes.</p> <p>* Each quarter the care plan team reviews with the resident his or her advanced directives to ensure that they are still the wishes of the resident.</p> <p>* If the resident is discharged from and readmitted to the facility, the DNR status must be reviewed to determine if it is still appropriate and desired by all parties involved. A new order for DNR is obtained at that time.</p> <p>This policy was not followed. Examples include:</p> <p>a. Resident #10 was admitted to the facility with hospice services on 4/12/18, with multiple diagnoses including anoxic brain damage (lack of</p>	F 578	<p>party. Education also to include discussing information regarding advanced directives with the resident and/or responsible party.</p> <p>3. At Resident Care Plan Conference, IDT will review current advanced directive if a copy has already been provided to the facility. If the facility does not have a copy of the resident's advanced directive, the IDT will inquire of the resident / responsible party for a copy of such to include in the resident record if one exists. If the resident / responsible party does not have an advanced directive, education will be provided regarding advanced directives, and documentation will be made in the resident record regarding the education provided and that the resident did not have an advanced directive at that time.</p> <p>4. Advanced Directive tab in the hard copy of Resident Record will include two sub tabs, one for the Advanced Directive and one for the POST.</p> <p>Monitor:</p> <p>1. DNS or Designee to audit admission and Resident Care Conference documentation to ensure compliance.</p> <p>2. Audits to be conducted at the following frequencies:</p> <p>a. Weekly for four (4) weeks</p> <p>b. Monthly for three (3) months</p> <p>3. Findings to be reviewed by Administrator and reported to QA Committee</p>		

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F 578	<p>Continued From page 7 oxygen) and developmental disability.</p> <p>An undated Resident Admission Agreement Acknowledgement documented that prior to admission, Resident #10 had executed an Advance Directive.</p> <p>An admission MDS assessment, dated 4/20/18, documented Resident #10 was on hospice services and was moderately cognitively impaired.</p> <p>Resident #10's completed POST, signed by her father, who was her guardian and conservator, on 4/12/18 and signed by the hospice physician on 4/17/18, was found under the Advance Directive tab in her record. The POST documented Resident #10 was comfort measures only, do not resuscitate, and did not want a feeding tube, intravenous fluids (IV), antibiotics, or blood products.</p> <p>A significant change in status MDS assessment, dated 7/2/18, documented Resident #10 was no longer on hospice service.</p> <p>On 10/25/18 at 3:01 PM, the LMSW stated she talked to Resident #10's father on 10/23/18 regarding the DNR POST. The LMSW stated Resident #10's father would like Resident #10's code status to be Full Code. The LMSW agreed that on 10/25/18, Resident #10's POST read DNR, comfort measures only, no tube feeding, no IV fluids, no antibiotics, and no blood products.</p> <p>On 10/26/18 at 7:58 AM, Resident #10 stated she would like to have antibiotics if she got an</p>	F 578			

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F 578	<p>Continued From page 8</p> <p>infection. When asked about IV fluids and blood transfusions, she initially said no. When asked why, Resident #10 stated, "it hurts." When asked if she would want everything done to save her life if she stopped breathing or her heart stopped beating, Resident #10 stated yes.</p> <p>b. Resident #50 was admitted to the facility on 1/13/09 with multiple diagnoses, including history of traumatic brain injury, depression, and epilepsy.</p> <p>Resident #50's Quarterly MDS assessment, dated 9/20/18, documented she was cognitively intact and was capable of decision making.</p> <p>Resident #50's medical record included a POST form located under the Advanced Directive tab, signed by the resident and the resident's physician, and had been in effect since 1/20/09. There was no documentation Advance Directives had been discussed with Resident #50.</p> <p>c. Resident #33 was admitted to the facility on 5/29/18, with multiple diagnoses including anxiety disorder and depression.</p> <p>Resident #33's Significant Change in Status MDS Assessment, dated 10/2/18, documented she was severely cognitively impaired and received hospice care.</p> <p>Resident #33's undated Resident Admission Agreement Acknowledgement documented she executed an Advance Directive prior to her admission to the facility.</p> <p>Resident #33's October 2018 recapitulated</p>	F 578			

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F 578	<p>Continued From page 9</p> <p>physician's order documented a code status of DNR was ordered on 5/29/18.</p> <p>Resident #33's care plan documented she had an Advance Directive and if her heart stopped beating CPR would not be initiated. The care plan directed staff to review the Advance Directive and POST upon admit, quarterly, during Significant Change in Status, and PRN.</p> <p>Resident #33's POST form, found under the Advance Directive tab in her medical record, documented a code status of DNR with comfort measures only.</p> <p>There was no Advance Directive found in Resident #33's clinical record.</p> <p>d. Resident #41 was admitted to the facility on 8/29/17 with multiple diagnoses, including diabetes and muscle weakness.</p> <p>Resident #41's annual MDS assessment, dated 9/4/18, documented she was cognitively intact.</p> <p>Resident #41's October 2018 recapitulated physician's order documented a code status of DNR was ordered on 10/4/17.</p> <p>Resident #41's care plan documented she had an Advance Directives on record, and if her heart stopped beating CPR would not be initiated. The care plan directed staff to review the Advance Directive and POST upon admit, quarterly, during Significant Change in Status, and PRN.</p> <p>There was no Advance Directive found in Resident #41's clinical record.</p>	F 578			

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F 578	<p>Continued From page 10</p> <p>e. Resident #56 was admitted to the facility of 9/18/18 with multiple diagnoses which included prostate cancer.</p> <p>Resident #56's admission MDS assessment, dated 9/25/18, documented he had moderate cognitive impairment.</p> <p>Resident #56's undated Resident Admission Agreement Acknowledgement documented she executed an Advance Directive prior to his admission to the facility.</p> <p>Resident #56's October 2018 recapitulated physician's orders documented "Full Code" was ordered on 9/18/18.</p> <p>Resident #56's care plan documented he had an Advance Directive of "Full Code," Resident #56's Advance Directives were in effect and his wishes and directions would be carried out. The care plan directed staff to review the Advance Directive, and POST upon admit, quarterly, during Significant Change in Status, and PRN.</p> <p>Resident #56's POST form found under the Advance Directive tab in his clinical record documented "Full Code" with aggressive interventions.</p> <p>There was no Advance Directive, or evidence Advance Directives had been offered and discussed with Resident #56, in his clinical record.</p> <p>f. Resident #21 was admitted to the facility on 12/2/15 with multiple diagnoses, including</p>	F 578			

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F 578	<p>Continued From page 11</p> <p>chronic kidney disease, stage 4 (severe), dependence on renal dialysis, a left above the knee amputation, and anoxic (lack of oxygen) brain damage.</p> <p>Resident #21's MDS assessment, dated 8/10/18, documented he was cognitively intact. Resident #21's MDS assessments also documented he was discharged to a hospital on 9/14/18, and readmitted to the facility on 9/17/18. There was no documentation Advance Directives were discussed this Resident #21 when he was readmitted to the facility on 9/17/18.</p> <p>Resident #21's medical record documented he had a POST. The POST form was located under the Advanced Directives tab of the record, signed by the resident and the resident's physician, and had been in effect since 12/16/15. There was no documentation of Advance Directives in Resident #21's medical record or documentation the facility provided the resident (or their representative) information to formulate Advance Directives.</p> <p>g. Resident #12 was admitted to the facility on 10/20/14 with multiple diagnoses, including Type 2 diabetes mellitus and anxiety disorder.</p> <p>A quarterly MDS assessment, dated 8/1/18, documented Resident #12 was cognitively intact.</p> <p>An undated Resident Admission Agreement Acknowledgement documented that prior to admission, Resident #12 had executed an Advance Directive.</p> <p>Resident #12's completed POST, signed by her</p>	F 578			

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F 578	<p>Continued From page 12</p> <p>son on 10/20/14 and signed by the physician on 10/21/14, was found under the Advance Directive tab in her record. The POST documented Resident #12's wishes to be resuscitated (full code) with limited interventions, and yes to a feeding tube, IV fluids, antibiotics, and blood products. Advanced Directives or evidence Advance Directives were discussed with Resident #12 and assistance offered, was not found in Resident #12's record.</p> <p>h. Resident #23 was re-admitted to the facility on 2/26/18 with multiple diagnoses, including difficulty in walking, muscle weakness, and benign paroxysmal vertigo (episodes of dizziness).</p> <p>Resident #23's quarterly MDS assessment, dated 8/15/18, documented she was cognitively intact.</p> <p>Resident #23's October 2018 physician orders documented a code status of DNR was ordered on 2/26/18.</p> <p>Resident #23's POST documented Do Not Resuscitate and was signed by her representative on 12/30/15.</p> <p>Resident #23's current care plan documented the following:</p> <ul style="list-style-type: none"> * Guardianship * DNR * Resident #23 was not capable of making informed consent regarding health care decisions. * Advise the resident/representative to provide copies of any Advanced Directives, advise of the 	F 578			

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F 578	<p>Continued From page 13</p> <p>right to establish an Advanced Directive, and offer assistance.</p> <p>* Review Advanced Directives and POST upon admission, quarterly, with significant changes, and as needed.</p> <p>On 10/23/18 at 9:13 AM, a POST was documented in Resident #23's clinical record. There was no Advanced Directive or documentation of the Advanced Directive being offered or the POST being reviewed quarterly with Resident #23, in her clinical record.</p> <p>On 10/25/18 at 12:15 PM, the DON said she would look to see if there was documentation of other discussions regarding the POST and Advanced Directive for Resident #23. The facility did not provide any additional documentation.</p> <p>i. Resident #44 was readmitted to the facility on 5/22/15 with multiple diagnoses, including multiple sclerosis and neuromuscular dysfunction of the bladder.</p> <p>Resident #44's quarterly MDS assessment, dated 9/11/18, documented she was cognitively intact</p> <p>Resident #44's October 2018 physician orders documented a code status of "Full Code" was ordered on 5/22/15.</p> <p>Resident #44's POST documented Full Code and was signed by the resident on 3/7/14.</p> <p>Resident #44's current care plan documented the following:</p> <p>* Full Code</p>	F 578			

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F 578	<p>Continued From page 14</p> <p>* She was capable of making informed consent regarding health care decisions.</p> <p>* "Discuss Advanced Directives including re-hospitalization, antibiotics, blood transfusions under specific circumstances with resident, responsible party as well as physician involvement."</p> <p>On 10/23/18 at 9:20 AM, a POST was documented in Resident #44's record. There was no Advanced Directive or documentation of the Advanced Directive being offered or the POST being reviewed quarterly with Resident #44, her clinical record.</p> <p>On 10/25/18 at 8:31 AM, UM #2 said he did not believe Resident #44 had an Advanced Directive, and at the last care conference just the POST was discussed.</p> <p>j. Resident #61 was re-admitted to the facility on 8/25/17 with multiple diagnoses, including COPD and acute respiratory failure with hypoxia (low oxygen level).</p> <p>Resident #61's quarterly MDS assessment, dated 9/28/18, documented she was cognitively intact.</p> <p>Resident #61's October 2018 physician orders documented "DNR with limited additional interventions" was ordered on 4/25/18.</p> <p>Resident #61's current care plan documented the following:</p> <p>* DNR</p> <p>* Resident #61 was not accepting of a feeding tube and would accept IV (intravenous) fluid,</p>	F 578			

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F 578	<p>Continued From page 15</p> <p>antibiotics, and blood products.</p> <p>* Advise the resident/representative to provide copies of any Advanced Directives, advise of the right to establish an Advanced Directive, and offer assistance.</p> <p>* Discuss Advanced Directives including re-hospitalization, antibiotics, blood transfusions under specific circumstances with resident, responsible party as well as physician involvement."</p> <p>* Review Advanced Directives and POST upon admission, quarterly, with significant changes, and as needed.</p> <p>A POST was documented in Resident #61's clinical record. There was no Advanced Directive or documentation of Advanced Directives being offered or the POST being reviewed quarterly in Resident #61's clinical record.</p> <p>On 10/26/18 at 10:02 AM, UM #2 said he did not see anything other than a POST documented in Resident #61's clinical record.</p> <p>On 10/23/18 at 1:35 PM, the DON stated the facility considered the POST form to be one of the resident's Advance Directives. The DON confirmed that in many cases the POST may be the only Advance Directive document available in the resident's medical record. The DON stated there was no documentation of Social Services offering the education regarding the completion of an Advance Directive in the residents' records. The DON stated she thought the POST was an Advance Directive. The DON stated a Performance Improvement plan would be completed to provide inservice to the staff of what a POST was and what an Advance Directive was.</p>	F 578			

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F 578	Continued From page 16	F 578			
F 583 SS=D	<p>On 10/23/18 at 3:04 PM, the LMSW said the facility recognized DNR orders as part of Advance Directives as indicated in the facility's policy for Advance Directives, and it was the Licensed Nurse who discussed the POST with the residents upon admission. The LMSW said the POST would then be reviewed during the resident's quarterly assessment and whenever there was a significant change in the resident's condition or PRN.</p> <p>Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)</p> <p>§483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.</p>	F 583		12/21/18	

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F 583	<p>Continued From page 17</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident and staff interviews, facility policy and procedure review, and record review, it was determined the facility failed to ensure a resident's privacy was maintained in her room. This was true for 1 of 18 residents (#44) reviewed for privacy, when a resident's room had private health information posted in view of people who entered the room. This failed practice created the potential for harm should residents experience embarrassment and/or diminished sense of self-worth when personal health information was available to seen by the public. Findings include:</p> <p>The facility's policy for Protecting Patient Privacy and Prohibiting Mental Abuse, dated 8/30/16, documented the facility would ensure the environment was as home-like as possible for all residents, and the culture of the environment would include treating each resident with respect and dignity.</p> <p>The facility's policy and procedure for Dignity, dated 6/17/08, documented all residents would be treated in a manner and in an environment that would maintain and enhance their dignity and respect.</p>	F 583	<p>Corrective Action:</p> <p>1. The private health information contained on the document identified in 2567 for Resident #44 has been placed out of sight from public view, as it has been previous to Day #2 of this Survey, and after.</p> <p>2. Any signage placed in a resident's room will be placed so as to be out of public view and the reason for any such signage will be included in the resident's Care Plan.</p> <p>Identification:</p> <p>All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes:</p> <p>Education provided to facility staff regarding protecting resident health information. Education included specific instruction regarding signage in resident rooms.</p> <p>Monitor:</p> <p>1. DNS or Designee to conduct audit of resident's that have signage in their</p>		

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F 583	<p>Continued From page 18</p> <p>The facility's Policy for Resident Rights, revised 11/9/16, documented "The resident has a right to personal privacy and confidentiality of his or her personal and medical records..."</p> <p>Resident #44 was readmitted to the facility on 5/22/15 with multiple diagnoses, including multiple sclerosis and neuromuscular dysfunction of the bladder.</p> <p>Resident #44's quarterly MDS assessment, dated 9/11/18, documented the following:</p> <ul style="list-style-type: none"> * She was cognitively intact. * She required extensive assistance of 2 or more people with bed mobility, toileting, and transfers. <p>Resident #44's October 2018 physician orders documented oxybutin (a medication for urinary incontinence and overactive bladder) 10 mg daily for neurogenic bladder</p> <p>Resident #44's current care plan documented the following:</p> <ul style="list-style-type: none"> * Provide prompt peri care as needed for incontinence between regularly scheduled toileting, initiated on 10/11/16. * Toilet every 2 hours and as needed, initiated on 10/11/16. * Staff and Resident #44 sign a form each time she is taken to the bathroom, initiated on 12/18/16. <p>On 10/25/18 at 8:30 AM, a sign labeled "(Resident #44's name) Toileting Schedule" was posted on the outside of Resident #44's closet</p>	F 583	<p>rooms to ensure compliance with privacy and protection of resident health information.</p> <p>2.DNS or Designee to conduct audit of Care Plans of residents with signage in their rooms to ensure reasons for such signage are included in the Care Plan.</p> <p>3.Audits to be conducted at the following frequencies:</p> <ul style="list-style-type: none"> a.Weekly for four (4) weeks b.Monthly for three (3) months <p>4.Findings to be reviewed by Administrator and reported to QA Committee</p>		

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F 583	<p>Continued From page 19</p> <p>door, which was closest to the hallway and was immediately visible to anyone who entered the room.</p> <p>On 10/25/18 at 8:40 AM, UM #2 said the DON had the rest of Resident #44's toileting schedules.</p> <p>On 10/25/18 at 9:15 AM, the surveyor requested a copy of Resident #44's toileting schedules.</p> <p>On 10/25/18 at 1:34 PM, the DON declined to provide a copy of Resident #44's toileting schedules and said it was something for her use so she could see Resident #44 was getting checked. The DON said the CNAs and Resident #44 were to sign the toileting schedule each time she was checked so the resident could be shown she was getting checked. The DON said the CNAs would turn in the toileting schedule every week and then she would usually discard them.</p> <p>On 10/25/18 at 2:09 PM, a sign labeled "(Resident #44's name) Toileting Schedule" was posted on the outside of Resident #44's closet door closest to the hallway and was immediately visible to anyone who entered the room. The toileting schedule was dated 10/25/18 at 2:30 AM, 4:30 AM, 5:34 AM, 10:25 AM, and 2:10 PM. The toileting schedule documented whether Resident #44 was changed or was dry and had signatures of staff and Resident #44. CNA #5 entered the room and asked Resident #44 to sign the toileting schedule form for 2:10 PM. Resident #44 was lying in bed and said CNA #5 just changed her. Resident #44 said staff did not ask her about posting the toileting schedule in her room prior to posting it on the closet door.</p>	F 583			

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F 583	Continued From page 20 On 10/26/18 at 7:56 AM, the UM #2 said Resident #44's toileting schedule should be on the inside of the closet door. On 10/26/18 at 8:12 AM, the DON said Resident #44's toileting schedule should not be posted on the outside of the closet door.	F 583			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 resident and staff interviews, review of clinical records, and review of the facility's policy and procedure, it was determined the facility failed to: *Ensure injuries of unknown origin were investigated.	F 610	Corrective Action: 1.Resident #10 is being treated as per physician order for the diagnosed fracture. (The statement in the 2567 that this fracture is typically caused by trauma is a matter of opinion by the Survey Team and not a matter of fact based on any	12/21/18	

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F 610	<p>Continued From page 21</p> <p>*Ensure allegations of verbal abuse reported by staff were thoroughly investigated.</p> <p>*Ensure residents were protected from verbal abuse and/or threats of physical abuse.</p> <p>This was true for 2 of 3 residents (#10 and #36) reviewed for resident incidents. These deficient practices placed Resident #10 at risk of ongoing abuse/neglect when she was diagnosed with a medial tibial plateau fracture (break of the upper part of the tibia [shinbone] that involves the knee joint, typically caused by trauma) of unknown origin and Resident #36 at risk of continued verbal threats and verbal aggression from another resident (#215). Findings include:</p> <p>The facility's Abuse Policy and Procedure, revised on 2/2018, documented the following:</p> <p>* It is the policy of this facility that reports of abuse, including injuries of unknown source, are promptly and thoroughly investigated.</p> <p>* Residents must not be subjected to abuse by anyone and all residents would be protected from all types of abuse. The policy and procedure required the facility to prevent and prohibit all types of abuse, identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect.</p> <p>* Any incident of resident abuse or suspected resident abuse should be reported to the supervisor and/or charge nurse. The charge nurse should initiate the following information when the incident was reported:</p>	F 610	<p>finding of trauma in this instance.)</p> <p>2.Resident #10 was seen by an Orthopedic Surgeon as noted in 2567. The physician stated that the resident had suffered some activity with some physical therapy, has had an injury to knee. Resident #10 has not had orders for, nor participated in any therapy since admission to this facility.</p> <p>3.Resident #10 was admitted with a knee brace due to diagnosis of osteoarthritis with pain.</p> <p>4.As noted in 2567, Resident #215 has discharged from facility.</p> <p>5.Resident #36 has had no other verbal altercations with any other residents since that time.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1.Education provided to facility staff regarding recognition of resident's pain, and other signs or symptoms that may indicate an injury, and reporting of any such findings or observations to LN staff. 2.Education provided to LN staff regarding policy and procedure of reporting and investigating injuries of unknown origin. 3.Education provided to facility staff regarding policy and procedure on abuse.</p> <p>Monitor: 1.DNS or Designee to conduct audit of Alert Charting documentation for</p>		

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F 610	<p>Continued From page 22</p> <ul style="list-style-type: none"> - name of the resident involved in the incident - date and time the incident occurred - where the incident took place - name(s) of the person(s) committing or involved in the incident - name(s) of any witnesses to the incident - type of abuse committed (verbal, physical, or sexual) - any additional information that may be pertinent to the incident <p>The charge nurse would complete and sign the Incident Report, notify the physician and the resident's representative of the occurrence, and report to the administrator and DON. The administrator, DON or designated representative would then complete an investigation of the incident including a written summary of the findings no later than five working days after the reported occurrence.</p> <p>This policy was not followed. Examples include:</p> <ol style="list-style-type: none"> 1. Resident #10 was admitted to the facility under hospice services on 4/12/18, with multiple diagnoses including anoxic brain damage/developmental disability, osteoarthritis, and pain in unspecified lower leg. <p>An admission MDS assessment, dated 4/20/18, documented Resident #10 was on hospice service, was moderately cognitively impaired, was dependent on staff for transfers and bed mobility, had frequent pain rated at a 6/10, and did not have a fracture.</p> <p>A Potential for Pain care plan, dated 4/12/18, documented Resident #10 stated she had pain in</p>	F 610	<p>increased pain to ensure compliance.</p> <ol style="list-style-type: none"> 2. Audits to be conducted at the following frequencies: <ol style="list-style-type: none"> a. Daily for four (4) weeks b. Weekly for four (4) weeks c. Monthly for three (3) months 3. DNS or Designee to continue to monitor 24 Report daily for any entries that may indicate abuse or neglect. 4. Findings to be reviewed by Administrator and reported to QA Committee 		

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F 610	<p>Continued From page 23</p> <p>her lower extremities and knees. The approaches included administration of medication, education to resident and family to request pain medication early, observe and report signs and symptoms of pain, and report changes in pain to the physician.</p> <p>A Hospice Comprehensive Assessment and Plan of Care Update Report, dated 4/20/18, documented Resident #10 complained of severe right knee pain that was palliated with morphine.</p> <p>A Hospice Comprehensive Assessment and Plan of Care Update Report, dated 4/23/18, documented Resident #10 complained of her right knee aching, had been medicated with morphine 45 minutes prior to the assessment, and the morphine order was changed to every hour.</p> <p>A Hospice Comprehensive Assessment and Plan of Care Update Report, dated 5/5/18, documented Resident #10 exhibited increased pain with movement, she was otherwise calm, and pain decreased when she did not move.</p> <p>An undated Hospice Comprehensive Assessment and Plan of Care Update Report, documented Resident #10 complained of right knee pain at 11/10, visual signs were not consistent with the pain score, Resident #10 was distracted with TV and conversation, and did not mention pain again.</p> <p>A physician telephone order, dated 6/22/18, documented Resident #10's hospice care was discontinued with a change in her primary care physician.</p>	F 610			

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F 610	<p>Continued From page 24</p> <p>A nursing note, dated 6/26/18, documented Resident #10's physician ordered a right knee x-ray and Voltaren 1% gel (an anti-inflammatory medication) to the affected areas two times daily as needed for pain. An addendum to the nursing note documented the x-ray results were reviewed with Resident #10's primary care provider, and an order for an orthopedic consult and a right knee immobilizer was given. The nursing note documented Resident #10's father was notified of the x-ray results. Resident #10's father told the staff Resident #10 had previously been to an orthopedic physician due to a separated meniscus (C-shaped pieces of cartilage that act like a cushion between the shinbone and thighbone). A bedside x-ray obtained on 6/26/18 documented an acute fracture of the right medial tibial plateau.</p> <p>An orthopedic physician Office History and Physical note, dated 7/26/18, documented Resident #10 had "suffered some activity with some physical therapy, has had an injury to her knee." The note documented Resident #10 was now following up roughly 5-6 weeks later since the initial injury.</p> <p>On 10/26/18 at 3:45 PM, the DON stated an investigation was not initiated related to the cause of Resident #10's fracture because Resident #10 did not have any falls. The DON stated "we thought it was a pathological fracture."</p> <p>2. Verbal Threats/Aggression by Resident #215 Directed at Resident #36:</p> <p>Resident #36 was admitted to the facility on 11/27/15 with multiple diagnoses, including</p>	F 610			

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F 610	<p>Continued From page 25</p> <p>chronic obstructive pulmonary disease (chronic lung disease that makes it hard to breathe), depression, and diabetes mellitus.</p> <p>Resident #36's quarterly MDS assessment, dated 6/7/18, documented she had severe cognitive impairment and had verbal behaviors directed towards others several days of the week.</p> <p>A Mood and Behavior Care Plan documented Resident #36 had a history of threatening and being combative with staff, was easily agitated, and calling out on a frequent basis. The care plan directed staff to leave the resident in a safe place when she became combative and re-approach her when she calmed down, place her behind the nurse's station while up, or west of the nurse's station when agitated.</p> <p>Resident #215's quarterly MDS assessment, dated 3/15/18, documented he was cognitively intact and had verbal behaviors directed towards others several days of the week.</p> <p>Resident #215's Care Plan documented he was verbally abusive, cursed at staff, was demanding, often refused cares and treatment, and was disruptive in the dining room. The care plan directed staff to monitor and report Resident #215's behavior as needed to the LN.</p> <p>On 10/26/18 at 10:22 AM, LPN #1 said she remembered a few months ago when a CNA reported to her that Resident #215 yelled at Resident #36 in the smoking area and Resident #215 told the CNA not to place Resident #36 next to him or he would slap Resident #36. LPN #1 said she could not remember the exact date</p>	F 610			

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F 610	<p>Continued From page 26</p> <p>when it was reported to her, but she thought it was close to the date Resident #215 was about to be discharged. LPN #1 said it was during the morning smoking break and she reported the incident to her UM. LPN #1 said she witnessed an incident involving Resident #36 and Resident #215 on the same day between 2:00 PM to 3:00 PM. Resident #36 was in the nurse's station and she heard Resident #36 say to a Shower Aide, who just came out of the shower room pushing a shower chair, not to hit her with that (shower chair). Resident #215, who was on the other side of the nurse's station, told the Shower Aide to hit Resident #36 hard with the shower chair. LPN #1 said she talked to Resident #215 about his behavior and told him it was inappropriate. LPN #1 said she was told by Resident #215 to go to hell. LPN #1 said she separated the two residents and reported the second incident to UM #2. When asked what UM #2 did after she reported it, LPN #1 said she did not know.</p> <p>On 10/26/18 at 10:31 AM, UM #2 said Resident #215 was a kind of a person who had no "filter." When asked what he meant by no "filter" UM #2 said Resident #215 would say anything he wanted to say. UM #2 also stated he did not remember any specific incident between Resident #36 and Resident #215. When asked if he remembered any incident between Resident #36 and Resident #215 being reported to him, UM #2 said if there was one he did not remember it.</p> <p>On 10/26/18 at 10:40 AM, LPN #2 said she heard a few months ago Resident #215 threatened Resident #36 but she did not know the details about it.</p>	F 610			

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F 610	Continued From page 27 On 10/26/18 at 10:45 AM, the DON said she remembered Resident #36 and Resident #215 had an incident in the smoking area, but she believed what Resident #215 said was not directed to Resident #36. The DON said any incident in the facility should be investigated. If there was a resident-to-resident incident, the staff should separate the two residents and make sure both residents were safe. The DON also said the nurse should make a report of the incident and submit the report to the DON. On 10/26/18 at 10:50 AM, LPN #3 said she heard Resident #215 threatened to slap Resident #36 in the smoking area, it was reported to the UM, and the two residents were to be separated on their next smoking break. On 10/26/18 at 10:53 AM, the Administrator said he would look for the investigation regarding the incidents between Resident #36 and Resident #215. On 10/26/18 at 12:20 PM, in the presence of the Administrator, the DON said verbal exchanges between Resident #36 and Resident #215 were a common thing. Resident #215 was known to be verbally inappropriate, yelled and cursed a lot, but she did not remember Resident #215 making verbal threats such as slapping another resident. The Administrator said Resident #36 never felt anything was wrong about these incidents, and if Resident #36 was asked she would not remember anything. The DON said Resident #36 was not affected by the behavior of Resident #215, she was hard of hearing, had dementia, and they made sure the two residents were	F 610			

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F 610	<p>Continued From page 28</p> <p>separated at all times. The DON and the Administrator both said they were not aware Resident #215 threatened Resident #36 in the smoking area and at the nurse's station. The Administrator said he received a letter from the facility's Compliance Center about an incident between Resident #36 and Resident #215, and during that time Resident #215 had already been discharged from the facility. The Administrator said he interviewed staff regarding an altercation between Resident #36 and Resident #215. The Administrator provided a copy of the staff interviews, which documented the following were interviewed: the DON, UM #2, four LPNs, three CNAs, the Director of Environmental Services, Central Supply personnel, and the Maintenance Director. The Administrator said he received the letter from the Compliance Center on 7/20/18 and he conducted the interview on 7/24/18. The undated document titled "Boise Investigation Compliance" did not contain signatures of the staff interviewed. The document contained several questions and documented the following:</p> <p>* Staff were asked if they knew of any resident to resident altercations between Resident #36 and Resident #215. Eleven out of 12 staff interviewed answered they knew Resident #215 was very [verbally inappropriate] and would always tell Resident #36 to shut up, and they made sure the two residents were separated from each other.</p> <p>* Staff were asked if anyone reported to them any verbal, sexual, or physical abuse involving Resident #36 and Resident #215. Eight out of 12 staff responded "No." One LPN said it was reported to her that Resident #215 threatened to slap Resident #36 while they were on a smoking</p>	F 610			

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F 610	<p>Continued From page 29 break.</p> <p>* Staff were asked if they had notified the DON or Nursing Management of any behavior or abuse involving Resident #36 and Resident #215. One LPN said she reported it to the DON. One LPN said she reported it to the UM. Central Supply personnel said she handled the incident in the smoking area and it was not aggressive or threatening, it was just the personalities of the two residents.</p> <p>* Staff were asked if there were any issues regarding Resident #36 and Resident #215 that had not been addressed. One LPN said she did not think Resident #36 was safe with Resident #215 "She was his target." The report documented the LPN reported the incident to the UM and she was told to keep Resident #36 behind the nurse's station.</p> <p>The facility's Incident and Accident Reports from February 2018 to October 2018 and Grievance file from April 2018 to October 2018 were reviewed. They did not contain incident reports between Resident #36 and Resident #125.</p> <p>Resident #36's clinical record did not include a Nursing Note from 5/1/18 to 5/24/18, the time period during which the incidents occurred.</p> <p>Resident #215 was discharged on 5/24/18. His Nursing Notes, dated 5/1/18 through 5/24/18, did not include documentation regarding his behavior toward Resident #36.</p> <p>On 10/26/18 at 3:03 PM, the DON said Resident #36 was placed behind the nurse's station</p>	F 610			

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F 610	Continued From page 30 because Resident #36 had a tendency to swing her arms whenever she was agitated and would hit another resident or staff. The DON also stated she got along with Resident #215, she knew he yelled and cursed a lot and would say some inappropriate words, but she believed Resident #215 would never be physically abusive to anyone. The DON said it was more of a personality issue between the two residents. On 10/26/18 at 3:30 PM, the SDC said she provided abuse training to the facility staff. The SDC said she gave CNA inservices, LN inservices, and all staff inservices. If some of the staff could not make it to the inservices, then she would give one on one training to the staff. The SDC said any allegation of abuse or mistreatment should be investigated. The SDC also said any resident-to-resident incident would be investigated the same way, staff or other residents who witnessed or heard about it would be interviewed. The SDC said the nurse to whom the incident was reported should complete the Incident Investigation Questionnaire form, sign and date it, and submit it to the DON. The DON or the Administrator would conduct the full investigation. The SDC also stated any incident in the facility should be reported to the state survey agency and a full investigative report should be submitted whether it was substantiated or not.	F 610			
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		12/21/18	

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F 657	<p>Continued From page 31 the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff, resident, and resident representative interviews, and record review, it was determined the facility failed to ensure a) residents or their representatives were included in the care conference meeting and care conferences occurred at least quarterly, and b) residents' care plans were updated to include bone fractures. This was true for 6 of 18 residents (#10, #12, #16, #41, #42 and #61) reviewed for care plan participation. The deficient practice created the potential for harm if care was provided in a way that was inconsistent with resident needs and preferences. Findings</p>	F 657	<p>Corrective Action:</p> <p>1. Resident #10's Care Plan has been updated to include the bone fracture.</p> <p>2. Resident #16's Care Plan has been reviewed by IDT and a Care Plan Conference has been conducted with the resident and family members.</p> <p>3. Resident #41's Care Plan has been reviewed by IDT and a Care Plan Conference has been scheduled with the resident and family members.</p> <p>4. Resident #12's Care Plan has been reviewed by the IDT in a Care Plan</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 657	<p>Continued From page 32 include:</p> <p>The facility's policy and procedure regarding Care Planning and Interventions dated 7/23/09, documented the care plan would be updated as needed, but no less than quarterly as resident's conditions change, goals were met, interventions were determined to be ineffective or needed to be revised.</p> <p>This policy was not followed. Examples include:</p> <p>1. Resident #10 was admitted to the facility under hospice services on 4/12/18, with multiple diagnoses including anoxic brain damage/developmental disability, osteoarthritis, and pain in unspecified lower leg.</p> <p>The area of Resident #10's care plan which addressed potential for pain, dated 4/12/18, documented Resident #10 stated she had pain in her lower extremities and knees. The approaches included administration of medication, education to resident and family to request pain medication early, observe and report signs and symptoms of pain, and report changes in pain to the physician.</p> <p>An admission MDS assessment, dated 4/20/18, documented Resident #10 was on hospice service, was moderately cognitively impaired, was dependent on staff for transfers and bed mobility, had frequent pain rated at a 6 on a pain scale of 1-10 (6/10), and did not have a fracture.</p> <p>An undated Hospice Comprehensive Assessment and Plan of Care Update Report, documented Resident #10 complained of right knee pain at 11/10, visual signs were not</p>	F 657	<p>Conference. The resident has refused a Care Plan Conference and the refusal has been documented in the resident record.</p> <p>5.Resident #42's Care Plan has been reviewed by the IDT and a Care Plan Conference has been scheduled with the resident and representative.</p> <p>6.Resident #61's Care Plan has been reviewed by IDT and a Care Plan Conference has been scheduled with the resident and representative.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1.Education provided to IDT regarding the Care Plan Conference process, specifically to conduct the conferences as required, and the requirement to document any resident's refusal to participate in a Care Plan Conference. 2.Education provided to IDT regarding policy to review of Resident Care Plan and to conduct Care Plan Conferences as per facility policy.</p> <p>Monitor: 1.DNS or Designee to conduct audit of Care Plan Conferences to ensure compliance for completion and documentation of refusals as applicable. 2.Audits to be conducted at the following frequencies: a.Weekly for four (4) weeks</p>		

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F 657	<p>Continued From page 33</p> <p>consistent with the pain score, Resident #10 was distracted with TV and conversation, and did not mention pain again.</p> <p>A physician telephone order, dated 6/22/18, documented Resident #10's hospice care was discontinued with a change in her primary care physician.</p> <p>A nursing note, dated 6/26/18, documented Resident #10's physician ordered a right knee x-ray and Voltaren 1% gel (an anti-inflammatory medication) to the affected areas two times daily as needed for pain. An addendum to the nursing note documented the x-ray results were reviewed with Resident #10's primary care provider, and an order for an orthopedic consult and a right knee immobilizer was given. The nursing note documented Resident #10's father was notified of the x-ray results. Resident #10's father told the staff Resident #10 had previously been to an orthopedic physician due to a separated meniscus (C-shaped pieces of cartilage that act like a cushion between the shinbone and thighbone). A bedside x-ray obtained on 6/26/18 documented an acute fracture of the right medial tibial plateau (break of the upper part of the tibia [shinbone] that involves the knee joint, typically caused by trauma).</p> <p>A Significant Change MDS assessment was completed on 7/2/18. The assessment documented Resident #10 was no longer on hospice services.</p> <p>Resident #10's care plan was reviewed and did not include goals and interventions related to her right medial tibial plateau fracture.</p>	F 657	<p>b.Monthly for three (3) months</p> <p>3.Findings to be reviewed by Administrator and reported to QA</p>		

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F 657	<p>Continued From page 34</p> <p>On 10/26/18 at 3:06 PM, UM #1 stated the fracture not being included in Resident #10's care plan was "probably due to lack of oversight on my part."</p> <p>2. Resident #16 was admitted to the facility on 3/1/17 with multiple diagnoses, including hypertension and heart failure.</p> <p>Resident #16's quarterly MDS assessment, dated 8/3/18, documented he was impaired cognitively and required extensive assistance of two staff members for all ADLs.</p> <p>On 10/23/18 at 2:53 PM, Resident #16's representative said the care plan had not been discussed with her in about 10 months or so.</p> <p>On 10/24/18 at 11:11 AM, a Care Plan Conference record, dated 9/19/17, was found in Resident #16's clinical record. There was no other documentation that Resident #16 had care plan conferences.</p> <p>On 10/24/18 at 12:34 PM, the RSS (LMSW Assistant) reviewed Resident #16's clinical record and said it looked like Resident #16 did not have a recent care conference. The RSS said the care conferences should be done every three months. The RSS stated they schedule the care plan conferences and invite the resident's representatives. If the representatives could not attend the conference then they would not have a care conference, and each member of the team would then update the care plan.</p> <p>On 10/24/18 at 12:40 PM, the DON said the care</p>	F 657			

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F 657	<p>Continued From page 35</p> <p>plan conferences were being held quarterly. If the resident's representative did not want to attend the conferences, then each member of the team would do their part in updating the care plan.</p> <p>3. Resident #41 was admitted to the facility on 8/29/17 with multiple diagnoses, including diabetes mellitus and muscle weakness.</p> <p>Resident #41's annual MDS assessment, dated 9/4/18, documented she was cognitively intact.</p> <p>On 10/22/18 at 10:41 AM, Resident #41 said she could not remember if she had a care conference while in the facility.</p> <p>On 10/25/18 at 8:13 AM, a Care Conference record dated 9/7/17, was found in Resident #41's clinical record. There was no other documentation that Resident #41 had care plan conferences.</p> <p>On 10/25/18 at 8:21 AM, the LMSW said the care conference should be held quarterly, but sometimes resident's representatives refused to attend the meeting for various reasons such as they had no concern, they were happy with the care or could not attend at all. The LMSW stated the care conference team composed of the resident, resident's representative, social worker, licensed nurse, and physical therapist, and they would sit together and discuss the resident's plan of care. If the resident or resident's representative refused to attend the meeting, then there would be no care conference and each member of the facility staff would update their part in the care plan. The LMSW also said if there was a concern regarding the resident's</p>	F 657			

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F 657	<p>Continued From page 36</p> <p>health status, then the team would meet even in the absence of the resident or their representatives. The LMSW said she just started about seven months ago and she did not know why Resident #41 did not have care conferences.</p> <p>4. Resident #12 was admitted to the facility on 10/11/14 with multiple diagnoses, including Type 2 diabetes mellitus and anxiety disorder.</p> <p>A quarterly MDS assessment, dated 8/1/18, documented Resident #12 was cognitively intact.</p> <p>Resident #12's Care Plan Conference Record, dated 2/7/17, documented Resident #12 declined a care plan conference. The form was otherwise blank.</p> <p>Resident #12's Care Plan Conference Record, dated 10/6/17, documented diet, weight, code status, and concerns Resident #12 had experienced with staff. The form documented Resident #12 was in attendance and her family was not invited and not in attendance.</p> <p>On 10/26/18 at 2:39 PM, the LMSW stated the last care plan conference for Resident #12 was dated 10/2017. The LMSW stated that if the resident did not have problems or the resident did not want to attend, the care plan conference was not held. The LMSW stated each department would complete their assessments and update the care plans but not have a care plan meeting.</p> <p>5. Resident #42 was admitted to the facility on 8/8/12 with multiple diagnoses, including major depressive disorder, chronic pain, suicidal</p>	F 657			

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F 657	<p>Continued From page 37</p> <p>ideation, hemiplegia (paralysis on one side) and hemiparesis (weakness on one side) following cerebral infarction (stroke) affecting the left side, retention of urine, and chronic viral hepatitis C.</p> <p>Resident #42's quarterly MDS assessment, dated 9/10/18, documented he was cognitively intact.</p> <p>Resident #42's Care Plan Conference Records, dated 2/17/16 and 2/23/17, documented he and his representative attended the care plan conferences. There was no documentation of another care plan conference occurring or of Resident #42 or his representative being invited to a care conference after 2/23/17.</p> <p>On 10/22/18 at 2:35 PM, Resident #42 said he had a care plan conference meeting maybe once a year.</p> <p>On 10/26/18 at 11:45 AM, the LMSW said she was sure Resident #42 was invited to other care plan conferences but she did not have any recollection of when and it was not documented.</p> <p>6. Resident #61 was re-admitted to the facility on 8/25/17 with multiple diagnoses, including chronic obstructive pulmonary disease, acute respiratory failure with hypoxia (low oxygen level), unspecified dementia with behavioral disturbance, and bipolar disorder.</p> <p>Resident #61's quarterly MDS assessment, dated 9/28/18, documented she was cognitively intact.</p> <p>Resident #61's Care Plan Conference Record, dated 3/27/18, documented her family attended the care plan conference. There was no</p>	F 657			

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F 657	Continued From page 38 documentation of another care conference occurring or of Resident #61 or her family being invited to a care conference since 3/27/18. On 10/23/18 at 1:36 PM, Resident #61 said she was not sure when her last care conference occurred. On 10/26/18 at 10:29 AM, the LMSW said if it was not documented in the resident's record then a care plan conference did not happen. The LMSW said it could be the resident/family did not want to come to the care plan conference, but it was not documented.	F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, it was determined the facility failed to ensure residents were provided with personal hygiene consistent with their needs. This was true for 1 of 18 residents (#56) reviewed for personal hygiene. This failure created the potential for residents to experience embarrassment, isolation, or decreased sense of self-worth, related to lack of hygiene. Findings include: Resident #56 was admitted to the facility on 9/18/18 with multiple diagnoses, including prostate cancer.	F 677	Corrective Action: Resident #56 was shaved on 10-23-2018. He had refused help with shaving several times on 10-22-2018, however those interactions were not documented. He is offered the assistance from nursing staff to shave on a daily basis. Identification: All residents are identified as potentially being affected by this deficiency. Systemic Changes: Nursing staff educated regarding providing shaving care to those residents	12/21/18	

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F 677	Continued From page 39 Resident #56's admission MDS assessment, dated 9/25/18, documented his cognition was moderately impaired and he required the assistance of one staff member for personal hygiene. On 10/22/18 at 11:25 AM, Resident #56 said he had not had been shaved for the last two days as he was touching his chin. On 10/23/18 at 7:59 AM, Resident #56 was in the Main Dining Room. His hair was combed, and he was appropriately dressed, but his chin was not shaved. Whiskers were easily visible on Resident #56's chin. On 10/23/18 at 11:14 AM, Resident #56 said he wanted his chin to be shaved. When asked if he told the staff, Resident #56 just looked at the surveyor and did not give a verbal response. On 10/24/18 at 1:13 PM, CNA #3 said Resident #56 was scheduled to receive his showers every Monday and Thursday. CNA #3 said she would usually shaved the chin of male residents after she gave them a shower. When asked if she shaved Resident #56's chin when she gave him a bath two days ago, CNA #3 did not answer. CNA #3 and the surveyor went to Resident #56's room and the CNA said Resident #56 needed a shave.	F 677	requiring such services as necessary and/or as requested. Monitor: 1.DNS or Designee to conduct audit on a sampling of residents for shaving needs. 2.Audits to be conducted at the following frequencies: a.Daily for two (2) weeks b.Weekly for four (4) weeks c.Monthly for three (3) months 3.Findings to be reviewed by Administrator and reported to QA Committee		
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	F 684		12/21/18	

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F 684	<p>Continued From page 40</p> <p>that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, resident interview, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 18 residents (Resident #10) reviewed for quality of care. Resident #10 was harmed when steps were not taken to determine the cause of her right knee pain for 9 weeks and was subsequently diagnosed as having a medial tibial plateau fracture (break of the upper part of the tibia [shinbone] that involves the knee joint, typically caused by trauma). Findings include:</p> <p>Resident #10 was admitted to the facility under hospice services on 4/12/18 with multiple diagnoses, including severe dysphagia (swallowing difficulty,) anoxic brain damage/developmental disability, osteoarthritis, and pain in unspecified lower leg.</p> <p>A Potential for Pain care plan, dated 4/12/18, documented Resident #10 stated she has pain in her lower extremities and knees. The approaches included administration of medication, education to resident and family to request pain medication early, observe and report signs and symptoms of pain, and report changes in pain to the physician.</p> <p>An admission MDS assessment, dated 4/20/18, documented Resident #10 was on hospice services, moderately cognitively impaired, dependent on staff for transfers and bed mobility, had frequent pain rated at a 6 on a rating scale of</p>	F 684	<p>Corrective Action:</p> <ol style="list-style-type: none"> 1.Resident #10 is being treated as per physician order for the diagnosed fracture. (The statement in the 2567 that this fracture is typically caused by trauma is a matter of opinion by the Survey Team and not a matter of fact based on any finding of trauma in this instance.) 2.Resident #10 was seen by an Orthopedic Surgeon that stated that she had suffered some activity with some physical therapy, has had an injury to knee. Resident #10 has not had any orders for, nor participated in any therapy since admission to this facility. 3.Resident #10 was admitted with a knee brace due to diagnosis of osteoarthritis with pain. <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> 1.Education provided to facility staff regarding recognition of resident's pain, and other signs or symptoms that may indicate an injury, and reporting of any such findings or observations to LN staff. 2.Education provided to LN staff regarding policy and procedure of reporting and investigating injuries of 		

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F 684	<p>Continued From page 41 1-10 (6/10), and did not have a fracture.</p> <p>A Hospice Comprehensive Assessment and Plan of Care Update Report, dated 4/20/18, documented Resident #10 complained of severe right knee pain that was palliated with morphine.</p> <p>A Hospice Comprehensive Assessment and Plan of Care Update Report, dated 4/23/18, documented Resident #10 complained of her right knee aching, had been medicated with morphine 45 minutes prior to the assessment, and the morphine order was changed to every hour.</p> <p>A Hospice Comprehensive Assessment and Plan of Care Update Report, dated 5/5/18, documented Resident #10 exhibited increased pain with movement, she was otherwise calm, and pain decreased when she did not move.</p> <p>An undated Hospice Comprehensive Assessment and Plan of Care Update Report documented Resident #10 complained of right knee pain at 11/10, visual signs were not consistent with the pain score, Resident #10 was distracted with TV and conversation, and did not mention pain again.</p> <p>A physician telephone order, dated 6/22/18, documented Resident #10's hospice care was discontinued with a change in her primary care physician.</p> <p>A nursing note, dated 6/26/18, documented Resident #10's physician ordered a right knee x-ray and Voltaren 1% gel (an anti-inflammatory medication) to the affected areas two times daily</p>	F 684	<p>unknown origin.</p> <p>Monitor: 1.DNS or Designee to conduct audit of Alert Charting documentation for increased pain to ensure compliance. 2.Audits to be conducted at the following frequencies: a.Daily for two (2) weeks b.Weekly for four (4) weeks c.Monthly for three (3) months 3.Findings to be reviewed by Administrator and reported to QA Committee</p>		

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

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F 684	<p>Continued From page 42</p> <p>as needed for pain. An addendum to the nursing note documented the x-ray results were reviewed with Resident #10's primary care provider, and an order for an orthopedic consult and a right knee immobilizer was given. The nursing note documented Resident #10's father was notified of the x-ray results. Resident #10's father told the staff Resident #10 had previously been to an orthopedic physician due to a separated meniscus (C-shaped pieces of cartilage that act like a cushion between the shinbone and thighbone). A bedside x-ray obtained on 6/26/18 documented an acute fracture of the right medial tibial plateau.</p> <p>A Family Nurse Practitioner (FNP) note, dated 6/29/18, documented Resident #10 had complained of right leg pain while on hospice. Resident #10's knee pain was treated but an x-ray was never ordered to determine the cause of pain.</p> <p>An orthopedic physician Office History and Physical note, dated 7/26/18, documented Resident #10 had "suffered some activity with some physical therapy, has had an injury to her knee." The note documented Resident #10 was now following up roughly 5-6 weeks later since initial injury.</p> <p>On 10/22/18 at 1:38 PM, Resident #10 stated she had arthritis in her right knee. Resident #10 stated the pain in her knee was there 24 hours a day. Resident #10 stated she had not had any falls.</p> <p>On 10/26/18 at 3:06 PM, UM #1 stated Resident #10 exhibited pain from the date of admission</p>	F 684			

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F 684	Continued From page 43 and it became more severe as time progressed while she was receiving hospice services. UM #1 stated Resident #10 had pain medication provided but it did not help. UM #1 stated she had requested an order from Resident #10's hospice physician to x-ray her right knee, but the request was denied. UM #1 stated Resident #10 had no falls since her admission, had used a Hoyer lift for transfers, and was non-weight bearing. UM #1 was aware Resident #10 had resided at another care facility prior to her hospitalization, and stated they did not call the facility to inquire about any injury or event. UM #1 stated the facility's Medical Director was not approached regarding Resident #10's continued pain or denial of an x-ray order from the hospice physician. On 10/26/18 at 3:45 PM, the DON stated residents on hospice were not treated any differently than anyone else. The DON stated the staff could have gone to the Medical Director and he could have overridden the hospice physician and ordered an x-ray for Resident #10. The DON stated, "we thought it was a pathological fracture."	F 684			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		12/21/18	

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F 690	<p>Continued From page 44</p> <p>§483.25(e) Incontinence.</p> <p>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, and resident representative interviews, and review of</p>	F 690	<p>Corrective Action: 1. Resident #16 <input type="checkbox"/>s normal bowel pattern is</p>		

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F 690	<p>Continued From page 45</p> <p>records, it was determined the facility failed to ensure a bowel protocol was consistently implemented and urinary care needs were met. This was true for 2 of 4 residents (#16 and #44) reviewed for bowel and bladder care. Resident #16 had the potential for harm from constipation and impaction. Resident #44 had the potential for harm due to skin breakdown, urinary tract infection and discomfort when her soiled adult brief was not changed in a timely manner. Findings include:</p> <p>1. Resident #16 was admitted to the facility on 3/1/17 with multiple diagnoses which included hypertension and heart failure.</p> <p>Resident #16's quarterly MDS assessment, dated 8/3/18, documented he was severely cognitively impaired, incontinent of both bowel and bladder, and was dependent on 1 to 2 staff members for all cares.</p> <p>The facility's Bowel Protocol policy documented:</p> <p>*If no bowel movement for 2 days, staff were directed to assess resident for signs and symptoms of constipation, if the resident was alert and oriented ask about any unrecorded bowel movements, if acute abdominal symptoms were present contact the physician immediately.</p> <p>*If no bowel movements for 3 days and there were no acute abdominal symptoms, staff were directed to administer a PRN laxative or enema as ordered by the physician or contact the physician if there was no PRN order.</p> <p>*If no bowel movements for 4 days or there was</p>	F 690	<p>specific to him and not facility protocol. His bowel protocol is per physician order. Resident Care Plan updated to reflect his specific pattern.</p> <p>2. Resident # 44's room checked, her clothes changed, linens changed, and room cleaned.</p> <p>Identification: All residents that require bowel protocol and/or a toileting program are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1. Nursing staff educated regarding Resident #16's bowel pattern, Care Plan, and documentation of refusals. 2. Nursing and Housekeeping staff educated regarding Resident #44's Care Plan with regard to toileting, changing of linen and clothing, and documentation of refusals.</p> <p>Monitor: 1. DNS or Designee to conduct audit Resident #16's bowel program documentation to ensure compliance. 2. DNS or Designee to conduct audit of Resident #44's room, personal hygiene, and bladder program for compliance. 3. Audits to be conducted at the following frequencies: a. Daily for two (2) weeks b. Weekly for four (4) weeks c. Monthly for three (3) months 4. Findings to be reviewed by Administrator and reported to QA</p>		

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F 690	<p>Continued From page 46</p> <p>inadequate response to previous interventions, staff were directed to call the physician.</p> <p>*If constipation was a chronic problem, staff were directed to ensure resident had an adequate fluid intake, request dietary consult regarding a fiber enriched diet and request an order for bulk laxative or stool softener as needed.</p> <p>Resident #16's October 2018 Physician Order summary included the following:</p> <p>*Miralax 17 grams mixed in 4-8 ounces of fluid of choice PO daily ordered on 3/1/17 for bowel care.</p> <p>*Bisacodyl 10 mg PO PRN daily ordered on 4/21/18 for bowel care</p> <p>*Senna Plus 2 tablets PO twice daily ordered on 10/4/17 for bowel care.</p> <p>Resident #16's Bowel Movement Record, documented he did not have a bowel movement as follows:</p> <p>*9/3/18 through 9/5/18 (3 days)</p> <p>*9/12/18 through 9/16/18 (5 days)</p> <p>*9/20/18 through 9/22/18 (3 days)</p> <p>*9/28/18 through 9/30/18 (3 days).</p> <p>*10/5/18 through 10/7/18 (3 days)</p> <p>*10/13/18 through 10/15 18 (3 days)</p> <p>*10/19/19 through 10/23/18 (5 days).</p> <p>There was no documentation found in the Resident #16's record the physician was notified when he did not have a bowel movement for 4 to 5 days.</p> <p>Resident #16's 9/1/18 to 9/30/18 MAR</p>	F 690	Committee		

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F 690	<p>Continued From page 47 documented;</p> <p>*Miralax 17 grams was not administered on 9/7/18, 9/9/18, 9/12/18, 9/15/18, 9/20/18, 9/23/18, 9/25/18, and 9/29/18. *Senna Plus was not administered on 9/20/18, and was administered once on 9/6/18, 9/12/18, 9/17/18, 9/21/18, 9/23/18, 9/26/18, 9/27/18/ and 9/29/18. **Bisacodyl 10 mg PO PRN was not administered</p> <p>Resident #16's 10/1/18 to 10/24/18 MAR documented:</p> <p>*Miralax 17 grams was not administered on 10/2/18, 10/3/18, 10/6/18, 10/13/18, 10/14/18, 10/16/18, 10/19/19, 10/21/18 and 10/23/18. *Senna Plus was not administered on 10/2/18, 10/3/18, 10/14/18 and 10/19/18 and was administered once on 10/6/18, 10/9/18, 10/13/18, 10/20/18, 10/21/18 and 10/23/18. *Bisacodyl 10 mg PO PRN was not administered</p> <p>Resident #16's MAR Routine Standing Orders documented:</p> <p>* Miralax 17 gram in 8 oz juice or water daily PRN for no bowel movement for three days *Dulcolax suppository every day PRN for constipation (except for dialysis residents) *Fleet enema PRN for constipation</p> <p>On 10/23/18 at 2:49 PM, Resident #16's representative said it was common for Resident #16 to sleep all day long for two days in a row since Resident #16's spouse passed away. The representative said he will be awake on the third</p>	F 690			

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F 690	<p>Continued From page 48 day, then sleep again the following day.</p> <p>On 10/24/18 at 4:32 PM, CNA #7 said he would report to the nurse if a resident did not have a bowel movement for 3 days.</p> <p>On 10/25/18 at 11:57 AM, the Standing Orders were reviewed with LPN #6 for clarification. LPN #6 said the order was confusing. LPN #6 said if a resident did not have a bowel movement for 4 days, she would administer a suppository, and a fleet enema if there was no bowel movement for 5 days. When asked if Resident #16 was given a suppository when he had no bowel movement for 4 days, or fleet enema when he had no bowel movement for 5 days. LPN #6 said maybe it was given and the nurse forgot to document or maybe Resident #16 had a bowel movement and it was not charted.</p> <p>On 10/25/18 at 2:34 PM, the Standing Orders were reviewed with the DON for clarification. The DON said the Standing Orders on the MAR was very general. The DON said the facility used a Bowel Care Worksheet which was a daily log of residents who required bowel intervention. The Bowel Care Worksheet documented the following:</p> <p>*Day Shift - Resident with no bowel movement for 3 days: staff were directed to give Miralax to the resident and document the result.</p> <p>*Evening Shift - Resident with no bowel movement for 4 days: staff were directed give Dulcolax suppository and document the result.</p> <p>*NOC Shift - if no results from suppository, staff</p>	F 690			

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F 690	<p>Continued From page 49</p> <p>were directed to give enema and document the result.</p> <p>The DON provided the Bowel Care Worksheet for 10/16/18, 10/17/18 and 10/24/18, and documented the following:</p> <p>*10/16/18 - Resident #16 did not have a bowel movement for 4 days and he refused the suppository.</p> <p>*10/24/18 at 5:00 AM - Resident #16 was given suppository during the NOC shift.</p> <p>The DON said she only had the 10/16/18, 10/17/18 and 10/24/18 Worksheet for October and she could not find the September 2018 Bowel Care Worksheet.</p> <p>2. Resident #44 was re-admitted to the facility on 5/22/15 with multiple diagnoses including multiple sclerosis and neuromuscular dysfunction of the bladder.</p> <p>Resident #44's quarterly MDS assessment, dated 9/11/18, documented she was cognitively intact and required extensive assistance of 2 or more people with bed mobility, toileting, and transfers.</p> <p>Resident #44's October 2018 physician orders included oxybutin (a medication for urinary incontinence and overactive bladder) 10 mg daily for neurogenic bladder</p> <p>Resident #44's current care plan documented the following:</p> <p>* Provide prompt peri care as needed for incontinence between regularly scheduled</p>	F 690			

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F 690	<p>Continued From page 50 toileting, initiated on 10/11/16.</p> <ul style="list-style-type: none"> * Resident #44 required extensive assistance of 2 persons with sit to stand (a type of mechanical lift) for toileting/transferring. * Provide incontinent care and monitor skin for signs of breakdown during cares, and report all concerns to the licensed nurse. * Toilet every 2 hours and as needed, initiated on 10/11/16. * Staff and Resident #44 sign a form each time she is taken to the bathroom, initiated on 12/18/16. <p>On 10/25/18 at 8:30 AM, a sign labeled "(Resident #44's name) Toileting Schedule" was posted on the outside of Resident #44's closet door.</p> <p>On 10/25/18 at 8:40 AM, UM #2 said the DON had the rest of Resident #44's toileting schedules.</p> <p>On 10/25/18 at 8:52 AM, the DON said she would expect residents to be assisted with toileting every 2 hours while awake.</p> <p>On 10/25/18 at 9:15 AM, the surveyor requested a copy of Resident #44's toileting schedules.</p> <p>On 10/25/18 at 1:34 PM, the DON declined to provide a copy of Resident #44's toileting schedules and said it was something for her use so she could see Resident #44 was getting checked. The DON said there was missing documentation on the toileting schedule. The CNAs and Resident #44 were to sign the toileting schedule each time Resident #44 was checked so it could be verified she was getting checked.</p>	F 690			

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F 690	Continued From page 51 The DON said the CNAs would turn in the toileting schedule every week and then she usually discarded them. On 10/25/18 at 2:09 PM, a strong urine smell was noted in Resident #44's room. Resident #44 was lying in bed and said CNA #5 just changed her, and it was the first time she was changed all day. On 10/25/18 at 3:32 PM, Resident #44 was sitting in her wheelchair in her room. CNA #6 said it smelled like urine in Resident #44's room. A large wet area was noted on Resident #44's bed that smelled like urine. CNA #6 said Resident #44 was changed at 2:10 PM, then she checked Resident #44 at 3:15 PM and she was wet. CNA #6 said the wet area on Resident #44's bed was urine. On 10/26/18 at 7:57 AM, UM #2 said the CNAs should check and change Resident #44 every two hours, and he would expect her to be changed if there was a smell and if it was obvious that she needed to be changed.	F 690			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		12/21/18	

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F 695	<p>Continued From page 52</p> <p>by: Based on observation, record review, facility policy and procedure review, and resident and staff interviews, it was determined the facility failed to ensure residents received respiratory care as ordered by a physician. This was true for 1 of 1 (#61) residents reviewed for oxygen therapy. This failure created the potential for harm if residents did not receive oxygen therapy to maintain adequate oxygen levels. Findings include:</p> <p>The facility's policy and procedure for Oxygen Administration/Safety/Storage/Maintenance, revised 11/29/17, documented oxygen would be administered only when ordered by the physician. The physician order must specify the liter flow of oxygen, the method of administration, and length of time for oxygen administration.</p> <p>Resident #61 was re-admitted to the facility on 8/25/17, with multiple diagnoses including COPD and acute respiratory failure with hypoxia (low oxygen level).</p> <p>Resident #61's quarterly MDS assessment, dated 9/28/18, documented she was cognitively intact and received oxygen therapy.</p> <p>Resident #61's October 2018 Physician Orders documented Oxygen at 3 LPM (liters per minute) via nasal cannula continuously, ordered on 8/25/17.</p> <p>On 10/24/18 at 9:15 AM, Resident #61's care plan documented she used oxygen continuously per the physician's order, initiated on 8/10/15.</p>	F 695	<p>Corrective Action: 1.Oxygen orders for Resident #61 have been received to provide 1-3 Liters to maintain O2 SATS above 90%. SATS are checked during every shift. 2.Resident Care Plan updated to reflect resident's tendency to remove her oxygen. Nursing staff to monitor resident for this tendency.</p> <p>Identification: All residents with orders for oxygen are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: Nursing staff educated regarding oxygen orders and carrying out of the same as per order.</p> <p>Monitor: 1.DNS or Designee to conduct audit of residents with oxygen orders for accurate implementation of those orders. 2.Audits to be conducted at the following frequencies: a.Daily for two (2) weeks b.Weekly for four (4) weeks c.Monthly for three (3) months 3.Findings to be reviewed by Administrator and reported to QA Committee.</p>		

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F 695	<p>Continued From page 53</p> <p>On 10/22/18 at 1:28 PM, Resident #61's oxygen concentrator was on at 2 LPM in her room. The oxygen tubing was wrapped around the right bed rail, and Resident #61 was in her wheelchair and was not wearing her nasal cannula. Resident #61 said she wore oxygen most of the time.</p> <p>On 10/23/18 at 3:13 PM and 10/24/18 at 9:15 AM, Resident #61 was lying in bed and was not wearing her nasal cannula.</p> <p>On 10/25/18 at 7:40 AM, Resident #61 came out of her room in her wheelchair. The portable oxygen and tubing were hanging on the back of the wheelchair, and she was not wearing her nasal cannula. LPN #1 said the facility was trying to taper Resident #61 off oxygen. LPN #1 said she was watching Resident #61's oxygen saturation and she had not checked it yet that morning. LPN #1 said Resident #61's oxygen saturation was last checked the previous day.</p> <p>On 10/25/18 at 7:48 AM, LPN #1 said Resident #61 frequently went around without wearing oxygen. LPN #1 said she did a spot check of Resident #61's oxygen level the previous day and it was okay, so she talked to UM #2 about doing oxygen spot checks PRN (as needed) and he said write an order. LPN #1 said a nurse could write an order for PRN oxygen saturation checks. LPN #1 said Resident #61's current order was for oxygen be on at 3 LPM continuously.</p> <p>On 10/26/18 at 8:05 AM, UM #2 said he expected the oxygen to be on Resident #61 when she was in bed, when the order said oxygen was to be administered continuously.</p>	F 695			
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758			12/21/18

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F 758 SS=D	Continued From page 54 CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is	F 758			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	<p>Continued From page 55</p> <p>appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure adverse side effects were specified and monitored for psychotropic medications, non-pharmacological approaches were attempted prior to the use of these medications, and the effectiveness of the medication was monitored when ordered on an as needed basis unless contraindicated. This was true for 3 of 3 residents (#12, #23, and #33) reviewed for unnecessary medications. This created the potential for residents to experience adverse reactions from unnecessary psychotropic medications. Findings include:</p> <p>1. Resident #12 was admitted to the facility on 10/11/14, with multiple diagnoses including anxiety disorder and depression.</p> <p>A quarterly MDS assessment, dated 8/1/18, documented Resident #12 was cognitively intact, had diagnoses of depression and anxiety disorder, and received antidepressant medication on 7 of the last 7 days and antianxiety medication on 2 of the last 7 days.</p>	F 758	<p>Corrective Action:</p> <p>1. Resident #12's order for Xanax has been updated to include specific non-pharmacological interventions to help address resident's anxiety. The resident's Care Plan has also been updated.</p> <p>2. Resident #33's MAR and Care Plan have been updated to include monitoring for specific side effects of the prescribed anti-psychotic medication.</p> <p>3. Resident #23's MAR and Care Plan have been updated to include monitoring for specific side effects of the prescribed anti-psychotic medication.</p> <p>Identification:</p> <p>All residents with orders for anti-psychotic and anti-anxiety medications are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes:</p> <p>1. Education provided to nursing staff regarding policy and procedure for administration and documentation of</p>		

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F 758	<p>Continued From page 56</p> <p>Resident #12's October 2018 Physician Orders included the following:</p> <ul style="list-style-type: none"> * Xanax 0.5 mg daily, give 30 minutes before showers on Monday and Thursday for anxiety. * Xanax 0.5 mg daily as needed. * Cymbalta 60 mg daily for depression. * Monitor for adverse side effects of antidepressants every shift three times daily (y) = positive, (n) = negative. <p>The Physician Orders did not provide direction regarding when to administer the PRN antianxiety medication Xanax.</p> <p>Resident #12's care plan documented Resident #12 was taking an antidepressant and an antianxiety medication. The care plan directed staff to:</p> <ul style="list-style-type: none"> a. Observe for and report to nurse and physician, if noted, signs and symptoms of drug related hypotension (low blood pressure,) gait disturbance, cognitive impairment, behavioral impairment, ADL decline, and decline in appetite. b. Encourage non-pharmacological interventions that may be effective in minimizing behaviors. c. Monitor effectiveness of psychotropic drugs and review for changes at the psychotropic committee meeting. d. Licensed nurse to monitor for adverse side effects to psychotropic medication and document on the MAR each shift. 	F 758	<p>anti-psychotic and anti-anxiety medications. This education included identification and documentation of resident specific non-pharmacological interventions and side effects.</p> <p>2.Education provided to facility staff regarding identifying and use of resident specific non-pharmacological interventions.</p> <p>Monitor:</p> <ul style="list-style-type: none"> 1.DNS or Designee to conduct audit of Orders, Care Plans, and documentation of residents with orders for anti-psychotic and anti-anxiety medications for compliance 2.Audits to be conducted at the following frequencies: <ul style="list-style-type: none"> a.Weekly for four (4) weeks b.Monthly for three (3) months 3.Findings to be reviewed by Administrator and reported to QA Committee. 		

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

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F 758	<p>Continued From page 57</p> <p>Resident #12's October 2018 MAR directed staff to monitor for adverse side effects of antidepressants every shift three times daily (y) = positive, (n) = negative. The MAR did not direct staff to monitor for adverse side effects of the antianxiety medication when given or monitor for effectiveness of the medication.</p> <p>Resident #12's October 2018 MAR directed staff to provide Xanax 0.5 mg daily as needed for anxiety. The MAR did not direct staff to monitor for effectiveness, to utilize the Behavior Monitor for non-pharmacological interventions prior to delivery of the PRN medication, or what adverse side effects to monitor.</p> <p>A Pharmacy Consultation Report, dated 5/15/18, requested consideration of a dose reduction for the Xanax 0.5 mg order prior to showers. The report also requested consideration of stopping the PRN Xanax 0.5 mg as it had not been given over the last 3 months. Resident #12's NP provided an order on 5/16/18, to continue administration of Xanax prior to showers and postpone a gradual dose reduction. There were no non-pharmacological interventions identified for the PRN dose.</p> <p>The September 2018 Behavior Monitor Record included monitoring Resident #12 for episodes of anxious behaviors. There were no anxious behaviors documented for Resident #12 9/1/18 through 9/30/18. The interventions for Resident #12's anxiety directed staff to "provide support" and "let her vent her feelings."</p> <p>The October 2018 Behavior Monitor Record included monitoring Resident #12 for episodes of</p>	F 758			

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F 758	<p>Continued From page 58</p> <p>anxious behaviors. There were no anxious behaviors documented for Resident #12 10/1/18 through 10/24/18.</p> <p>On 10/26/18 at 9:30 AM, the DON stated adverse side effects psychotropic medications were monitored on the MAR and non-pharmacological interventions were documented on the Behavior Monitor Record. The DON said the Xanax was PRN and if it was not used for the entire month, it should be discontinued.</p> <p>2. Resident #33 was admitted to the facility on 5/29/18 with multiple diagnoses, including anxiety disorder, depression, and dementia.</p> <p>Resident #33's Significant Change in Status MDS Assessment, dated 10/2/18, documented she was severely cognitively impaired, had physical and behavioral symptoms directed toward others several days of the week, received antipsychotic, antianxiety and antidepressant medication daily, and received hospice care.</p> <p>Resident #33's October 2018 recapitulated Physician's Orders included she was to receive:</p> <ul style="list-style-type: none"> * Sertraline (antidepressant medication) 100 mg daily ordered on 7/5/18 for depression. * Lorazepam (antianxiety medication) 0.5 mg, as needed, ordered on 6/13/18 for anxiety. * Buspar (antianxiety medication) 15 mg two times a day ordered on 9/5/18 for anxiety. * ABHR Cream (Ativan, Benadryl, Haldol, Reglan - compound medication composed of antianxiety, antihistamine, antipsychotic and antiemetic medication) 1 mg/ 25 mg/ 2 mg/ 10 mg, apply 1 ml topically four times a day ordered on 9/20/18 	F 758			

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F 758	<p>Continued From page 59 for behavioral and psychological symptoms of dementia.</p> <p>The October 2018 recapitulated Physician's Orders directed to monitor for the adverse side effects of antidepressants every shift three times daily and to indicate "Y" for presence of side effects and "N" for the absence side effects. The physician order did not indicate the specific side effects the staff were to monitor and there was no order to monitor for the side effects of the antipsychotic medication.</p> <p>Resident #33's care plan documented she had a history of being physically combative, vocalized frustrations by calling people names, and she used psychotropic medications which placed her at risk for drug related hypotension, gait disturbance, cognitive impairment, behavioral impairment, ADL decline, and decline in appetite. The care plan directed staff to encourage non-pharmacological interventions that may be effective in minimizing her behaviors, administer medications and monitor laboratory results per physician's order, monitor effectiveness of psychotropic medications, monitor for adverse side effects and document on the MAR every shift, and report to physician any signs and symptoms of side effects related to use of medication.</p> <p>An NP note, dated 7/11/18, documented Resident #33 had advanced dementia and associated anxiety, and she did not believe making changes to the resident's antianxiety medications was appropriate. The NP note documented Resident #33 was using Ativan much less since she started taking Buspar 7.5</p>	F 758			

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F 758	<p>Continued From page 60</p> <p>mg BID (twice a day) and it was unwise to discontinue Ativan at that time. The NP note did not include a stop date for Ativan order.</p> <p>On 10/24/18 at 2:45 PM, UM #2 said he would look in the overflow records to see if there were any additional orders for Resident #33's Ativan. UM #2 also said he was not aware Resident #33 was not monitored for the side effects of her antipsychotic medication and she should have been.</p> <p>On 10/24/18 at 2:57 PM, RN #3 said the side effects of Resident #33's antidepressant were lethargy, confusion, and somnolence, and for her antipsychotic medication the side effects would be the same as her antidepressant but more confusion. RN #3 said whenever a resident started on a new medication or there was a decrease or increase in their medications, they would monitor the resident for 14 days. RN #3 also said staff would continue to monitor for the side effects of the antidepressants but not the antipsychotics.</p> <p>On 10/25/18 at 9:18 AM, UM #2 presented a copy of the Nurse Practitioner's clarification order, dated 7/20/18. The order documented Resident 33's current Ativan order should be discontinued on 12/12/18. UM #2 said he found the order in the Medical Record Office. UM #2 said he did not know why the order was not put on Resident #33's September and October 2018 recapitulation orders.</p> <p>3. Resident #23 was re-admitted to the facility on 2/26/18, with multiple diagnoses including unspecified lack of expected physiological</p>	F 758			

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F 758	<p>Continued From page 61 development in childhood and hypothyroidism (underactive thyroid).</p> <p>Resident #23's quarterly MDS assessment, dated 8/15/18, documented she was cognitively intact, had anxiety disorder, depression, and bipolar disease, and antipsychotic and antidepressant medications were received on 7 of the last 7 days.</p> <p>Resident #23's October 2018 physician orders included the following:</p> <ul style="list-style-type: none"> * Venlafaxine ER (Effexor-an antidepressant medication) 112.5 mg daily for depression. * Abilify (an antipsychotic medication) 5 mg at bedtime for Bipolar disorder. * Monitor for adverse side effects of antidepressants every shift y=positive n=negative. * Monitor for adverse effect of antipsychotic medication every shift. <p>Resident #23's current care plan documented the following:</p> <ul style="list-style-type: none"> * Administer medications per physician order and monitor for side effects and efficacy. * Resident #23 was taking antipsychotic and antidepressant medication for Bipolar disorder. * Observe for and report to nurse, if noted, signs/symptoms of drug related hypotension (low blood pressure), gait disturbance, cognitive impairment, behavioral impairment, ADL decline, and decline in appetite. * Report to physician any signs/symptoms of side effects related to medications. * Monitor for signs/symptoms of adverse side 	F 758			

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F 758	<p>Continued From page 62</p> <p>effects to antidepressant and antipsychotic medications. Licensed nurse to document "+/-" every shift. There was no description of the side effects, if experienced.</p> <p>Resident #23's October 2018 MAR documented the following:</p> <ul style="list-style-type: none"> * Monitor for adverse side effects of antidepressants every shift (y)=yes (n)=no. * Monitor for adverse side effects of antipsychotic medication every shift (y)=yes (n)=no. * The venlafaxine and Abilify were administered each day from 10/1/18-10/24/18. <p>On 10/26/18 at 8:01 AM, UM #2 said Resident #23's care plan directed staff to monitor for psychotropic medication side effects but he did not see the side effects listed on the care plan.</p> <p>On 10/26/18 at 8:18 AM, the DON said the MDS nurse, Social Services, and RN completed the care plan for psychotropic medications. The DON said Resident #23's care plan should provide more details about the side effects of psychotropic medications. The DON said the side effects were documented on Resident #23's MAR but they should be on the care plan.</p> <p>On 10/26/18 at 8:23 AM, the LMSW said adverse effects of psychotropic medications were documented on the care plan, and if the resident had anxiety or depression Social Services would complete the portion of the care plan that addressed behavior and to watch for signs and symptoms of depression.</p> <p>On 10/26/18 at 8:40 AM, LPN #1 said she could</p>	F 758			

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F 758	Continued From page 63 look up the side effects of medications on her phone, and she could look at the hospital notes in Resident #23's clinical record to see what should be monitored. LPN #1 said staff charted whether Resident #23 was having positive or negative reactions related to her psychotropic medications. LPN #1 said she looked on Google or in a drug book for the side effects of venlafaxine and Abilify, and it was documented on the MAR as plus or minus.	F 758			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review, and review of the Idaho Food Code, the facility failed to ensure food was	F 812	Corrective Action: 1. Tater Tots identified in 2567 were properly labeled and dated on	12/21/18	

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F 812	<p>Continued From page 64</p> <p>properly labeled to include a date when opened, and to properly cover food items in the walk-in refrigerator. These failures had the potential to impact all the residents in the facility and created the potential for harm should residents experience adverse health outcomes from improperly stored or outdated food. Findings include:</p> <p>Review of the facility's Safe Food Handling policy, revised 11/28/17, documented all food purchased, stored, and distributed should be handled with accepted food-handling practices and per federal, state, and local requirements.</p> <p>The 2017 FDA Food Code 3-305.11, related to food storage states food shall be protected from contamination by storing it in a clean, dry location and where it is not exposed to splash, dust, or other contamination.</p> <p>The 2017 FDA Food Code at 3-501.17 states except as specified in (E) -(G) of this section, refrigerated ready to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section</p> <p>The initial kitchen inspection was conducted on 10/22/18 at 7:36 AM with the Dietary Manager (DM) present. The refrigerator contained a 42-ounce cardboard carton of cranberry juice</p>	F 812	<p>10-22-2018.</p> <p>2.Cranberry Juice and Soy Milk containers identified in 2567 were disposed of on 10-22-2018.</p> <p>Identification: All residents are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: Dietary staff educated regarding facility policy and procedure for labeling, dating, and storage of food products.</p> <p>Monitor: 1.Administrator or Designee to conduct audit of refrigerators in Dietary Department to ensure compliance. 2.Audits to be conducted at the following frequencies: a.Daily for two (2) weeks b.Weekly for four (4) weeks c.Monthly for three (3) months 3.Findings to be reviewed by Administrator and reported to QA Committee.</p>		

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F 812	Continued From page 65 cocktail and a 32-ounce carton of soy milk. Both cartons were open and were not labeled with an open date to indicate when the items should be discarded if not used. The DM confirmed the items should be labeled with an open date. Upon inspection of the walk-in refrigerator on 10/22/18 at 7:48 AM, a large tray of tater tots was located on the third shelf of a metal shelving unit. The tater tots were placed on a tray and left uncovered in the walk-in refrigerator. The DM stated "I just put the tater tots in there for lunch today." The DM confirmed the food items should have been covered to prevent cross contamination.	F 812			

Bureau of Facility Standards

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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the licensing survey conducted on October 22, 2018 to October 26, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Presie Billington, RN Cecilia Stockdill, RN</p> <p>Abbreviations include: ICN = Infection Control Nurse</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a representative from each department participated in the facility's Infection Control Committee meetings. This failure created the potential to affect all residents, staff and visitors to the facility. Findings include:</p> <p>On 10/25/18 at 2:57 PM, the Infection Control Nurse (ICN) said the facility held its Infection Control Committee meetings monthly. Review of the sign-in sheets from September 2017 to August 2018, covering the last 4 quarters, showed the Dietary Manager did not attend the</p>	C 664	<p>Corrective Action: Infection Control Meeting was held on 11-27-2018. The facility Dietary Manager was in attendance as required.</p> <p>Identification: All residents, staff, and visitors are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: Infection Control Committee educated on the members that are required to attend</p>	12/21/18

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
12/03/18

Bureau of Facility Standards

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 664	Continued From page 1 monthly meetings during the first quarter (September to November 2017) and third quarter (March to May 2018). The ICN said she just started as an ICN about six weeks ago and she did not know why the Dietary Manager did not attend the first and third quarter meetings.	C 664	the Infection Control Committee Meetings. Monitor: 1.Administrator to audit of attendance of Infection Control Meetings to ensure compliance 2.Audits to be conducted at the following frequencies: Monthly for three (3) months 3.Findings to be reported to QA Committee.	



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June 24, 2019

Joe Rudd Jr, Administrator
Life Care Center of Boise
808 North Curtis Road,
Boise, ID 83706-1306

Provider #: 135038

Dear Mr. Rudd Jr:

On **October 26, 2018**, an unannounced on-site complaint survey was conducted at Life Care Center of Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007890

ALLEGATION #1:

Resident to resident incident was not thoroughly investigated.

FINDINGS #1:

Four surveyors conducted an unannounced, onsite federal recertification survey and complaint investigation from 10/22/18 to 10/26/18. During the investigation, 17 residents were observed and their records were reviewed for Quality of Care. The facility's Abuse Policy and Procedure, Incident and Accident reports from 2/2018 to 10/2018, and Grievance files from 4/2018 to 10/2018 were reviewed. Residents and staff interviews were conducted.

In an interview with a Licensed Practical Nurse (LPN), she said she remembered a few months ago a Certified Nursing Assistant (CNA) reported to her a resident yelled and threatened to slap another resident in the smoking area if the CNA placed the resident next to him. The LPN said

she witnessed an incident involving the two residents later in the afternoon at the nurse's station. The LPN said the first resident told the Shower Aide coming out of the shower room pushing a shower chair not to hit her with that (shower chair). The LPN said the second resident told the Shower Aide to hit the first resident hard with the shower chair. The LPN stated she spoke to the second resident about his inappropriate behavior and she reported both incidents to her Unit Manager (UM).

In an interview with the UM, he said he did not remember any specific incident between the two residents, and if there was one reported to him, he could not remember it because it had been a few months ago.

Two LPNs interviewed said they heard there was an incident between the two residents in the smoking area, but they did not know the details.

The Director of Nursing (DON) was interviewed and said she remembered there was an incident between the two residents in the smoking area but knowing second resident, she believed what he said was not directed to the first resident. The DON said any incident in the facility should be investigated. If there was a resident to resident incident, the staff should separate the two residents and make sure both residents were safe. The DON also said the nurse should make a report of the incident and submit the report to the DON.

In an interview with the facility's Administrator he said he received a letter from their Compliance Center about an incident between two residents and during that time the second resident had already been discharged from the facility. He said he conducted an interview of the staff regarding an altercation between the two residents.

Review of the facility's Incident and Accident Reports from February 2018 to October 2018 and Grievance files from April 2018 to October 2018 did not include incident reports between the two residents.

The first resident's record did not include a Nursing Note from 5/1/18 to 5/24/18.

The second resident's Nursing Notes, dated 5/1/18 through 5/24/18, did not include any documentation regarding his behavior toward the other resident.

In an interview with the Staff Development Coordinator (SDC), she said she provided abuse training to the facility staff and she provided all staff inservices. If some of the staff could not make it to the inservices, then she would give one on one training to the staff. She stated any allegation of abuse or mistreatment should be investigated. The SDC also said any resident-to-resident incident would be investigated the same way, staff or other residents who witnessed or heard about it would be interviewed. The SDC said the nurse to whom the incident

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was reported should complete the Incident Investigation Questionnaire form, sign and date it, and submit it to the DON. The DON or the Administrator would conduct the full investigation. The SDC also stated any incident in the facility should be reported to the state survey agency and a full investigative report should be submitted whether it was substantiated or not.

CONCLUSIONS:

Based on investigative findings, the allegation was substantiated, and deficiency was cited at F610 related to failure of the facility to investigate allegation of verbal abuse between residents.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



BELINDA DAY, RN, Supervisor
Long Term Care Program

BD/slj