



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

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

February 1, 2019

Rick Holloway, Administrator  
Idaho State Veterans Home - Boise  
320 Collins Road, 83702-4519 Po Box 7765  
Boise, ID 83707-1765

Provider #: 135131

Dear Mr. Holloway:

Enclosed are the findings of the Informal Dispute Resolution Panel's decision.

Also enclosed you will find an amended Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies (if applicable) that incorporates all revisions based on the Informal Dispute Resolution Panel's decision. Please resubmit the facility's Plan of Correction for the deficiencies listed and return the Form CMS-2567 and State Form (if applicable) to this office by **February 14, 2019**. This amended Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form (if applicable) will become the facility's survey of record.

If you have any questions, comments or concerns, please contact this office at (208) 334-6626, option 5. Thank you for your participation in this process.

Sincerely,

DEBBY RANSOM, R.N., R.H.I.T, Chief  
Bureau of Facility Standards

DR/Debby Ransom, RN, RHIT  
Enclosures



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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December 7, 2018

Rick Holloway, Administrator  
Idaho State Veterans Home - Boise  
320 Collins Road, 83702-4519  
Boise, ID 83707-1765

Provider #: 135131

Dear Mr. Holloway:

On **November 9, 2018**, a survey was conducted at Idaho State Veterans Home - 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.

Rick Holloway, Administrator  
December 7, 2018  
Page 2 of 3

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 17, 2018**. Failure to submit an acceptable PoC by **December 17, 2018**, may result in the imposition of civil monetary penalties by **January 9, 2019**.

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

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

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

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

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

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

- **Civil Monetary Penalty**
- **Denial of payment for new admissions February 9, 2019**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 9, 2019**, if substantial compliance is not achieved by that time.

Rick Holloway, Administrator  
December 7, 2018  
Page 3 of 3

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

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

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

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

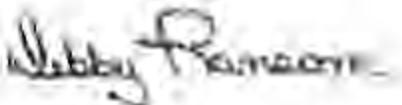
go to the middle of the page to **Information Letters** section and click on **State** and select the following:

- BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process  
2001-10 IDR Request Form

This request must be received by **December 17, 2018**. If your request for informal dispute resolution is received after **December 17, 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: 02/08/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135131</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/09/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO STATE VETERANS HOME - BOISE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 COLLINS ROAD, 83702-4519 BOISE, ID 83707</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted November 5, 2018 to November 9, 2018.</p> <p>This report reflects changes of the Informal Dispute Resolution conducted on January 17, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Coordinator Wendi Gonzales, RN Ina Tso, RN Carmen Blake, RN</p> <p>Abbreviations:</p> <p>ADL = Activities of Daily Living AROM = Active Range of Motion CNA = Certified Nursing Assistant DON = Director of Nursing GDR = Gradual Dose Reduction IDT = Interdisciplinary Team IM = Intramuscularly LPN = Licensed Practical Nurse LSW = Licensed Social Worker LMSW= Licensed Master Social Worker MAR = Medication Administration Record MDS = Minimum Data Set mg = Milligram RN = Registered Nurse PRN = As Needed RNA = Restorative Nursing Assistant PROM = Passive Range of Motion SW = Social Worker</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

12/17/2018

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

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F 000	Continued From page 1 1:1 = one-on-one staff supervision	F 000			
F 552 SS=E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5)  §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:  §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.  §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.  §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents receiving psychoactive medication had consents in place prior to initiation of the medications. This was true for 5 of 6 residents (#2, #30, #87, #100, and #261) reviewed for unnecessary medications. This deficient practice placed residents at risk of receiving psychotropic medications without knowledge of the risks and benefits associated with each medication, alternative treatment options, and the right to refuse the medications. Findings include:	F 552	1/14/19		
			Response to the citations listed on this 2567-L is required by federal law. The fact that the Idaho State Veterans Home-Boise is responding to them does not indicate that we agree with the findings or citations, or that, even if the observations listed are true, this facility is not in substantial compliance with the intent of federal law.  1. Residents #2 and #261 have expired. Consents have been completed for		

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F 552	<p>Continued From page 2</p> <p>A facility policy Mood and Behavior Medication Review Committee, undated, documented the committee identified and evaluated residents' use of medication for behaviors or mood and the committee ensured consents were completed.</p> <p>a. Resident #261 was admitted to the facility on 6/19/17, with diagnoses including dementia with Lewy bodies (abnormal protein deposits in the brain) and behavioral disturbances, depression, and sleep disorder.</p> <p>A significant change MDS assessment, dated 6/7/18, documented Resident #261 was severely cognitively impaired and he was totally dependent or required extensive assistance from one to two staff members with cares. The MDS documented Resident #261 had signs and symptoms of mild depression and he exhibited delusions and hallucinations. The MDS documented Resident #261 had physical, verbal, and other behaviors 4-6 days a week.</p> <p>Resident #261's May 2018 Physician Orders included the following scheduled and PRN medications:</p> <p>Scheduled Medications:</p> <ul style="list-style-type: none"> <li>- Depakote (anticonvulsant) 500 mg by mouth one time a day for Lewy bodies dementia with hallucinations and agitation, ordered on 5/31/18 and discontinued the same day.</li> <li>- Remeron (antidepressant) 15 mg at bedtime for depression and insomnia, ordered on 4/2/18 and discontinued on 6/1/18.</li> <li>- Seroquel (antipsychotic) 200 mg at bedtime for</li> </ul>	F 552	<p>residents #30, #87, and #100.</p> <p>2. All current and new residents who are prescribed psychoactive medications have the potential to be impacted. The records of residents who are currently receiving psychoactive medications were reviewed to ensure signed consents were present for the use of those medications.</p> <p>3. New residents, or current residents who are newly prescribed psychoactive medications will have signed or documented verbal consents in the resident's chart prior to administration. Each unit's Social Worker will track consents to ensure documented verbal consents are followed up with signed consents. All licensed nurses will be educated to inform the social workers in the event a new psychoactive medication was ordered so that proper consents can be obtained. In PointClickCare, the "Order Progress Note" template was updated to include the need to obtain consent prior to administering newly ordered psychoactive medications. During non-business hours, the nurse taking the order from the physician will secure the verbal consent prior to medication administration.</p> <p>4. The Director of Social Services or his designee will perform weekly audits of at least 10 percent of residents who received new psychoactive medications for the first four weeks, then monthly for the following 3 months, and quarterly</p>		

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F 552	<p>Continued From page 3</p> <p>dementia with hallucinations, ordered on 4/24/18 and discontinued on 5/23/18.</p> <ul style="list-style-type: none"> <li>- Seroquel 100 mg two times a day for dementia with hallucinations, ordered on 4/27/18 and discontinued on 5/23/18.</li> <li>- Seroquel 300 mg at bedtime for dementia with hallucinations, ordered on 5/23/18 and discontinued on 5/31/18.</li> <li>- Topamax (anticonvulsant) 25 mg at bedtime for unstable mood, ordered on 3/30/18 and discontinued on 6/12/18.</li> <li>- Zoloft (antidepressant) 200 mg one time a day for depression, ordered on 3/30/18 and discontinued on 6/1/18.</li> </ul> <p>PRN Medications:</p> <ul style="list-style-type: none"> <li>- Ativan (antianxiety) 1 mg intramuscularly (IM) one time only for extreme anxiety, ordered on 5/9/18.</li> <li>- Ativan 1 mg IM one time only for Lewy bodies dementia related to delirium, ordered on 5/23/18.</li> <li>- Ativan 1 mg IM one time only for Lewy bodies dementia related to delirium, ordered on 5/24/18.</li> <li>- Ativan 0.5 mg IM one time only for extreme anxiety, ordered on 5/27/18.</li> <li>- Ativan 1 mg intramuscularly every 24 hours PRN for agitation, ordered on 5/31/18 and discontinued on 6/4/18.</li> <li>- Oxycodone (narcotic) 5 mg every 6 hours PRN for pain, ordered on 5/21/18 and discontinued on 6/12/18.</li> <li>- Seroquel 100 mg one time only for dementia with hallucinations, ordered on 5/23/18.</li> <li>- Trazadone (antidepressant, with sedating effects) 25 mg every 8 hours PRN for anxiety, ordered on 4/2/18 and discontinued on 5/23/18.</li> <li>- Trazadone 50 mg every 8 hours PRN for</li> </ul>	F 552	<p>thereafter, to verify consents are in place for all psychoactive medications the residents are prescribed. If any residents are found to not have consents in place, the consents will be secured as soon as possible from the resident/responsible party. The results of these audits will be reported to the QA committee the following month.</p>		

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F 552	<p>Continued From page 4</p> <p>anxiety, ordered on 5/23/18 and discontinued on 6/12/18.</p> <p>Resident #261 received 2 antidepressant medications, Remeron and Zoloft, daily from 4/2/18 to 6/1/18, and 1 antipsychotic medication, Seroquel, daily from 4/24/18 to 5/31/18. Two medications, Seroquel and Depakote, were prescribed for hallucinations according to the MAR documentation. He also had orders for 2 antianxiety medications PRN, Ativan and Trazadone. Additionally, the medications Seroquel, Remeron, Trazadone, Ativan, and Oxycodone had sedative effects.</p> <p>Resident #261's June 2018 Physician Orders included the following scheduled and PRN medications:</p> <p>Scheduled Medications:</p> <ul style="list-style-type: none"> <li>- Ativan 1 mg/ml by mouth three times a day for agitation, ordered on 6/5/18 and discontinued on 6/6/18.</li> <li>- Ativan 1 mg/ml by mouth two times a day for agitation, ordered on 6/6/18 and discontinued the same day.</li> <li>- Ativan 1 mg/ml by mouth every eight hours for agitation, ordered on 6/6/18 and discontinued on 6/14/18.</li> <li>- Clonazepam (antianxiety) 0.5 mg by mouth two times a day for comfort and seizure control, ordered on 6/1/18 and discontinued on 6/6/18.</li> <li>- Depakote extended release 500 mg by mouth at bedtime for Lewy bodies dementia with hallucinations and agitation, ordered on 6/1/18 and discontinued on 6/12/18.</li> <li>- Seroquel 50 mg two times a day for dementia</li> </ul>	F 552			

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F 552	<p>Continued From page 5 with hallucinations, ordered on 5/23/18 and discontinued on 6/12/18.</p> <ul style="list-style-type: none"> <li>- Seroquel 200 mg at bedtime for dementia with hallucinations, ordered on 5/31/18 and discontinued on 6/12/18.</li> <li>- Topamax 25 mg at bedtime for unstable mood, ordered on 3/30/18 and discontinued on 6/12/18.</li> </ul> <p>PRN Medications:</p> <ul style="list-style-type: none"> <li>- Ativan 0.5 mg by mouth every 2 hours PRN for agitation, ordered on 6/1/18 and discontinued on 6/5/18.</li> <li>- Ativan 0.5 mg by mouth every hour PRN for agitation, ordered on 6/5/18 and discontinued on 6/14/18.</li> <li>- Ativan 1 mg IM every 24 hours PRN for agitation, ordered on 5/31/18 and discontinued on 6/4/18.</li> <li>- Ativan 1 mg IM every 24 hours PRN for agitation, ordered on 6/4/18 and discontinued on 6/14/18.</li> <li>- Morphine Sulfate (narcotic) 10 mg sublingually every 2 hours PRN for pain and air hunger, ordered on 6/1/18 and discontinued on 6/14/18.</li> <li>- Oxycodone 5 mg every 6 hours PRN for pain, ordered on 5/21/18 and discontinued on 6/12/18.</li> <li>- Trazadone 50 mg every 8 hours PRN for anxiety, ordered on 5/23/18 and discontinued on 6/12/18.</li> </ul> <p>Resident #261's antidepressants, Remeron and Zoloft, were discontinued and he had 2 antianxiety medications added to be taken daily, Ativan and Clonazepam. He also had PRN orders for Ativan, and a new order for Morphine Sulfate for pain.</p>	F 552			

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

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F 552	<p>Continued From page 6</p> <p>Resident #261's 5/1/18 through 6/14/18 MAR documented he was administered a PRN psychotropic medication, Trazadone or Ativan, at the same time as PRN pain medications, Oxycodone or Morphine, being administered. Examples include:</p> <ul style="list-style-type: none"> <li>- Oxycodone and Trazadone were administered together on 5/23/18 at 2:25 PM and 10:06 PM, 5/24/18 at 3:45 PM, 5/30/18 at 12:33 AM, and 6/4/18 at 3:30 AM.</li> <li>- Oxycodone and Ativan were administered together on 6/2/18 at 1:12 PM, 6/3/18 at 10:45 AM, and 6/5/18 at 3:03 PM.</li> <li>- Morphine and Trazadone were administered together on 6/6/18 at 4:00 AM.</li> <li>- Morphine and Ativan were administered together on 6/1/18 at 1:30 PM, 6/3/18 at 1:40 PM, 6/3/18 at 4:10 PM, 6/4/18 at 6:30 AM, 9:35 AM, and 12:15 PM, 6/6/18 at 3:07 PM, 5:07 PM, and 9:15 PM, 6/10/18 at 10:01 PM, 6/11/18 at 3:32 PM, and 6/12/18 at 1:50 PM.</li> </ul> <p>Resident #261's record did not include consents for his ordered psychotropic medications including Clonazepam, Depakote, Remeron, Seroquel, Topamax, Trazadone, and Zoloft.</p> <p>b. Resident #30 was readmitted to the facility on 3/10/16, with diagnoses including dementia.</p> <p>A quarterly MDS assessment, dated 8/13/18, documented Resident #30 was severely cognitively impaired and had no signs and symptoms of depression. The MDS documented he did not exhibit inappropriate behaviors, hallucinations, delusions, rejection of cares, or wandering.</p>	F 552			

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F 552	<p>Continued From page 7</p> <p>Resident #30's October 2018 Physician Orders included:</p> <ul style="list-style-type: none"> <li>- Zyprexa (antipsychotic) 5 mg by mouth in the afternoon and evening for dementia, ordered 10/22/18.</li> <li>- Trazadone 100 mg at bedtime for insomnia, ordered 4/2/18.</li> <li>- Trazadone 25 mg in the afternoon for anxiety, ordered 10/19/18.</li> <li>- Oxycodone 5 mg twice daily for arthritis pain, ordered 9/28/18.</li> </ul> <p>Resident #30's clinical record did not include a consent for the use of Trazadone.</p> <p>A Psychoactive Medication Consent, dated 6/29/15, documented Resident #30 received Zyprexa 2.5 mg at twice daily. The consent did not include the black box warning for this medication. The Nursing 2019 Drug Handbook included the following black box warnings for Zyprexa:</p> <ul style="list-style-type: none"> <li>* If Zyprexa is used in conjunction with an opioid (oxycodone) this increases the risk of sedation and death.</li> <li>* Use of Zyprexa may increase the risk of cardiovascular or infection-related deaths in elderly patients with dementia. Zyprexa is not approved to treat patients with dementia related psychosis and is to be used cautiously in the elderly with dementia as it may increase their risk of death.</li> </ul> <p>c. Resident #100 was readmitted to the facility on 8/27/18, with diagnoses including insomnia and</p>	F 552			

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F 552	<p>Continued From page 8 depression.</p> <p>A quarterly MDS assessment, dated 10/9/18, documented Resident #100 was cognitively intact and had minimal signs and symptoms of depression. The MDS documented she experienced delusions and no other behaviors.</p> <p>Resident #100's October 2018 Physician Orders included:</p> <ul style="list-style-type: none"> <li>- Trazadone 50 mg at bedtime for insomnia, ordered 8/27/18.</li> <li>- Wellbutrin (antidepressant) 150 mg once daily for depression, 8/27/18.</li> </ul> <p>Resident #100's clinical record did not include consents for the psychotropic medications Trazadone or Wellbutrin.</p> <p>d. Resident #87 was readmitted to the facility on 6/26/18, with multiple diagnoses including dementia.</p> <p>Resident #87's current care plan documented he experienced pain, difficulty concentrating, fear of others causing him harm, and changes in sleep patterns.</p> <p>Resident #87's physician orders documented he was started on duloxetine (antidepressant, also used to treat pain) 20 milligrams (mg) orally every day. On 11/7/18, the dose was increased to 60 mg each day.</p> <p>Resident #87's record did not include a consent from Resident #87 or his representative for the use of the duloxetine.</p>	F 552			

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F 552	Continued From page 9  e. Resident #2 was readmitted to the facility on 2/20/18, with multiple diagnoses including insomnia, dementia, PTSD, anxiety, depression, and Alzheimer's disease.  Resident #2's physician's orders, included:  * Escitalopram Oxalate (antidepressant) 10 mg by mouth one time a day for depression/PTSD, ordered on 4/3/18. * Risperdal (antipsychotic) 1 mg by mouth two times a day for unstable mood, ordered on 8/9/18. * Trazadone HCl 100 mg by mouth at bedtime for insomnia, ordered on 11/2/18.  Resident #2's record did not include a consent for the use of psychotropic medications which included Escitalopram Oxalate 10 mg by mouth one time a day for depression/PTSD, and Trazadone HCl 100 mg by mouth at bedtime for insomnia.  On 11/8/18 at 1:25 PM, the DON and Pharmacist confirmed the facility was unaware of the need to obtain resident/responsible party consent to administer psychoactive medications, including antidepressants. The facility failed to obtain consent from the residents and/or responsible parties to treat the resident with psychoactive medications prior to starting the medication.	F 552			
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6)  §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the	F 559		1/14/19	

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F 559	<p>Continued From page 10 arrangement.</p> <p>§483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.</p> <p>§483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, policy review, and record review, it was determined the facility failed to ensure a) written notice was provided to residents and/or their representatives prior to room and/or roommate changes, and b) residents were allowed to share a room with a roommate of their choice when practicable. This was true for 3 of 23 residents (#1, #30, and #89) reviewed for a room change and created the potential for harm should the residents experience a diminished sense of self-worth due to lack of control over their environment. Findings include:</p> <p>The facility's Change of Room or Roommate Policy/Procedure, dated 2/14/18, documented the resident would be provided with advanced written notice of a room transfer or roommate change, and the notice would include the reason for the recommended move. Prior to the room transfer, the resident, his/her roommate, and the resident's representative would be provided with information regarding the decision for the room transfer. The policy documented after the decision to move a resident was made, the</p>	F 559	<ol style="list-style-type: none"> <li>1. Written notices, with the reason for the change, were provided to residents #1, #30, and #89.</li> <li>2. All residents who change the bed or room where they live have the potential to be affected.</li> <li>3. Any resident who facility staff believe needs a room change, or who may have a new roommate, will have a written notice signed by the resident or responsible party in place prior to the resident moving rooms or beds, or the new roommate moving in. We currently have a policy in place which addresses this. In the case of new admissions, the roommate or his/her responsible party will be notified of the new admission and written notice will be secured. Each morning during leadership stand up meeting, room moves are discussed and the need for written notice is also an agenda item.</li> </ol>		

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F 559	<p>Continued From page 11</p> <p>facility would involve the resident in the decision and selection of a room or roommate when possible, allow the resident to ask questions, show the resident the new space, introduce any new roommates, and explain to other resident why the change was necessary.</p> <p>This policy was not followed. Examples include:</p> <p>a. Resident #1 was admitted to the facility on 5/1/17, with diagnoses including depression.</p> <p>A quarterly MDS assessment, dated 10/17/18, documented Resident #1 had moderate cognitive impairment. The assessment also documented Resident #1 had the ability to express ideas and wants and to consider both verbal and nonverbal expressions. The assessment further documented Resident #1 had clear comprehension and the ability to understand others.</p> <p>On 11/5/18 at 11:21 AM and 11/6/18 at 9:44 AM, Resident #1 was observed in room 218-1.</p> <p>A Progress Note, dated 11/6/18 at 8:04 AM, documented Resident #1's daughter requested Resident #1 move to a room with a window. The note documented Resident #1 stated to social services he did not need to move but would move. The note documented a room was being prepared for Resident #1.</p> <p>On 11/6/18 at 10:37 AM, Resident #1 was moved to room 215-2 by the window.</p> <p>On 11/6/18 at 3:26 PM, Resident #1 stated the facility had not shown him his new room or</p>	F 559	<p>4. Each unit's Social Workers will perform weekly audits of at least 10 percent of residents who moved beds or rooms for the first four weeks, then monthly for the following 3 months, and quarterly thereafter to verify written notices are in place for any room/bed change or roommate changes in the case of new admissions. If any residents are found to not have written notices in place, they will be secured as soon as possible from the resident/responsible party. The results of these audits will be reported to the QA committee the following month.</p>		

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F 559	<p>Continued From page 12</p> <p>introduced him to his new roommate until he was moving. Resident #1 stated he was told he had to move. Resident #1 stated he was not sure why he had to move, and he preferred his old room. Resident #1 stated he now had a roommate he did not know, and he left a roommate he had liked.</p> <p>On 11/14/18, after the completion of the survey, the facility provided a copy of written notice to Resident #1's family regarding the room change. The notice did not include the date the notice was drafted and was not signed by Resident #1's daughter or Resident #1.</p> <p>b. Resident #30 was readmitted to the facility on 3/10/16, with diagnoses including dementia.</p> <p>A quarterly MDS assessment, dated 8/13/18, documented Resident #30 was severely cognitively impaired.</p> <p>On 11/5/18 at 11:15 AM, Resident #30 was observed in room 215-1.</p> <p>A Progress Note, dated 11/5/18 at 4:08 PM, documented Resident #30 was moved to room 213 "today." The note documented Resident #30's wife was notified, and she had no issues with the move.</p> <p>On 11/6/18 at 9:40 AM, Resident #30 was observed in room 213.</p> <p>On 11/14/18 after the completion of the survey the facility provided a copy of a written notice to Resident #30's family regarding the room change. The notice did not include the date the</p>	F 559			

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F 559	<p>Continued From page 13</p> <p>notice was drafted and was not signed by Resident #30's wife.</p> <p>c. Resident #89 was admitted to the facility on 6/28/18, with diagnoses including cerebral infarction (stroke).</p> <p>A quarterly MDS assessment, dated 9/23/18, documented Resident #89 had moderate cognitive impairment.</p> <p>On 11/5/18 at 11:15 AM, Resident #89 was observed in room 215-2.</p> <p>On 11/6/18 at 9:40 AM, Resident #89 was observed in room 215-1.</p> <p>A Progress Note, dated 11/6/18 at 9:05 AM, documented Resident #89 was moved to a different bed in the same room. The note documented Resident #89's family verbalized no concerns.</p> <p>A Progress Note, dated 11/6/18 at 9:09 AM, documented Resident #89 received a new roommate and he was introduced to Resident #1.</p> <p>On 11/7/18 at 3:05 PM, the DON stated Resident #30 was moved to accommodate Resident #1's behavior of wandering and eloping. The DON stated Resident #1's family had requested he be placed near a window, which was what facilitated the move. The DON stated Resident #30's family was out of the country and could not sign a form.</p> <p>On 11/7/18 at 3:14 PM, LMSW #2 stated she had completed written notices to Resident #1, #30, and #89's families, however, she could not locate</p>	F 559			

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F 559	Continued From page 14 the notices. LMSW #2 stated she did not talk to the residents due to their limited cognitive status. LMSW #2 stated she provided a written notice to the families because of the residents' cognitive status.  On 11/14/18, after the completion of the survey, the facility provided a copy of a written notice to Resident #89's family regarding Resident #89's roommate change. The notice did not include the date the notice was drafted and was not signed by Resident #89's family.	F 559			
F 605 SS=G	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)  §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:  §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).  §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for	F 605		1/14/19	

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F 605	<p>Continued From page 15</p> <p>purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility did not ensure residents were free from chemical restraints. There was no documented evidence a systematic process of evaluation and care planning was utilized for staff to first implement resident-specific focused non-pharmacological interventions should residents demonstrate aggressive behaviors. This resulted in harm to 1 of 6 residents (Resident #261) reviewed for psychotropic drug use. Resident #261 was harmed when he experienced increased somnolence, sedation, and a decline in ADL's as a result of multiple psychotropic medications. Findings include:</p> <p>A facility policy, Mood and Behavior Medication Review Committee, undated, documented the committee identified and evaluated residents use of medication for behaviors or mood and the committee would determine the appropriate interventions and ensure consents, orders, and care plans were completed.</p> <p>The facility's ADL Behavior Monitor flowsheets documented the following behaviors for each resident in the facility, wandering, verbal abusive, physical abusive, socially inappropriate behavior, resistive or rejection of care, or there were no</p>	F 605	<ol style="list-style-type: none"> <li>1. Residents #261 has expired.</li> <li>2. All current and new residents who are prescribed psychoactive medications have the potential to be impacted. Individualized non-pharmacological interventions were identified and incorporated into each Resident's current care plan.</li> <li>3. The care plans of residents who are currently receiving PRN psychoactive medications which have been ordered for specific identified behaviors/medical symptoms have been reviewed for the presence of non-pharmacological interventions to implement prior to administration of PRN psychoactive medications. In PCC there is currently a PRN psychoactive medication assessment which includes the use of non-pharmacological interventions. Licensed nursing staff have been educated to use the PRN assessment tool and the need to review the care plan and implement specified non-pharmacological interventions prior to use of PRN psychoactive medications. This education has been added to the</li> </ol>		

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F 605	<p>Continued From page 16 behaviors.</p> <p>The facility's ADL Mood Symptoms Monitor flowsheets documented the following behavior for each resident in the facility, little interest or pleasure in doing things, feeling or appearing down/depressed, trouble falling asleep or staying asleep, feeling tired, poor appetite or overeating, feeling bad about themselves, trouble concentrating, moving extremely slow and speaking slow so that others notice, suicidal ideation's, and short tempered. The facility did not identify resident specific behaviors for staff to monitor.</p> <p>Resident #261 was admitted to the facility on 6/19/17, with diagnoses including dementia with Lewy bodies (abnormal protein deposits in the brain) and behavioral disturbances, depression, and sleep disorder.</p> <p>A significant change MDS assessment, dated 6/7/18, documented Resident #261 was severely cognitively impaired and he was totally dependent or required extensive assistance from one to two staff members with cares. The MDS documented Resident #261 had signs and symptoms of mild depression and he exhibited delusions and hallucinations. The MDS documented Resident #261 had physical, verbal, and other behaviors 4-6 days a week. The MDS documented he did not wander or reject cares.</p> <p>Resident #261's May 2018 Physician Orders included the following scheduled and PRN medications:</p> <p>Scheduled Medications:</p>	F 605	<p>licensed nurse competency skills checklist which is completed upon hire and no less than annually thereafter. PRN psychoactive medication order template includes additional directions relating to the need to complete the assessment. The DNS or her designee, each work day, will review the PRN psychotropic medication administration record in PCC in conjunction with the clinical meeting.</p> <p>4. The Director of Social Services or his designee will perform weekly audits for the first four weeks, monthly audits for three months, then quarterly thereafter, of at least 20 percent of the current residents, including new admissions, to verify the resident's care plan includes behaviors/medical symptoms that the Resident typically demonstrates, and the non-pharmacological interventions to implement prior to the administration of a PRN psychoactive medication. Any care plans found to not have resident-specific behavior/medical symptoms and non-pharmacological interventions in place will be updated to include this information. The results of these audits will be reported to the QA committee the following month.</p>		

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F 605	Continued From page 17  - Depakote (anticonvulsant) 500 mg by mouth one time a day for Lewy bodies dementia with hallucinations and agitation, ordered on 5/31/18 and discontinued the same day. - Remeron (antidepressant) 15 mg at bedtime for depression and insomnia, ordered on 4/2/18 and discontinued on 6/1/18. - Seroquel (antipsychotic) 200 mg at bedtime for dementia with hallucinations, ordered on 4/24/18 and discontinued on 5/23/18. - Seroquel 100 mg two times a day for dementia with hallucinations, ordered on 4/27/18 and discontinued on 5/23/18. - Seroquel 300 mg at bedtime for dementia with hallucinations, ordered on 5/23/18 and discontinued on 5/31/18. - Topamax (anticonvulsant) 25 mg at bedtime for unstable mood, ordered on 3/30/18 and discontinued on 6/12/18. - Zoloft (antidepressant) 200 mg one time a day for depression, ordered on 3/30/18 and discontinued on 6/1/18.  PRN Medications:  - Ativan (sedative and antianxiety) 1 mg intramuscularly (IM) one time only for extreme anxiety, ordered on 5/9/18. - Ativan 1 mg IM one time only for Lewy bodies dementia related to delirium, ordered on 5/23/18. - Ativan 1 mg IM one time only for Lewy bodies dementia related to delirium, ordered on 5/24/18. - Ativan 0.5 mg IM one time only for extreme anxiety, ordered on 5/27/18. - Ativan 1 mg intramuscularly every 24 hours PRN for agitation, ordered on 5/31/18 and discontinued on 6/4/18.	F 605			

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F 605	<p>Continued From page 18</p> <ul style="list-style-type: none"> <li>- Oxycodone (narcotic) 5 mg every 6 hours PRN for pain, ordered on 5/21/18 and discontinued on 6/12/18.</li> <li>- Seroquel 100 mg one time only for dementia with hallucinations, ordered on 5/23/18.</li> <li>- Trazadone (sedative and antidepressant) 25 mg every 8 hours PRN for anxiety, ordered on 4/2/18 and discontinued on 5/23/18.</li> <li>- Trazadone 50 mg every 8 hours PRN for anxiety, ordered on 5/23/18 and discontinued on 6/12/18.</li> </ul> <p>Resident #261 received 2 antidepressant medications, Remeron and Zoloft, daily from 4/2/18 to 6/1/18, and 1 antipsychotic medication, Seroquel, daily from 4/24/18 to 5/31/18. Two medications, Seroquel and Depakote, were prescribed for hallucinations according to the MAR documentation. He also had orders for 2 antianxiety medications PRN, Ativan and Trazadone. Additionally, the medications Seroquel, Remeron, Trazadone, Ativan, and Oxycodone had sedative effects.</p> <p>Resident #261's June 2018 Physician Orders included the following scheduled and PRN medications:</p> <p>Scheduled Medications:</p> <ul style="list-style-type: none"> <li>- Ativan 1 mg/ml by mouth three times a day for agitation, ordered on 6/5/18 and discontinued on 6/6/18.</li> <li>- Ativan 1 mg/ml by mouth two times a day for agitation, ordered on 6/6/18 and discontinued the same day.</li> <li>- Ativan 1 mg/ml by mouth every eight hours for agitation, ordered on 6/6/18 and discontinued on</li> </ul>	F 605			

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F 605	<p>Continued From page 19 6/14/18.</p> <ul style="list-style-type: none"> <li>- Clonazepam (antianxiety) 0.5 mg by mouth two times a day for comfort and seizure control, ordered on 6/1/18 and discontinued on 6/6/18.</li> <li>- Depakote extended release 500 mg by mouth at bedtime for Lewy bodies dementia with hallucinations and agitation, ordered on 6/1/18 and discontinued on 6/12/18.</li> <li>- Seroquel 50 mg two times a day for dementia with hallucinations, ordered on 5/23/18 and discontinued on 6/12/18.</li> <li>- Seroquel 200 mg at bedtime for dementia with hallucinations, ordered on 5/31/18 and discontinued on 6/12/18.</li> <li>- Topamax 25 mg at bedtime for unstable mood, ordered on 3/30/18 and discontinued on 6/12/18.</li> </ul> <p>PRN Medications:</p> <ul style="list-style-type: none"> <li>- Ativan 0.5 mg by mouth every 2 hours PRN for agitation, ordered on 6/1/18 and discontinued on 6/5/18.</li> <li>- Ativan 0.5 mg by mouth every hour PRN for agitation, ordered on 6/5/18 and discontinued on 6/14/18.</li> <li>- Ativan 1 mg IM every 24 hours PRN for agitation, ordered on 5/31/18 and discontinued on 6/4/18.</li> <li>- Ativan 1 mg IM every 24 hours PRN for agitation, ordered on 6/4/18 and discontinued on 6/14/18.</li> <li>- Morphine Sulfate (narcotic) 10 mg sublingually every 2 hours PRN for pain and air hunger, ordered on 6/1/18 and discontinued on 6/14/18.</li> <li>- Oxycodone 5 mg every 6 hours PRN for pain, ordered on 5/21/18 and discontinued on 6/12/18.</li> <li>- Trazadone 50 mg every 8 hours PRN for anxiety, ordered on 5/23/18 and discontinued on</li> </ul>	F 605			

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F 605	<p>Continued From page 20 6/12/18.</p> <p>Resident #261's antidepressants, Remeron and Zoloft, were discontinued and he had 2 antianxiety medications added to be taken daily, Ativan and Clonazepam. He also had PRN orders for Ativan, and a new order for Morphine Sulfate for pain. Additionally, the medications Ativan, Clonazepam, Seroquel, Morphine Sulfate, Oxycodone, and Trazadone had sedative effects.</p> <p>Resident #261's care plan did not include specific behaviors and did not identify or include depression and anxiety.</p> <p>Resident #261's care plan addressed cognition, dated 3/27/18, and documented he had impaired cognition related to Lewy body dementia and was rarely understood and had difficulty understanding. The care plan did not document how his dementia presented.</p> <p>Resident #261's care plan area addressing elopement risk, dated 4/13/18, and documented he verbalized wanting to leave the facility and wandered the facility. Interventions included Resident #261 had a roam alert bracelet on his wheelchair, dated 4/13/18, and staff were to provide 1:1 supervision until Resident #261 stopped attempting to leave the facility, dated 5/26/18. The care plan did not include identification of behaviors associated with the 1:1 intervention initiated on 5/26/18.</p> <p>The care plan area addressing Resident #261's behaviors and mood, dated 6/28/17, documented he was cognitively impaired and had dementia. The care plan documented he had behavioral</p>	F 605			

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F 605	<p>Continued From page 21</p> <p>issues with hallucinations and delusions. The care plan documented Resident #261 had suicidal ideation, hit staff, and screamed.</p> <p>Resident #261's care plan did not identify if Resident #261's hallucinations and or delusions were tactile [touch], visual, auditory, and olfactory [smell]), was not resident specific and did not document clearly how his hallucinations or delusions presented. The care plan did not document if his hallucinations or delusions were harmful to him.</p> <p>Resident #261 did not have a care plan for his anxiety or his depression. The facility did not identify how Resident #261's anxiety, agitation, or depression presented.</p> <p>Resident #261's Sleep Monitors, MAR, and Progress Notes documented Resident #261's hours of sleep increased as the medications were added, and he experienced falls and increased confusion with the medication changes. Examples include:</p> <ul style="list-style-type: none"> <li>- Resident #261's Sleep Monitor for 5/2/18 MAR documented he slept 11 hours. A progress note, dated 5/2/18, documented Resident #261 was administered a PRN Trazadone due to him not being able to sleep and settle down. Resident #261's Trazadone was ordered for anxiety and not sleep.</li> <li>- A Progress note, dated 5/14/18 at 9:39 PM, documented Resident #261 was agitated and continued to ambulate without his wheelchair or assistance and PRN Trazadone was provided at 2:53 PM. The note documented Resident #261</li> </ul>	F 605			

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F 605	<p>Continued From page 22</p> <p>needed 1:1 staff supervision from 1:00 PM to 9:00 PM and a light duty staff member was only available from 4:00 PM to 6:00 PM. Resident #261's care plan was not updated to include the need for 1:1 staff supervision on 5/14/18, and it was unclear if he was to have a 1:1 CNA present for the duration of time between 1:00 PM and 9:00 PM.</p> <p>- A Progress Note, dated 5/19/18 at 5:15 AM, documented Resident #261 experienced an unwitnessed fall in his room while attempting to walk in his room.</p> <p>- A Progress Note, dated 5/22/18 at 1:39 PM, documented Resident #261 had increased behaviors of hitting staff, aggression, paranoia and was not redirectable. The note documented he spoke in word salad (gibberish) and appeared in distress. The note documented pharmacy recommended increasing his psychotropic medications, Topamax and Trazadone, and Resident #261's spouse agreed. Resident #261's clinical record did not document an episode of physical abusive behaviors occurring on 5/22/18. The behavior monitoring documented he experienced one behavior of being physically abusive for the month of May, on 5/21/18.</p> <p>- A Progress note, dated 5/22/18 at 2:43 PM, documented Resident #261 was easily frustrated and angry at nursing staff. The note documented he wanted to leave the facility and attempted to pick up items off the floor that were not there. The note documented he "yelled" at staff when they attempted to assist him to the restroom during the day, and later in the evening he was unable to bear weight to transfer onto a toilet and</p>	F 605			

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F 605	<p>Continued From page 23</p> <p>was resistive when they attempted to assist him into bed "due to sleepiness."</p> <p>- A Progress Note, dated 5/23/18 at 5:45 AM, documented Resident #261 experienced a witnessed fall in the TV room. The note documented Resident #261 was sitting in his wheelchair and he was leaning to the side and fell out of his wheelchair before the staff member sitting next to him could stop it. The note documented Resident #261 was up all night and was assisted into a recliner chair using a Hoyer lift, and he "immediately" fell asleep.</p> <p>Resident #261's 5/23/18 MAR documented he was administered a dose of PRN oxycodone and PRN Trazadone at 2:25 PM. The MAR documented he was administered a PRN dose of Ativan at 9:53 PM, then at 10:06 PM, he was administered a dose of PRN Trazadone and PRN oxycodone, then at 10:13 PM he was administered a dose of PRN Seroquel. There was 13 minutes between the PRN Ativan and PRN oxycodone, Seroquel, and Trazadone doses.</p> <p>According to the Nursing 2019 Drug Handbook, Ativan by IM injection take up to 60 minutes to take effect. According to the Nursing 2019 Drug Handbook Ativan, Trazadone, and oxycodone side effects include sedation, confusion, insomnia, dizziness, and drowsiness. The staff did not provide adequate time for the anxiety medication administered to take effect before administering another two psychotropic medications and a pain medication.</p> <p>- A Progress Note, dated 5/23/18 at 11:05 PM,</p>	F 605			

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F 605	<p>Continued From page 24</p> <p>documented Resident #261 was provided PRN oxycodone at 2:25 PM and at 10:06 PM and they were effective with relieving pain from his fall. The note documented he was anxious the majority of the shift and rested for a few hours after dinner while his "1:1 supervision CNA was with him." Resident #261's care plan was not updated to include the need for 1:1 staff supervision on 5/23/18, and it was unclear if he was to have a 1:1 CNA.</p> <p>The 5/23/18 note documented the IM Ativan was not "initially effective" and PRN Trazadone, oxycodone, and Seroquel were administered. The same note documented at 10:30 PM Resident #261 was asleep and "snoring" in the common area. The note documented Resident #261 required the assistance of 2 staff members with a Hoyer lift for all transfers during the remainder of the shift.</p> <p>- A Progress Note, dated 5/27/18 at 3:00 AM, documented Resident #261 woke up and he was calling out he wanted to use the bathroom and go home. Resident #261 was unable to stand up and comprehend instructions with using the mechanical lift and required 3 CNAs to assist with the transfer. He was given a dose of PRN Trazadone related to anxiety, which was ineffective. Resident #261 was moved to the nurses' station and continued to call out. The note documented a 1:1 sitter was not available for the night shift and a staff member assigned to a different unit volunteered to assist as Resident #261's 1:1 for 1-2 hours. Resident #261 was administered a PRN IM Ativan dose at 3:22 AM. There was no documentation describing how Resident #261's anxiety presented.</p>	F 605			

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F 605	Continued From page 25  - A Progress Note, dated 6/1/18 at 8:15 AM, documented Resident #261 experienced a witnessed fall in the common room. The note documented Resident #261 was attempting get out of a recliner chair and sat on the footrest causing it to collapse to the floor. The note documented a "new care plan intervention" was implemented of a 1:1 staff member. It was unclear if Resident #261's 1:1 staff was near him at the time of the fall, or if the 1:1 was currently in place as care planned on 5/26/18.  - A Progress Note, dated 6/2/18 at 10:38 AM, documented a conversation between Resident #261's physician and nursing staff from 5/31/18 through 6/1/18. The note documented Resident #261's psychotropic medications were adjusted. The note documented on 5/31/18 at 11:52 AM, Resident #261 had not slept for 2 days and an IV Ativan was provided per the physician's order and Resident #261 was "finally resting."  - A Progress Note, dated 6/4/18 at 10:41 AM, documented Resident #261 had increased confusion and was restless and picked up unseen items on the floor. The note documented he had a change in his previous normal pattern of behavior with an increase in negative behaviors and increased confusion and agitation. Resident #261's 6/4/18 MAR documented he was administered a dose of PRN Ativan and PRN Morphine at 12:15 PM, a dose of PRN Trazadone at 2:00 PM, and a dose of PRN IM Ativan at 2:40 PM. According to the Nursing 2019 Drug Handbook, Ativan, Trazadone, Morphine, and oxycodone side effects include anxiety, irritability, agitation, hostility, anger, sedation, confusion,	F 605			

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F 605	<p>Continued From page 26 insomnia, dizziness, and drowsiness.</p> <p>- A Progress Note, dated 6/5/18 at 3:00 AM, documented Resident #261 was with a 1:1 staff member for safety. The note documented he was agitated and fidgety. The note documented Resident #261 was rubbing his knees for possible pain and attempted to rise from his bed frequently. The note documented he was provided PRN morphine for possible pain and later PRN Ativan for "cont [inued] wakefulness/agitation." Resident #261's 6/5/18 MAR documented he was administered a dose of PRN Ativan at 6:49 AM, a dose of scheduled Ativan at 8:00 AM, a dose of PRN Ativan at 10:28 AM, a dose of PRN IM Ativan at 3:03 PM, a dose of PRN oxycodone at 3:15 PM, a dose of scheduled Ativan at 4:00 PM, and a dose of PRN Morphine at 7:36 PM, 9:40 PM, and 11:46 PM.</p> <p>Resident #261's May 2018 MAR documented he was sleeping from 3 hours to 16 hours a day and averaged 9 hours daily. Examples include:</p> <p>- On 5/2/18, the MAR documented he slept 11 hours. A progress note, dated 5/2/18, documented Resident #261 was administered a PRN Trazadone as he was unable to sleep and settle down. Resident #261's Trazadone was ordered for anxiety, not sleep.</p> <p>- Resident #261's MAR documented he slept 9 hours during the 5/8/18 evening shift.</p> <p>- Resident #261's MAR documented for the night shift on 5/23/18 he slept 7 hours, and during the day shift on 5/24/18 he slept for 4 hours.</p>	F 605			

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F 605	<p>Continued From page 27</p> <ul style="list-style-type: none"> <li>- Resident #261's MAR documented for the night shift on 5/27/18 he slept 7 hours, and during the day shift on 5/28/18 he slept for 4 hours.</li> <li>- Resident #261's MAR documented he slept for 10 hours on 5/29/18, on 5/30/18 he slept 7 hours, and on 5/31/18 he slept 10 hours during the 24 hour period.</li> </ul> <p>Resident #261's June 2018 MAR documented he was sleeping from 7 to 24 hours a day and averaging 15 hours daily. Examples include:</p> <ul style="list-style-type: none"> <li>- Resident #261's Sleep Monitor for 6/4/18 documented he slept 8 hours during the 24 hour period.</li> <li>- Resident #261's Sleep Monitor for 6/5/18 documented he slept 9 hours during the 24 hour period.</li> <li>- Resident #261's Sleep Monitor for 6/6/18 documented he slept 16 hours during the 24 hour period.</li> <li>- Resident #261's Sleep Monitor documented he slept 11 hours on 6/7/18, 16 hours on 6/8/18, 21 hours on 6/9/18, 16 hours on 6/10/18, 21 hours on 6/11/18, and 24 hours on 6/12/18 and 6/13/18.</li> </ul> <p>On 11/9/18 at 10:19 AM, LMSW #1 stated Resident #261 was actively delusional, he experienced hallucinations, and was paranoid of people trying to do bad things to him. LMSW #1 stated the medications were managed by a psychiatrist. LMSW #1 stated he received alerts from staff when a resident was experiencing increased behaviors and the GDR committee</p>	F 605			

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F 605	<p>Continued From page 28</p> <p>evaluated the residents from the alerts. LMSW #1 stated the CNA behavior monitors did not include hallucinations and delusions, but staff documented these in the MDS and throughout the progress notes. LMSW #1 stated psychotropic medications could increase a resident's fall risk and the facility did not provide PRN psychotropic medications when a 1:1 staff member was unavailable. LMSW #1 stated staff provided PRN medications when a resident's behavior exhibited. LMSW #1 stated the specific behavior the resident exhibited should be documented in their clinical record for any PRN psychotropic medication administration. LMSW #1 stated the care plan should identify resident specific behaviors for dementia, hallucinations, and delusions and if they were harmful. The LMSW #1 stated the current behavior monitors were helpful with gathering information in addition to the alerts he received along with the resident MDS.</p> <p>On 11/9/18 at 12:23 PM, the DON stated according to the care plan Resident #261 was to have a 1:1 staff member with him on 5/26/18. The DON stated he may have been provided a 1:1 for short durations before that time. The DON stated the facility did not provide PRN psychotropic medications when a 1:1 staff member was unavailable, only when residents' behaviors increased. The DON stated the behavior monitors were not resident specific and the staff documented specific instances throughout the progress notes. The DON stated when the GDR team met the team reviewed each resident's behaviors and evaluated items such as sleep and what the team discussed was documented on the GDR note.</p>	F 605			

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F 607 SS=D	<p>Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, and policy review, it was determined the facility failed to ensure all allegations of potential abuse were thoroughly investigated. This was true for 1 of 3 residents (#76) who were reviewed for potential abuse and neglect. The failure created the potential for harm when suspected abuse was not immediately reported to the Administrator or designee, a resident was not protected, and an investigation of potential abuse for Resident #76 was not investigated. Findings include:</p> <p>An undated facility policy titled, Freedom from Abuse, Neglect and Exploitation, documented a person who had knowledge of potential acts of abuse, neglect, exploitation or misappropriation of resident property would report the information to an immediate supervisor or the charge nurse. The policy documented the charge nurse would report the incident to the Administrator. The policy documented "all alleged violation" would be thoroughly investigated by the facility. The</p>	F 607	<p>The facility will be submitting a request for Informal Dispute Resolution (IDR) on this citation under separate letter. The reason is the incident referenced in the 2567 was immediately determined to not constitute abuse by nurse managers and the facility social worker at the time of the incident. The CNA who reported the alleged abuse had overheard two other staff members talking and admitted she misheard the conversation at that time. The report of abuse made to the surveyors was done by the CNA who previously admitted she misheard the conversation but only decided to report it to the surveyors immediately after being reprimanded due to job performance issues.</p> <p>1. The alleged abuse for #76 was investigated and was found to not be substantiated.</p>	1/14/19	

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F 607	<p>Continued From page 30</p> <p>policy documented "all suspected cases of abuse" would be investigated following the guidelines set forth by the Bureau of Facility Standards. The policy documented after an allegation was received, the facility would protect the resident from potential further crimes. The policy documented the facility would interview staff and obtain written, dated and signed statements from direct care staff assigned to the resident. The policy documented the residents' clinical record should reflect the following questions answered of who, what, where, and when related to the incident.</p> <p>Resident #76 was admitted to the facility on 9/12/18, with diagnoses which included vascular dementia without behavioral disturbance, chronic pain, hemiplegia (paralysis/weakness on one side of the body), and urinary incontinence.</p> <p>An admission MDS assessment, dated 9/18/18, documented Resident #76 had short and long-term memory problems and was severely cognitively impaired. The MDS assessment documented he exhibited physical behaviors that included hitting, kicking, pushing, scratching, grabbing, and these behaviors significantly interfered with resident cares. The MDS assessment documented he exhibited rejection of care in 1-3 of 7 days. The MDS assessment documented Resident #76 required 2-person extensive assist with cares including bed mobility, transfers, and toilet use.</p> <p>Physician Orders, dated November 2018, documented Resident #76 received Celexa (antidepressant) 20 mg daily for anxiety, depression, and dementia, and Seroquel</p>	F 607	<p>2. All current and potential Residents have the potential to be impacted by the deficient practice. All allegations of potential abuse have been thoroughly investigated.</p> <p>3. Resident Abuse Prevention Education, which includes reporting of allegations of potential abuse, is provided to all new hires upon hire and current staff no less than annually. All staff were retrained related to the need to ensure that all allegations of potential abuse are reported up the chain of command and that the Administrator is always notified of any potential abuse situation. All allegations of potential abuse are investigated by the social worker for the unit where the resident or abuse allegedly occurred. This process is outlined in our current policy and procedure relating to abuse investigations. IDT leadership Meeting agenda sheets will include discussion of allegations of abuse investigation progress. The investigative report is reviewed by the IDT for completeness and appropriate follow-up action prior to submitting to the State Portal.</p> <p>4. The agenda sheets will be reviewed to ensure the subject of alleged abuse investigations was discussed, weekly for the first four weeks, then monthly for the following 3 months, and quarterly thereafter by the Director of Nursing or designee to ensure that the subject of any</p>		

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F 607	<p>Continued From page 31 (antipsychotic) 25 mg three times daily for worsening behaviors related to vascular dementia.</p> <p>The care plan area addressing Resident #76's self care, dated 9/12/18, documented it was difficult to obtain Resident #76's cooperation with bathing and staff were to re-approach with different staff members as needed and at various times</p> <p>The care plan area addressing Resident #76's behaviors, dated 9/12/18, documented he had the potential to be physically aggressive during cares. The care plan documented Resident #76 complied best when caregivers did things slow and verbalized what they were doing. The care plan documented Resident #76 benefited from conversations and 1:1 time and if he was angry and frustrated talking to his family sometimes helped.</p> <p>On 11/8/18 at 1:50 PM, a person who wished to remain anonymous wanted to speak privately with a surveyor. The anonymous person (AP) stated she spoke with CNA #3 about an incident involving Resident #76. The AP stated CNA #3 told him/her one evening she was working with CNA #1 and they were assisting Resident #76 with cares. The AP stated CNA #3 said Resident #76 was combative and they held the resident hands to transfer him and "held his hands down" to change him. The AP stated he/she said to CNA #3 that the CNAs should have reapproached Resident #76. The AP told RN #1 immediately after hearing about the incident. RN #1 instructed the AP to write it up, sign and date it, and this was done by the AP. The AP could not find RN</p>	F 607	<p>alleged abuse investigations was addressed. Director of Nursing and/or designee will initial as to the audit on the agenda sheet next to the applicable item. The results of this audit will be presented at the monthly QA meeting.</p>		

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F 607	<p>Continued From page 32</p> <p>#1 to give him the signed document as requested, so he/she gave it to LMSW #1.</p> <p>On 11/8/18 at 2:12 PM, the AP stated the incident occurred on 10/23/18 on the evening shift. The AP said RN #1 and LMSW #1 had the written statement.</p> <p>On 11/8/18 at 2:38 PM, LMSW #1 identified LSW #1 as the lead investigator for the incident involving Resident #76. He said LSW #1 assisted with investigations and reported them and any allegations should be reported to the State Survey Agency. When LMSW #1 was asked if there was an abuse allegation/incident involving Resident #76, he responded "yes" he thought there was something and would look for documentation. LMSW #1 stated he had not received a written summary from staff members that he could recall.</p> <p>On 11/8/18 at 2:45 PM, LMSW #1 reviewed the allegation/incident log with the surveyor and said there was no allegation of abuse documented for Resident #76 during the week of 10/23/18.</p> <p>On 11/8/18 at 2:56 PM, RN #1 stated he reported suspected abuse immediately to LMSW #1 and the DON and then completed a risk management report. RN #1 stated if an allegation of abuse occurred he would ensure the resident was safe and remove the staff member from the floor if need be. RN #1 stated there was not an abuse allegation involving Resident #76 that he could recall.</p> <p>On 11/8/18 at 3:15 PM, CNA #1 said Resident #76's behaviors changed fast, he could go from</p>	F 607			

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F 607	<p>Continued From page 33</p> <p>nice to swinging at CNA's quickly. CNA #1 stated Resident #76 liked it when staff members sat next to him. CNA #1 stated Resident #76's cares included the use of a sit-to-stand lift (used when residents are unable to transition from a seated position to standing position on their own). CNA #1 stated Resident #1 would sometimes "swing" and "cuss" if staff touched him. CNA #1 stated the aides tried to keep him safe and re-approach him multiple times. CNA #1 stated Resident #76 was incontinent, had pain issues, and switched gears fast. CNA #1 stated if he heard of an allegation of abuse, he would notify the nurse and he was unaware of an allegation of potential abuse involving Resident #76.</p> <p>On 11/8/18 at 3:43 PM, CNA #3 said Resident #76 was confused, combative and did not know what was happening around him. CNA #3 stated if he was combative staff would talk to him and staff would take their time when providing cares. CNA #3 stated Resident #76 did not like peri-care provided and he would swear, punch, and kick staff. CNA #3 stated he was a two person assist partly because of his behaviors. CNA #3 was asked to describe the incident in October 2018 and she said she (CNA #3) and CNA #1 "held his hands" while they assisted Resident #76 into bed. After they (CNA #1 and CNA #3) assisted Resident #76 into bed, he allowed them to change him and Resident #76 thanked them. CNA #3 stated they did not utilize a sit to stand but a gait belt with a pivot transfer (stand, turn or pivot, then sit), so they could hold his hands and hold the gait belt. CNA #3 stated Resident #76 held the aides' hands with no screaming and crying. CNA #3 stated she received a phone call from RN #1 and LSW #1 about the cares during</p>	F 607			

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F 607	<p>Continued From page 34</p> <p>the incident. CNA #3 stated if a resident reported abuse, she would immediately go to her unit manager and tell them what occurred.</p> <p>On 11/8/18 at 4:10 PM, CNA #1 said on the night of the incident, he "never" transferred Resident #76 with a gait belt. CNA #1 said the staff "only" used a sit to stand (lift) because Resident #76 would cry out and scream. CNA #1 stated someone walking by could hear him. CNA #1 stated if a gait belt was used to transfer Resident #76 he would be able to strike out at staff easier, however, a sit to stand gave Resident #76 something to hold onto (the handle bars). CNA #1 stated he did not receive a phone call about the incident from facility staff.</p> <p>On 11/8/18 at 4:23 PM, RN #1 said he thought about things and did recall an incident involving Resident #76 and two CNAs that occurred approximately 10-15 days ago. RN #1 stated CNA #2 overheard other CNAs speaking, and the CNA's "used bad wordage." RN #1 said he heard it from CNA #2 that the CNAs "held" Resident #76 down. RN #1 stated he called the DON and LSW #1. RN #1 stated he and LSW #1 called CNA #3 for clarification of the conversation and they did not call CNA #1. RN #1 said he concluded it "was bad wordage."</p> <p>On 11/8/18 at 5:19 PM LMSW #2, the Administrator, and the DON stated the following:</p> <p>* LMSW #2 said the story she received was that CNA #2 overheard a staff member talking about how they assisted Resident #76 with cares, and Resident #76 became aggressive and the CNAs held him down to complete cares. The LMSW #2</p>	F 607			

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F 607	<p>Continued From page 35</p> <p>said she would look for documentation on the incident. LMSW #2 stated as a social worker, she "looks for willful intent." LMSW #2 stated RN #1 informed her there was no "willful intent." LMSW #2 stated there were three social workers who each had their own unit to manage. LMSW #2 said the incident did not occur on her floor, so she reported the incident to the unit's social worker (LSW #1) for the unit's social worker to complete the investigation and report to the Administrator and the State Survey Agency. LMSW #2 stated an abuse investigation consisted of acquiring documentation from "anyone involved," talk to other residents, other staff, and peers. LMSW #2 stated the staff examine the resident, complete an assessment, and then discuss the incident with the staff members. LMSW #2 said LSW #1 did not feel the incident should be reported and it was not reported.</p> <p>* The Administrator stated he was not aware of the incident until surveyors started asking questions about it during the survey. The Administrator stated he would expect those involved in the investigation to talk to every staff member, including both staff members involved. The Administrator said the allegation reported was "hearsay," and it was not made a formal allegation.</p> <p>* The DON stated she was made aware of the situation. The DON said she received a text 10/27/18 from RN #1 that said a staff member overheard Resident #76 was held down. The DON said she trusted the staff had done what they needed to, so she did not follow up with the LSW #1 or RN #1. The DON said all allegations</p>	F 607			

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F 607	<p>Continued From page 36</p> <p>of abuse should be reported to the facility Administrator, however from talking to the staff, this incident did not appear to be potential abuse and did not need to be reported to the Administrator.</p> <p>On 11/9/18 at 9:06 AM, LSW #1 said Resident #76 had a severe cognitive impairment related to alcohol use. LSW #1 stated Resident #76 had suffered from stokes and needed assistance with all ADLs. LSW #1 stated Resident #76 displayed behaviors of being combative, fearful, yelling, screaming, and cursing, but he could be nice. LSW #1 stated Resident #76 could get "startled" and then he was "mean." LSW #1 stated Resident #76 did well with music and picture books. LSW #1 stated when Resident #76 was combative and refused cares, staff were to re-approach and/or get different staff members to assist. LSW #1 stated the allegation occurred when a staff member (CNA #2) overheard CNA #3 say Resident #76 was combative during cares, and the staff "held him down" during cares. LSW #1 stated CNA #2 was concerned and wrote up a statement as directed by social services. LSW #1 stated he and RN #1 spoke with CNA #3 over the phone and did not call CNA #1. LSW #1 stated CNA #3 detailed what occurred and stated the resident was combative, and CNA #1 and CNA #3 were "blocking punches" while they were performing cares, and "not holding him down." LSW #1 said he did not document the phone call with CNA #3. LSW #1 said he discussed the call with LMSW #1, CNA #3, and RN #1, and they discussed how best to approach Resident #76, and deal with his combative behaviors. LSW #1 stated he received CNA #2's written statement from LMSW #1 after</p>	F 607			

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F 607	Continued From page 37 LMSW #1 had reviewed it.  On 11/9/18 at 9:39 AM, LMSW #1, said he reviewed CNA #2's written statement and it did not rise to the level of needing an investigation. LMSW #1 stated he did not know where the statement was located now.  On 11/9/18 at 12:45 PM, LMSW #2 said she could not find documentation regarding the incident/allegation related to Resident #76.  There was no documentation available of an investigation completed by the facility into the allegation of abuse for Resident #76.	F 607			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		1/14/19	

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F 609	Continued From page 38  §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 staff interview, record review, and policy review, it was determined the facility failed to ensure all allegations of a potential abuse or neglect were reported to the Administrator and State Survey Agency within 2-24 hours. This was true for 1 of 3 residents (#76) reviewed for abuse/neglect and had the potential to adversely affect any resident experiencing a potential incident of abuse or neglect. The deficient practice created the potential for harm if potential abuse was not reported and investigated completely. Findings include:  An undated facility policy titled, Freedom from Abuse, Neglect and Exploitation, documented a person who had knowledge of potential acts of abuse, neglect, exploitation or misappropriation of resident property would report the information to an immediate supervisor or the charge nurse. The policy documented the charge nurse would report the incident to the Administrator. The policy documented "all suspected cases of abuse" would be investigated following the guidelines set forth by the State Survey Agency.  Resident #76 was admitted to the facility on 9/12/18, with diagnoses which included vascular dementia without behavioral disturbance, chronic	F 609	The facility will be submitting a request for Informal Dispute Resolution (IDR) on this citation under separate letter. The reason is the incident referenced in the 2567 was immediately determined to not constitute abuse by nurse managers and the facility social worker at the time of the incident. The CNA who reported the alleged abuse had overheard two other staff members talking and admitted she misheard the conversation at that time. The report of abuse made to the surveyors was done by the CNA who previously admitted she misheard the conversation but only decided to report it to the surveyors immediately after being reprimanded due to job performance issues.  1. The report of alleged abuse of Resident #76 was not reported to the Administrator and/or the State Portal because facility staff did not conclude that the incident constituted alleged potential abuse.  2. All current and potential Residents have the potential to be impacted by the		

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F 609	<p>Continued From page 39</p> <p>pain, hemiplegia (paralysis/weakness on one side of the body), and urinary incontinence.</p> <p>An admission MDS assessment, dated 9/18/18, documented Resident #76 had short and long-term memory problems and was severely cognitively impaired. The MDS assessment documented he exhibited physical behaviors that included hitting, kicking, pushing, scratching, grabbing, and these behaviors significantly interfered with resident cares. The MDS assessment documented he exhibited rejection of care in 1-3 of 7 days. The MDS assessment documented Resident #76 required 2-person extensive assist with cares including bed mobility, transfers, and toilet use.</p> <p>Physician Orders, dated November 2018, documented Resident #76 received Celexa (antidepressant) 20 mg daily for anxiety, depression, and dementia, and Seroquel (antipsychotic) 25 mg three times daily for worsening behaviors related to vascular dementia.</p> <p>The care plan area addressing Resident #76's self-care, dated 9/12/18, documented it was difficult to obtain Resident #76's cooperation with bathing and staff were to re-approach with different staff members as needed and at various times</p> <p>The care plan area addressing Resident #76's behaviors, dated 9/12/18, documented he had the potential to be physically aggressive during cares. The care plan documented Resident #76 complied best when caregivers did things slow and verbalized what they were doing. The care</p>	F 609	<p>deficient practice. No other potential resident abuse situations have been identified.</p> <p>3. Resident Abuse Prevention Education, which includes reporting of allegations of potential abuse, is provided to all new hires and current staff no less than annually. All staff were retrained related to the need to ensure that all allegations of potential abuse are reported up the chain of command and that the Administrator is always notified of any potential abuse situation. The current Resident abuse prevention policy addresses the need to immediately notify the administrator of any potential violations of abuse and to report the allegation to the state within required timeframes. New allegations of abuse will be added to the IDT Leadership Stand-up Meeting agenda which the administrator attends daily.</p> <p>4. IDT leadership Meeting agenda sheets will be reviewed weekly for the first four weeks, then monthly for the following 3 months, and quarterly thereafter by the Director of Nursing or designee to ensure that the subject of any potential abuse allegations was addressed and that the Administrator had been notified and the allegation has been properly submitted to the state portal within required timeframes. Director of Nursing and/or designee will initial as to the audit on the agenda sheet next to the applicable item. The results of this audit will be presented</p>		

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F 609	<p>Continued From page 40</p> <p>plan documented Resident #76 benefited from conversations and 1:1 time and if he was angry and frustrated talking to his family sometimes helped.</p> <p>On 11/8/18 at 1:50 PM, a person who wished to remain anonymous wanted to speak privately with a surveyor. The anonymous person (AP) stated she spoke with CNA #3 about an incident involving Resident #76. The AP stated CNA #3 told him/her one evening she was working with CNA #1 and they were assisting Resident #76 with cares. The AP stated CNA #3 said Resident #76 was combative and they held the resident's hands to transfer him and "held his hands down" to change him. The AP stated he/she said to CNA #3 that the CNAs should have re-approached Resident #76. The AP told RN #1 immediately after hearing about the incident. RN #1 instructed the AP to write it up, sign and date it, and this was done by the AP. The AP could not find RN #1 to give him the signed document as requested, so he/she gave it to LMSW #1.</p> <p>On 11/8/18 at 2:12 PM, the AP stated the incident occurred on 10/23/18 on the evening shift. The AP said RN #1 and LMSW #1 had his/her written statement.</p> <p>On 11/8/18 at 2:38 PM, LMSW #1 identified LSW #1 as the lead investigator for the incident involving Resident #76. He said LSW #1 assisted with investigations and reported them and any allegations should be reported to the State Survey Agency. When LMSW #1 was asked if there was an abuse allegation/incident involving Resident #76, he responded "yes" he thought there was something and would look for</p>	F 609	at the monthly QA meeting.		

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F 609	<p>Continued From page 41 documentation.</p> <p>On 11/8/18 at 2:45 PM, LMSW #1 reviewed the allegation/incident log with the surveyor and said there was no allegation of abuse documented for Resident #76 during the week of 10/23/18.</p> <p>On 11/8/18 at 2:56 PM, RN #1 stated he reported suspected abuse immediately to LMSW #1 and the DON and then completed a risk management report. RN #1 stated if an allegation of abuse occurred he would ensure the resident was safe and remove the staff member from the floor if need be. RN #1 stated there was not an abuse allegation involving Resident #76 that he could recall.</p> <p>On 11/8/18 at 3:15 PM, CNA #1 said Resident #76's behaviors changed fast, he could go from nice to swinging at CNA's quickly. CNA #1 stated Resident #76 liked it when staff members sat next to him. CNA #1 stated Resident #76's cares included the use of a sit-to-stand lift (used when residents are unable to transition from a seated position to standing position on their own). CNA #1 stated Resident #1 would sometimes "swing" and "cuss" if staff touched him. CNA #1 stated the aides tried to keep him safe and re-approach him multiple times. CNA #1 stated Resident #76 was incontinent, had pain issues, and switched gears fast. CNA #1 stated if he heard of an allegation of abuse, he would notify the nurse and he was unaware of an allegation of potential abuse involving Resident #76.</p> <p>On 11/8/18 at 3:43 PM, CNA #3 said Resident #76 was confused, combative and did not know what was happening around him. CNA #3 stated</p>	F 609			

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F 609	<p>Continued From page 42</p> <p>if he was combative staff would talk to him and staff would take their time when providing cares. CNA #3 stated Resident #76 did not like peri-care provided and he would swear, punch, and kick staff. CNA #3 stated he was a two person assist partly because of his behaviors. CNA #3 was asked to describe the incident in October 2018 and she said she (CNA #3) and CNA #1 "held his hands" while they assisted Resident #76 into bed. After they (CNA #1 and CNA #3) assisted Resident #76 into bed, he allowed them to change him and Resident #76 thanked them. CNA #3 stated they did not utilize a sit to stand but a gait belt with a pivot transfer (stand, turn or pivot, then sit), so they could hold his hands and hold the gait belt. CNA #3 stated Resident #76 held the aides' hands with no screaming and crying. CNA #3 stated she received a phone call from RN #1 and LSW #1 about the cares during the incident. CNA #3 stated if a resident reported abuse, she would immediately go to her unit manager and tell them what occurred.</p> <p>On 11/8/18 at 4:10 PM, CNA #1 said on the night of the incident, he "never" transferred Resident #76 with a gait belt. CNA #1 said the staff "only" used a sit to stand (lift) because Resident #76 would cry out and scream. CNA #1 stated someone walking by could hear him. CNA #1 stated if a gait belt was used to transfer Resident #76 he would be able to strike out at staff easier, however, a sit to stand gave Resident #76 something to hold onto (the handle bars). CNA #1 stated he did not receive a phone call about the incident from facility staff.</p> <p>On 11/8/18 at 4:23 PM, RN #1 said he thought about things and did recall an incident involving</p>	F 609			

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F 609	<p>Continued From page 43</p> <p>Resident #76 and two CNAs that occurred approximately 10-15 days ago. RN #1 stated CNA #2 overheard other CNAs speaking, and the CNA's "used bad wordage." RN #1 said he heard it from CNA #2 that the CNAs "held" Resident #76 down. RN #1 stated he called the DON and LSW #1. RN #1 stated he and LSW #1 called CNA #3 for clarification of the conversation and they did not call CNA #1. RN #1 said he concluded it "was bad wordage."</p> <p>On 11/8/18 at 5:19 PM LMSW #2, the Administrator, and the DON stated the following:</p> <p>* LMSW #2 said the story she received was that CNA #2 overheard a staff member talking about how they assisted Resident #76 with cares, and Resident #76 became aggressive and the CNAs held him down to complete cares. The LMSW #2 said she would look for documentation on the incident. LMSW #2 stated as a social worker, she "looks for willful intent." LMSW #2 stated RN #1 informed her there was no willful intent. LMSW #2 stated there were three social workers who each had their own unit to manage. LMSW #2 said the incident did not occur on her floor, so she reported the incident to the unit's social worker (LSW #1) for the unit's social worker to complete the investigation and report to the Administrator and the State Survey Agency. LMSW #2 said LSW #1 did not feel the incident should be reported and it was not reported.</p> <p>* The Administrator stated he was not aware of the incident until surveyors started asking questions about it during the survey. The Administrator said the allegation reported was "hearsay," and it was not made a formal</p>	F 609			

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F 609	Continued From page 44 allegation.  * The DON stated she was made aware of the situation. The DON said she received a text 10/27/18 from RN #1 that said a staff member overheard two CNAs saying they held Resident #76 down. The DON said she trusted the staff had done what they needed to, so she did not follow up with the LSW #1 or RN #1. The DON said all allegations of abuse should be reported to the facility Administrator, however from talking to the staff, this incident did not appear to be potential abuse and did not need to be reported to the Administrator.	F 609			
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)  §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:  §483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.  §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:	F 644		1/14/19	

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F 644	<p>Continued From page 45</p> <p>Based on resident and staff interview, observation, and record review, it was determined the facility failed to ensure Pre-Admission Screening and Resident Reviews (PASARR) were complete and accurate for 2 of 3 residents (#64 and #84) reviewed for PASARRs. The deficient practice had the potential to cause harm if residents required, but did not receive, specialized services for mental health needs while residing in the facility. Findings include:</p> <p>1. Resident #64 was readmitted to the facility on 9/5/18, with diagnoses which included quadriplegia, major depressive disorder, bipolar disorder, anxiety disorder, and alcohol dependence in remission.</p> <p>An admission MDS assessment, dated 9/11/18, documented Resident #64 was cognitively intact and he had minimal signs and symptoms of depression. The MDS documented Resident #76 had no signs of delirium, psychosis, behaviors, rejection of care or wandering. The MDS documented a level 2 PASARR evaluation was not completed despite qualifying diagnoses.</p> <p>On 11/6/18 at 2:42 PM, Resident #64 was observed in bed watching television. Resident #64 stated he went to VA service providers when scheduled and he had no concerns.</p> <p>Resident #64's Level 1 PASARR, dated 05/01/17, documented his PASARR was good for 30 days.</p> <p>Resident #64's November 2018 Physician Orders included Paxil 20 mg for depression and Trazodone 150 mg for sleep.</p>	F 644	<ol style="list-style-type: none"> <li>Residents #64 and #84 have Level II PASARR's sent to the Medicaid Regional Office pending review.</li> <li>All new residents who trigger a Level II PASARR have the potential to be impacted. All current Residents have had their PASARR reviewed and appropriate PASARR is in place and all recommendations have been followed.</li> <li>The policy in place at the Idaho State Veterans Home-Boise states that we will ensure any new residents who trigger a Level II has a completed, current PASARR prior to admission. Any current residents who have a significant change of condition will have their PASARR reviewed by the Director of Social Services or his designee to ensure it is still accurate for the resident's new condition. If indicated, a new PASARR will be submitted to the state. Admission Coordinator will add the PASARR component to the preadmission checklist form to ensure a current PASARR was completed within 30 days prior to admission. The Director of Social Services will be added to the email group distribution list and all PASARR's will be reviewed by the Director of Social Services or designee to ensure accuracy and appropriateness of the admission.</li> <li>Each unit's Social Worker will perform audits of at least 20 percent of the new admissions to verify Level II PASARR reviews have been done by the State</li> </ol>		

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F 644	<p>Continued From page 46</p> <p>The care plan area addressing Resident #64's PASARR I, dated 6/28/18, documented he met the requirements for NF (nursing facility) level of care per his PASARR screen level. The care plan documented staff were to ensure his PASARR reflected a thorough evaluation of Resident #64 and he was appropriately placed in a nursing facility with appropriate care and services.</p> <p>On 11/8/18 at 8:20 AM, LMSW #2 stated the Resident #64 transferred from another nursing facility and his PASARR came with him and she did not question its accuracy. LMSW #2 reviewed the PASARR with the surveyor and LMSW #2 stated the PASARR showed the level 1 expired in 30 days in the prior nursing facility and a new PASARR should have had been completed. LMSW #2 stated Resident #64 had bipolar disorder and would require a Level 2 PASARR.</p> <p>On 11/9/18 at 3:30 PM, LMSW #1 said the facility only received "completed level 1 and level 2 PASARRs" from transferring facilities. LMSW #1 said if the PASARR was incorrect or not done, the facility contacted the admission's director to obtain a correct/completed form from the transferring facility before the resident was admitted to the facility. LMSW #1 stated this was not completed prior to Resident #64's transfer.</p> <p>2. Resident #84 was readmitted to the facility on 1/15/16, with diagnoses which included major depressive disorder and post-traumatic stress disorder (PTSD).</p> <p>A Quarterly MDS assessment, dated 9/26/18, documented Resident #84 was cognitively intact. The MDS assessment documented he had no</p>	F 644	<p>within 30 days prior to the resident being admitted. They will also audit at least 20 percent of the residents who have experienced a significant change of condition to be sure the PASARR is still accurate for the resident's current condition. This audit will be completed weekly for the first four weeks, then monthly for the following 3 months, and quarterly thereafter. The results of these audits will be reported to the QA committee the following month.</p>		

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F 644	<p>Continued From page 47</p> <p>documented evidence of delirium, psychosis, behaviors, rejection of care, or wandering.</p> <p>On 11/6/18 at 2:03 PM, Resident #84 was observed propelling himself down the hallway in his wheelchair.</p> <p>Resident #84's PASARR Level 1, dated 1/14/16, documented all questions were answered "No" (including the question on psychoactive medications). The PASARR was signed by the physician on 1/14/16.</p> <p>Resident #84's November 2018 Physician Orders, documented he received Lexapro 20 mg daily, ordered on 5/16/18.</p> <p>The care plan area addressing Resident #84's PASARR, dated 12/13/17, documented he meet the requirements for NF level of care per his PASARR 1 screen. The care plan documented staff were to ensure his PASARR reflected a thorough evaluation of Resident #84 and he was appropriately placed in a nursing facility with appropriate care and services. The care plan documented his current PASARR was a level 1.</p> <p>On 11/8/18 at 7:53 AM, LMSW #2 stated she was the social worker for the unit where Resident #84 lived. LMSW #2 said Resident #84 was on Lexapro and the form should have been sent to the state for review. LMSW #2 stated she did not have time to update PASARRs when there was a psychoactive medication change because she would be completing them all the time. LMSW #2 stated she spoke with the state about when the PASARR did not match with the medications and they told her that was ok, she did not need</p>	F 644			

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F 644	Continued From page 48 update the PASARR. LMSW #2 stated she should have sent a new PASARR to the state for Resident #84.	F 644			
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		1/14/19	

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F 656	<p>Continued From page 49</p> <p>whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and staff interview, it was determined the facility failed to develop resident-specific care plans. This was true for 3 of 6 residents (#30, #87, and #261) reviewed for psychotropic medications. The residents' care plans did not include resident specific behaviors related to the use of psychotropic medications and/or did not include behaviors for which the psychotropic medications were administered. This failure created the potential for residents to receive inappropriate or inadequate care with a subsequent decline in health. Findings include:</p> <p>1. Resident #261 was admitted to the facility on 6/19/17, with diagnoses including dementia with Lewy bodies and behavioral disturbances, depression, and REM sleep disorder. Resident #261 passed away at the facility on 6/14/18.</p> <p>A significant change MDS assessment, dated 6/7/18, documented Resident #261 was severely cognitively impaired and he was totally dependent or required extensive assistance from one to two staff members with cares. The MDS documented Resident #261 had signs and symptoms of mild depression and he exhibited delusions and hallucinations. The MDS</p>	F 656	<p>1. Resident #261 has expired. The care plans for #30 and #87 were updated to include specific behaviors related to the use of psychotropic medications and the behaviors for which the psychotropic medication is being administered.</p> <p>2. All residents receiving psychotropic medications have the potential to be affected by the deficient practice. The care plans for residents receiving psychotropic medications were reviewed and revised as appropriate to include specific behaviors for which psychotropic medications are being administered.</p> <p>3. The care plans for residents who are prescribed new orders for psychotropic medication and/or changes in medication dosage, will be evaluated and updated as appropriate to ensure behaviors are included for which the medication was ordered. Care plans are reviewed/revised no less than quarterly. All physician orders are reviewed during the daily clinical meeting. Members of this meeting include the DON, nurse managers, social workers, activities, the Administrator and</p>		

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F 656	Continued From page 50 documented Resident #261 had physical, verbal, and other behaviors 4-6 days a week.  Resident #261's June 2018 Physician Orders included:  - Ativan (antianxiety) 1 mg/ml by mouth every eight hours for agitation, ordered 6/6/18 and discontinued 6/14/18. - Clonazepam (benzodiazepine, a central nervous system depressant used to treat seizure disorders and panic disorders) 0.5 mg by mouth two times a day for comfort and seizure control, ordered 6/1/18 and discontinued 6/6/18. - Depakote (anticonvulsant) extended release 500 mg by mouth at bedtime for Lewy bodies dementia with hallucinations and agitation, order 6/1/18 and discontinued 6/12/18. - Seroquel (antipsychotic) 50 mg two times a day for dementia with hallucinations, ordered 5/23/18 and discontinued 6/12/18. - Seroquel 200 mg at bedtime for dementia with hallucinations, ordered 5/31/18 and discontinued 6/12/18. - Topamax (anticonvulsant) 25 mg at bedtime for unstable mood, ordered 3/30/18 and discontinued 6/12/18. - Ativan 0.5 mg by mouth every 1 hour PRN for agitation, ordered 6/5/18 and discontinued 6/14/18. - Ativan 1 mg intramuscularly every 24 hours PRN for agitation, ordered 5/31/18 and discontinued 6/4/18. - Ativan 1 mg intramuscularly every 24 hours PRN for agitation, ordered 6/4/18 and discontinued 6/14/18. - Morphine Sulfate (narcotic) 10 mg sublingually every 2 hours PRN for pain and air hunger,	F 656	other IDT members as appropriate. The clinical meeting agenda sheet will be modified to include reviewing the care plan for all new psychotropic medication orders to ensure specific behaviors are present.  4. The Administrator or his designee will review the Clinical Meeting agenda to ensure a review of care plans developed in response to psychotropic medication changes has been done. The Administrator or his designee will initial the specific agenda item and will follow up as appropriate. This will occur weekly for four weeks, then monthly for three months, then quarterly thereafter. The results of this review will be presented to the QA Committee monthly.		

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F 656	<p>Continued From page 51 ordered 6/1/18 and discontinued 6/14/18. - Trazadone 50 mg (antidepressant) every 8 hours PRN for anxiety, ordered 5/23/18 and discontinued 6/12/18.</p> <p>The care plan area addressing Resident #261's behaviors and mood documented he was cognitively impaired and had dementia. The care plan documented he had behavioral issues with hallucinations and delusions. The care plan documented Resident #261 had poor safety awareness, attempted to walk without assistance, experienced suicidal ideation, hit staff, was unable to walk, and required 1:1 supervision. Resident #261's care plan did not identify if Resident #261's hallucinations and delusions were tactile [touch], visual, auditory, or olfactory [smell]) and how they presented. The care plan did not include resident specific behaviors related to the hallucination and delusions and did not identify if they were harmful to Resident #261.</p> <p>The care plan area addressing Resident #261's cognition documented he had impaired cognition related to Lewy body dementia, was rarely understood, and had difficulty understanding others. The care plan did not document how his dementia presented.</p> <p>Resident #261 care plan did not identify how Resident #261's anxiety, agitation, and depression presented, or otherwise address them.</p> <p>On 11/9/18 at 10:19 AM, LMSW #1 stated the specific behavior the resident exhibited should be documented in the resident's clinical record for all</p>	F 656			

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F 656	<p>Continued From page 52</p> <p>PRN psychotropic medication administrations. LMSW #1 stated the care plan should identify resident specific behaviors for dementia, hallucinations, and delusions and if they were harmful.</p> <p>2. Resident #30 was readmitted to the facility on 3/10/16, with diagnoses including dementia.</p> <p>A quarterly MDS assessment, dated 8/13/18, documented Resident #30 was severely cognitively impaired and he had no signs and symptoms of depression. The MDS documented he experienced no behaviors, hallucinations, delusions, rejection of cares, or wandering.</p> <p>Resident #30's October 2018 Physician Orders included:</p> <ul style="list-style-type: none"> <li>- Zyprexa (antipsychotic) 5 mg by mouth in the afternoon and evening for dementia, order 10/22/18.</li> <li>- Trazadone (antidepressant) 100 mg at bedtime for insomnia, ordered 4/2/18.</li> <li>- Trazadone 25 mg in the afternoon for anxiety, ordered 10/19/18.</li> </ul> <p>The care plan area addressing Resident #30's behaviors/cognition, revised 5/23/18, documented he was cognitively impaired and had dementia. The care plan documented Resident #30 was angry and frustrated at times.</p> <p>Resident #30's care plan did not include resident specific behaviors, goals, and interventions related to dementia and anxiety.</p> <p>On 11/9/18 at 9:56 AM, LMSW #1 stated</p>	F 656			

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F 656	<p>Continued From page 53</p> <p>Resident #30's dementia presented at confusion and increased anxiety. LMSW #1 stated Resident #30 care plan should address anxiety and the care plan area related to dementia should specify specify resident specific behaviors. LMSW #1 stated with the care plan missing this information it would make it difficult for agency staff to observe for those behaviors and document it.</p> <p>3. Resident #87 was readmitted to the facility on 6/26/18, with which diagnoses included dementia and urinary and cardiac issues.</p> <p>A Quarterly MDS assessment, dated 9/29/18, documented Resident #87 had severe cognitive impairment.</p> <p>Resident #87's physician order dated 11/7/18, documented his medication duloxetine (a medication used to treat depression and pain) was increased from 20 milligrams (mg) orally every day to 60 mg each day.</p> <p>Resident #87's current care plan documented he experienced pain, difficulty concentrating, fear of others causing him harm, and changes in sleep patterns. .</p> <p>Resident #87's care plan lacked specific behaviors staff were to monitor Resident #87 for and lacked interventions related to the use of the psychoactive medication, duloxetine.</p> <p>On 11/8/18 at 1:25 PM, the Pharmacist confirmed the facility failed to develop and implement a resident specific care plan that described resident specific behaviors and included inventions related to his use of duloxetine.</p>	F 656			

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F 677 SS=D	<p>ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)</p> <p>§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:</p> <p>Based on record review, resident and staff interview, and policy review, it was determined the facility failed to ensure residents were provided with bathing care consistent with their needs. This was true for 2 of 5 (#30 and #41) residents reviewed for bathing. This failure created the potential for residents to experience embarrassment, isolation, decreased sense of self-worth, skin impairment, and compromised physical and psychosocial well-being. Findings include:</p> <p>The facility's Bathing policy and procedure, dated 10/2015, documented staff were to provide residents with bathing services at least once weekly or per resident preference.</p> <p>a. Resident #41 was admitted to the facility on 8/16/18, with diagnoses including scoliosis, arthritis, and intervertebral disc disorder. Intervertebral disc disorder is a common condition characterized by the breakdown (degeneration) of one or more of the discs that separate the bones of the spine.</p> <p>An admission MDS assessment, dated 8/22/18, documented Resident #41 was cognitively intact and was totally dependent or required extensive assistance from one to two staff members with all cares except eating.</p>	F 677	<ol style="list-style-type: none"> <li>1. Residents #30 and #41 have been bathed/showered as scheduled per their needs and preferences.</li> <li>2. All current and newly admitted Residents have the potential to be affected by this deficient practice. <ol style="list-style-type: none"> <li>a. All current Residents have been assessed for their needs and preferences related to bathing/showering; all bathing/showering activities have occurred per Resident needs and preferences.</li> <li>b. All Residents will be assessed upon admission for their needs and preferences related to bathing.</li> <li>c. Care plans have been updated to reflect each Resident's bathing needs and preferences.</li> <li>d. All new Residents will have their bathing/showering needs/preferences care planned.</li> <li>e. Bathing schedule has been developed consistent with Resident needs and preferences.</li> </ol> </li> <li>3. Systemic changes to prevent recurrence: <ol style="list-style-type: none"> <li>a. Licensed Nurses and CNAs have been educated to ISVH newly revised bathing/showering procedure.</li> <li>b. Point of Care has been adjusted to</li> </ol> </li> </ol>	1/14/19	

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F 677	<p>Continued From page 55</p> <p>The care plan area addressing Resident #41's bathing, revised on 10/3/18, documented staff were to assist her with bathing twice weekly.</p> <p>Resident #41's ADL Bathing Record, dated 9/1/18 through 11/7/18, documented the staff were to complete showers twice weekly. Resident #41's record documented she was not provided a bath or shower between 9/21/18 and 10/1/18 (9 days), 10/4/18 and 10/11/18 (6 days), and 10/29/18 and 11/6/18 (7 days).</p> <p>On 11/6/18 at 8:41 AM, Resident #41 stated the facility needed more staff. Resident #41 stated she did not always receive her showers twice a week. Resident #41 stated a staff member assisted her with her first shower in 8 days that morning (11/6/18).</p> <p>b. Resident #30 was readmitted to the facility on 3/10/16, with diagnoses including dementia, osteoarthritis, and history of transient ischemic attacks (temporary blockages of blood flow to the brain).</p> <p>A quarterly MDS assessment, dated 8/13/18, documented Resident #30 was severely cognitively impaired and he required extensive assistance from one to two staff members with all cares.</p> <p>The care plan area addressing Resident #30's bathing documented Resident #30 preferred bathing on the PM shift.</p> <p>Resident #30's ADL Bathing Record, dated 5/1/18 through 11/7/18, documented staff were to</p>	F 677	<p>allow CNAs to document if residents decline to take their bath/shower to provide for better tracking and documentation related to Resident needs and preferences.</p> <p>c. CNA assignment sheets have been updated to allow the licensed nurse assigned to the unit to assign bathing/showering tasks to other nursing staff when a designated bath aide is not available.</p> <p>4. Audit tool has been developed and put into place to ensure Residents are bathed per their needs/preferences.</p> <p>a. Bathing/showering activities are documented in PCC. Bathing/Showering documentation will be reviewed against bathing/showering schedule weekly x4 weeks; monthly x3 months and quarterly thereafter by the Director of Nurses or designee to ensure bathing/showering occurred as scheduled and results presented to the monthly QAPI for follow-up as necessary.</p>		

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F 677	<p>Continued From page 56</p> <p>complete showers twice weekly. Resident #30's record documented he was not provided a bath or shower between 5/22/18 and 5/29/18 (6 days), 5/29/18 and 6/6/18 (7 days), 6/12/18 and 6/19/18 (6 days), 6/19/18 and 6/26/18 (6 days), 6/26/18 and 7/3/18 (6 days), 7/3/18 and 7/10/18 (6 days), 7/21/18 and 7/28/18 (6 days), 9/21/18 and 9/28/18 (6 days), and 10/5/18 and 10/16/18 (10 days).</p> <p>c. The facility tracked baths on a secondary document titled the Bath List. The April through June 2018 Bath List documented multiple days when the bath aide was reassigned to work the floor. The days the shower aide was reassigned to work the floor were 4/11/18, 4/12/18 part of the day, 5/1/18, 5/2/18 part of the day, 5/8/18, 5/9/18, 5/16/18, 5/17/18, 5/21/18, 5/27/18, 5/29/18 part of the day, 6/1/18 part of the day, 6/5/18 part of the day, 6/12/18, 6/17/18, 6/18/18, 6/21/18 part of the day, 6/24/18 part of the day, and 6/25/18.</p> <p>The October 2018 Bath List documented multiple days when the bath aide was reassigned to work the floor. The days the shower aide was reassigned to the floor were 10/7/18, 10/9/18, 10/17/18, 10/23/18, 10/24/18 for half the day, and 10/30/18.</p> <p>On 11/8/18 at 1:21 PM, CNA #6 stated she was currently working as a RNA. CNA #6 stated she was reassigned to work the floor often and had been reassigned as a bath aide for most of October 2018. CNA #6 stated when she was working as a bath aide, residents had complained about not receiving showers. CNA #6 stated there were days she could not complete all showers and she would attempt to complete</p>	F 677			

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F 677	Continued From page 57 the residents' showers the next day if they missed one.  On 11/8/18 at 1:26 PM, CNA #9 stated she worked as a bath aide and she was reassigned to work the floor approximately two to three times a week during "bad" weeks. CNA #9 stated she was expected to complete the residents' showers if she was reassigned and she could not always complete all the showers. CNA #9 stated if residents were unable to receive a shower she attempted to complete the task on the make up day. CNA #9 stated she tried to provide at least 1 shower a week and she ensured residents with skin or incontinence issues received their showers twice a week if she was reassigned.  On 11/8/18 at 10:02 AM, the DON stated residents should have baths twice weekly at least unless the resident requests differently. The DON stated some residents request one shower a week and others request showers more often. The DON stated the shower aides were reassigned to work the floor when CNAs called in or were sick. The DON stated the nurse managers on the floors decided who to reassign to the floor duty. The DON stated she was aware of the shower aides being reassigned to work the floor.	F 677			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)  §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688		1/14/19	

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F 688	<p>Continued From page 58 of motion is unavoidable; and</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, policy review, and record review, it was determined the facility failed to ensure residents received treatment and services to prevent further decrease in range of motion (ROM). This was true for 3 of 5 residents (#27, #30, and #41) reviewed for treatment and services related to ROM. This deficient practice placed residents at increased risk of experiencing a decrease in mobility and function due to lack of active ROM (AROM) or passive ROM (PROM) services. Findings include:</p> <p>The facility's undated, Restorative policy and procedure documented staff were to provide restorative services to prevent contractures, restore normal movement, maintain function and prevent further deterioration of joints and muscles, and develop and retrain muscles.</p> <p>a. Resident #27 was admitted to the facility on 1/11/18, and readmitted on 10/2/18 with diagnoses including obesity, spinal cord injury,</p>	F 688	<p>1. Resident # 27 has expired. Residents # 30 and # 41 have remained on Restorative and services provided as planned. For clarification purposes the 2567 referenced the Restorative Program/care plan of services to be provided twice daily. The actual Restorative Program/care plan is 2 sets of 10 (not twice daily) to be administered in same therapy session.</p> <p>2. All Residents that receive Restorative Therapy and any future Residents referred to Restorative Therapy have the potential to be affected by the deficient practice.</p> <p>a. Restorative Manager reviewed all Residents that are currently receiving Restorative Services and clarified / revised the program per Resident needs and preferences.</p> <p>b. All Residents on Restorative Therapy have been provided services as planned.</p>		

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F 688	<p>Continued From page 59</p> <p>paraplegia, and subluxation of the distal radioulnar joint of the left wrist (partial dislocation of wrist joint).</p> <p>A significant change MDS assessment, dated 8/12/18, documented Resident #27 was cognitively intact and he required extensive assistance from one to two staff members with all cares except eating. The MDS assessment documented Resident #27 had a ROM impairment to one of his lower extremities.</p> <p>The care plan area addressing Resident #27's AROM, dated 1/24/18, documented he was to do AROM to his upper and lower extremities 6-7 days a week. The care plan documented the staff was to assist Resident #27 with AROM exercises of 10 repetitions for his cervical flexion, extension, and rotation twice daily and 10 repetitions to his bilateral upper and lower extremities twice daily.</p> <p>The care plan area addressing Resident #27's PROM, dated 1/24/18, documented he was to do PROM to his upper and lower extremities 6-7 days a week. The care plan documented staff was to assist Resident #27 with 10 repetitions of PROM to his bilateral upper and lower extremities twice daily. The care plan documented staff should perform gentle stretches to each joint twice daily.</p> <p>Resident #27's ADL AROM documentation, dated 10/1/18 through 11/7/18, documented staff completed AROM for 15 minutes on 10/3/18, 10/5/18, 10/16/18, 10/19/18, 11/1/18 through 11/4/18, 11/6/18, and 11/7/18. Resident #27 did not receive AROM 24 days during the time frame.</p>	F 688	<p>3. Systemic Change to prevent recurrence</p> <p>a. PCC was revised so that each Restorative Program is scheduled rather than PRN so that at the beginning of each Restorative shift, the Restorative Aides can pull a complete list of Residents with programs and plan for that day.</p> <p>b. Restorative Aides will review planned therapy as appropriate to ensure coverage for all residents that shift.</p> <p>c. Restorative Program Procedure has been updated to reflect the new process / system.</p> <p>d. Restorative Aides have been trained on new procedure.</p> <p>e. The PCC changes now allow the Restorative Manager to track, in real time, Restorative services to ensure these services are being provided as planned.</p> <p>f. The Restorative Manager will also review with staff on a weekly basis the completion of scheduled services. At any time, Restorative Manager can print a report to ensure services were provided.</p> <p>g. Restorative Staff have been educated on the new process.</p> <p>4. An Audit tool was developed to check that Restorative services were provided as planned.</p> <p>a. The audit will ensure Residents scheduled/care planned for Restorative services received services per needs and preferences. This audit will be done weekly for 4 weeks; monthly for 3 months and quarterly thereafter by the Director of</p>		

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F 688	<p>Continued From page 60</p> <p>Resident #27's ADL PROM documentation, dated 10/1/18 through 11/7/18, documented staff completed PROM for 15 minutes on 10/3/18, 10/5/18, 10/16/18, 10/19/18, 11/1/18 through 11/4/18, 11/6/18, and 11/7/18. Resident #27 did not receive PROM 24 days during the time frame.</p> <p>On 11/5/18 at 2:25 PM, Resident #27 stated he did not receive his restorative therapy daily. Resident #27 stated the staff did not always have time to complete his restorative therapy.</p> <p>b. Resident #41 was admitted to the facility on 8/16/18, with diagnoses including scoliosis, arthritis, and intervertebral disc disorder. Intervertebral disc disorder is a common condition characterized by the breakdown (degeneration) of one or more of the discs that separate the bones of the spine.</p> <p>An admission MDS assessment, dated 8/22/18, documented Resident #41 was cognitively intact and was totally dependent or required extensive assistance from one to two staff members with all cares except eating. The MDS assessment documented Resident #41 had bilateral ROM impairments to her lower extremities.</p> <p>The care plan area addressing Resident #41's AROM, dated 9/6/18, documented she was to do 10 repetitions of AROM to her upper extremities using 2 pound hand weights of biceps curls, shoulder raises, and arm stretched out to her side daily.</p> <p>The care plan area addressing Resident #41's</p>	F 688	Nurses or designee and results presented to the monthly QAPI for follow-up as necessary.		

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F 688	<p>Continued From page 61</p> <p>PROM, dated 9/6/18, documented she was to do 3 repetitions of PROM to her bilateral lower extremities of hip abduction exercises, hip flexion and extension, knee flexion stretches, and ankle stretches with a 30 second hold daily.</p> <p>Resident #41's ADL AROM documentation, dated 9/1/18 through 11/7/18, documented staff completed AROM for 15 minutes on 9/7/18, 9/10/18, 9/16/18, 9/17/18, 9/21/18, 9/23/18, 9/25/18, 9/26/18, 10/1/18, 10/3/18-10/5/18, 10/9/18, 10/12/18, 10/14/18, 10/16/18, 10/19/18, 10/23/18-10/25/18, 10/28/18, 10/29/18, 11/2/18-11/7/18. Resident #41 did not receive AROM 34 days during the time frame.</p> <p>Resident #41's ADL PROM documentation, dated 9/1/18 through 11/7/18 documented the staff completed PROM for 15 minutes on 9/7/18, 9/10/18, 9/16/18, 9/17/18, 9/21/18, 9/23/18, 9/25/18, 9/26/18, 10/1/18, 10/3/18-10/5/18, 10/9/18, 10/12/18, 10/14/18, 10/16/18, 10/19/18, 10/23/18-10/25/18, 10/28/18, 10/29/18, 11/2/18-10/7/18. Resident #41 did not receive PROM for 34 days during the time frame.</p> <p>On 11/6/18 at 8:41 AM, Resident #41 stated she did not receive her restorative therapy daily. Resident #41 stated she received restorative therapy for approximately 10 minutes at a time and staff assisted her approximately two to three times a week on average.</p> <p>c. Resident #30 was readmitted to the facility on 3/10/16, with diagnoses including dementia, osteoarthritis, and history of transient ischemic attacks (temporary blockages of blood flow to the brain).</p>	F 688			

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F 688	<p>Continued From page 62</p> <p>A quarterly MDS assessment, dated 8/13/18, documented Resident #30 was severely cognitively impaired and he required extensive assistance from one to two staff members with all cares. The MDS assessment documented Resident #30 had bilateral ROM impairments to his upper extremities.</p> <p>The care plan area addressing Resident #30's restorative bed mobility documented staff were assist Resident #30 with 3-5 repetitions of log rolls while in bed daily.</p> <p>The care plan area addressing Resident #30's PROM, dated 3/26/18, documented staff were to provide 3-5 repetitions of gentle PROM stretches to his upper and lower extremities daily.</p> <p>Resident #30's ADL Bed Mobility documentation, dated 5/1/18 through 11/7/18, documented staff were to complete his log rolls 3-5 times daily. Resident #30's record documented he was not assisted with the log rolls as follows:</p> <ul style="list-style-type: none"> <li>- May 2018: 12 out of 31 opportunities,</li> <li>- June 2018: 8 out of 30 opportunities</li> <li>- July 2018: 20 out of 31 opportunities,</li> <li>- August 2018: 7 out of 31 opportunities,</li> <li>- September 2018: 16 out of 30 opportunities,</li> <li>- October 2018: 12 out of 31 opportunities,</li> <li>- 11/1/18 through 11/7/18: 1 out of 7 opportunities.</li> <li>- Resident #30 did not receive assistance with the log rolls 76 days during the time frame.</li> </ul> <p>Resident #30's ADL PROM documentation, dated 5/1/18 through 11/7/18, documented staff were to</p>	F 688			

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F 688	<p>Continued From page 63</p> <p>provide 3-5 reps of gentle PROM stretches to his upper and lower extremities daily. Resident #30's record documented he was not assisted with his PROM as follows:</p> <ul style="list-style-type: none"> <li>- May 2018: 12 out of 31 opportunities,</li> <li>- June 2018: 8 out of 30 opportunities</li> <li>- July 2018: 19 out of 31 opportunities,</li> <li>- August 2018: 7 out of 31 opportunities,</li> <li>- September 2018: 15 out of 30 opportunities,</li> <li>- October 2018: 12 out of 31 opportunities,</li> <li>- 11/1/18 through 11/7/18: 1 out of 7 opportunities.</li> <li>- Resident #30 did not receive assistance with his PROM 74 days during the time frame.</li> </ul> <p>Staff Interviews:</p> <p>On 11/8/18 at 10:07 AM, LPN #1 stated the restorative program was run 7 days a week. LPN #1 stated the RNAs worked daily from 6:00 AM to-2:30 PM and there was one RNA on each floor and a float RNA. LPN #1 stated there were currently 81 residents on the caseload. LPN #1 stated it was difficult for all the residents to receive their restorative therapy daily.</p> <p>On 11/8/18 at 10:07 AM, CNA #4 stated she was an RNA on one of the floors. CNA #4 stated it was difficult to get through all of her caseload each day and it was increasingly difficult when she was reassigned to work the floor. CNA #4 stated if she was reassigned to work the floor the restorative therapy was not always be completed. CNA #4 stated she was reassigned to work the floor more frequently over the last year.</p> <p>On 11/8/18 at 1:05 PM, CNA #5 stated she was</p>	F 688			

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F 688	Continued From page 64 an RNA and it was difficult to complete her caseload each day. CNA #5 stated she was reassigned to work the floor as a CNA multiple times due to a staffing issue. CNA #5 stated if she was reassigned to work the floor the restorative services were not completed for all residents.  On 11/8/18 at 1:21 PM, CNA #6 stated she was currently working as an RNA. CNA #6 stated it was difficult to complete her caseload daily and she was reassigned for most of October 2018 to work the floor and restorative therapy was provided when she could.  On 11/8/18 at 10:02 AM, the DON stated she was aware RNAs were reassigned to work the floor.  On 11/8/18 at 10:24 AM, the DON stated the staffing was difficult to manage and that was why the facility utilized staffing agencies. The DON stated when staff called in they could not always get replacements. The DON stated the staff agencies did not always have staff available when she needed them.	F 688			
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)  §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 725		1/14/19	

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F 725	<p>Continued From page 65</p> <p>accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on review of facility grievances, resident records, and facility policies, and resident, resident family, and staff interview, it was determined the facility failed to ensure there were sufficient numbers of staff to meet the supervision, restorative, and ADL needs of residents. This was true for 8 of 22 residents (#27, #30, #41, #67, #77, #93, #100, and #261) reviewed for staffing concerns, and had the potential to affect all residents residing in the facility. This deficient practice created the potential for physical and psychosocial harm if residents did not receive appropriate care or received a delay of care. Findings include:</p> <p>a. Residents did not receive baths/showers consistent with their needs and bathing schedules.</p>	F 725	<p>We will be submitting a request for an Informal Dispute Resolution (IDR) hearing on this citation. The reason is the surveyors used only comments from residents and staff that we were "short-staffed" and never considered actual hours per patient day in their determination on whether the facility has sufficient staff. We are one of only nine non-hospital based skilled nursing facilities in Idaho with a 5-star rating for staffing and one of only 7 non-behavior skilled facilities in the state with a 5-star rating for staffing.</p> <p>1. Residents #27 and #261 has passed away. Residents # 30 and #41 received Restorative Therapy services as planned. Resident #67 is not listed on the Resident</p>		

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F 725	<p>Continued From page 66</p> <p>The facility's Bathing policy and procedure, dated 10/2015, documented staff were to provide residents with bathing services at least once weekly or per resident preference.</p> <p>i. On 11/6/18 at 11:17 AM, Resident #93 said he did not receive showers as he should. Resident #93 stated it was due to the facility being short staffed. Resident #93 stated it "irks" him when he does not receive his scheduled shower twice weekly. Resident #93 stated he had spoken with staff about his concerns often and nothing had changed.</p> <p>On 11/8/18 at 7:21 AM, Resident #93 stated he did not receive his shower the night of 11/7/18 because there was "not enough staff." Resident #93 stated the shower aide was reassigned to work the floor. Resident #93 stated he had fallen asleep in his chair while waiting to get his shower and woke up at 2:30 AM without staff notifying him he would not receive his shower. Resident #93 stated he needed staff assistance because he was legally blind.</p> <p>ii. Resident #41's care plan documented she was to receive 2 baths a week. Resident #41's Bathing Record showed she did not receive a bath 5 out of 18 bathing opportunities between 9/1/18 and 11/6/18.</p> <p>On 11/6/18 at 8:41 AM, Resident #41 stated the facility needed more staff. Resident #41 stated she did not always receive her showers twice a week. Resident #41 stated a staff member assisted her with her first shower in 8 days that morning (11/6/18).</p>	F 725	<p>identifier list. Residents #30, #41, #77, #93 and #100 were bathed/showered as scheduled per preference.</p> <p>2. All current and newly admitted Residents have the potential to be affected by this deficient practice.</p> <p>a. All current Residents have been assessed for their needs and preferences related to bathing/showering; all bathing/showering activities have occurred per Resident needs and preferences.</p> <p>b. All Residents will be assessed upon admission for their needs and preferences related to bathing.</p> <p>c. Care plans have been updated to reflect each Resident's bathing needs and preferences.</p> <p>d. All new Residents will have their bathing/showering needs/preferences care planned.</p> <p>e. Bathing schedule has been developed consistent with Resident needs and preferences.</p> <p>f. Restorative Manager reviewed all Residents that are currently receiving Restorative Services and clarified / revised the program per Resident needs and preferences.</p> <p>g. All Residents on Restorative Therapy have been provided services as planned.</p> <p>3. Systemic changes to prevent recurrence:</p> <p>a. Licensed Nurses and CNAs have been educated to ISVH newly revised bathing and showering procedure. Direct</p>		

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F 725	<p>Continued From page 67</p> <p>iii. On 11/6/18 at 11:22 AM, Resident #67's family member said she often found Resident #67 wet with urine that "soaked" through his clothing, bedding, and wheelchair pad. Resident #67's family member said the facility frequently failed to provide bathing for Resident #67, due to "lack of staffing."</p> <p>iv. On 11/5/18 at 2:42 PM, Resident #77 stated his only concern with the facility's care was the lack of bathing. Resident #77 stated he was to receive a bath twice weekly and it did not happen all the time. Resident #77 stated sometimes his family picked him up to allow him to bathe at home due to staffing concerns.</p> <p>v. On 11/5/18 at 2:58 PM, Resident #100 stated she did not always receive her showers as scheduled. Resident #100 stated sometimes she turned her call light on for things like showers and the staff answered the call light, did not meet her needs, and then did not return because they had gotten busy with other residents.</p> <p>vi. Resident #30 was severely cognitively impaired. His care plan did not specify how often he was to receive a bath. Resident #30's Bathing Record showed he did not receive a bath 11 out of 52 bathing opportunities between 5/1/18 and 11/7/18.</p> <p>vii. A 9/26/18 grievance documented an anonymous resident complained of not receiving a shower in 7-10 days. The grievance documented the anonymous residents was provided a shower on 9/27/18.</p> <p>viii. The facility tracked baths on a secondary</p>	F 725	<p>care staff were re-educated regarding the need to follow each resident's specific plan of care, particularly related to assistance with ADLs.</p> <p>b. Point of Care has been adjusted to allow CNA's to document a Resident's decision to decline to take their bath/shower. This provides better tracking and documentation related to Resident needs and preferences.</p> <p>c. CNA assignment sheets have been updated to allow the licensed nurse assigned to the unit to assign bathing/showering tasks to other nursing staff when a designated bath aide is not available.</p> <p>d. PCC was revised so that the Restorative Program is scheduled rather than PRN so that at the beginning of each Restorative shift the Restorative Aides are able to pull a complete list of Residents with programs and plan for that day.</p> <p>e. Restorative Aides will review planned therapy as appropriate to ensure coverage for all residents that shift.</p> <p>f. Restorative Program Procedure has been updated to reflect the new process / system.</p> <p>g. Restorative Aides have been trained on new procedure.</p> <p>h. The PCC changes now allow the Restorative Manager to track, in real time, Restorative services to ensure they are completed as planned.</p> <p>i. Restorative Manager will also check with staff. If Restorative Manager notices unmet needs to be able to coordinate services throughout shift. At any time,</p>		

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F 725	<p>Continued From page 68</p> <p>document titled the Bath List. The April through June 2018 Bath List documented multiple days when the bath aide was reassigned to work the floor. The days the shower aide was reassigned to work the floor were 4/11/18, 4/12/18 part of the day, 5/1/18, 5/2/18 part of the day, 5/8/18, 5/9/18, 5/16/18, 5/17/18, 5/21/18, 5/27/18, 5/29/18 part of the day, 6/1/18 part of the day, 6/5/18 part of the day, 6/12/18, 6/17/18, 6/18/18, 6/21/18 part of the day, 6/24/18 part of the day, and 6/25/18.</p> <p>The October 2018 Bath List documented multiple days when the bath aide was reassigned to work the floor. The days the shower aide was reassigned to work the floor were 10/7/18, 10/9/18, 10/17/18, 10/23/18, 10/24/18 for half the day, and 10/30/18.</p> <p>b. Residents did not receive restorative therapy as directed in their care plans.</p> <p>The facility's undated Restorative policy and procedure documented staff were to provide restorative services to prevent contractures, restore normal movement, maintain function, prevent further deterioration of joints and muscles, and develop and retrain muscles.</p> <p>i. Resident #27's care plan documented he was to receive active range of motion (AROM) and passive range of motion (PROM) restorative therapy 6-7 days a week. Resident #27's ADL AROM and ADL PROM documentation showed he was not provided the services 48 out of 76 opportunities between 10/1/18 and 11/7/18.</p> <p>On 11/5/18 at 2:25 PM, Resident #27 stated he did not receive his restorative therapy daily.</p>	F 725	<p>Restorative Manager can pull report for any period of time to ensure services were provided.</p> <p>j. Restorative Staff have been educated.</p> <p>k. There was adequate direct care staff available on all shifts to provide Resident needs and cares. The direct care nursing staff hours per patient day (after removal of 24 hour supervision) from April thru October averaged 4.06 hours per patient day.</p> <p>l. Staffing for the day/weekend is reviewed at each IDT Leadership meeting and adjustments made as necessary to ensure appropriate staffing levels are maintained.</p> <p>m. In the event there are direct care staff call-ins and the projected direct care nursing hours per patient day may not meet resident needs, agency staffing will be sought and, if agency staffing is not able to be secured, non-clinical staff from the business office, activities, maintenance, and administration will be used to perform non-CNA duties and allow CNAs and licensed nurses extra time to meet resident needs.</p> <p>4. Bathing/showering activities are documented in PCC. Bathing/Showering documentation will be reviewed against bathing/showering schedule weekly x4 weeks; monthly x3 months and quarterly thereafter by the Director of Nurses or designee to ensure bathing/showering occurred as scheduled and results</p>		

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F 725	<p>Continued From page 69</p> <p>Resident #27 stated the staff did not always have time to complete his restorative therapy.</p> <p>ii. Resident #41's care plan documented she was to receive AROM and PROM restorative therapy 7 days a week. Resident #41's ADL AROM and ADL PROM documentation showed she was not provided the services 68 out of 136 opportunities between 9/1/18 and 11/7/18.</p> <p>On 11/6/18 at 8:41 AM, Resident #41 stated the facility needed more staff. Resident #41 stated she did not receive her restorative therapy daily as directed in her care plan. Resident #41 stated she received restorative therapy for approximately 10 minutes at a time and staff assisted her approximately two to three times a week on average.</p> <p>iii. Resident #30 was severely cognitively impaired, and his care plan documented he was to receive restorative services to increase bed mobility and PROM restorative therapy 7 days a week. Resident #30's restorative bed mobility therapy and ADL PROM documentation showed he was not provided the services 150 out of 382 opportunities between 5/1/18 and 11/7/18.</p> <p>d. Staff Interviews:</p> <p>i. On 11/7/18 at 11:46 AM, LPN #2 stated every day was different for staffing depending on the need, but it would be better if there were more staff during the meal times.</p> <p>ii. On 11/7/18 at 12:45 PM, CNA #11 stated it would be helpful to have more staff to assist with getting residents up in the morning, taking them</p>	F 725	<p>presented to the monthly QAPI for follow-up as necessary. Audit will ensure Residents receiving Restorative services received services per needs and preferences. weekly x4 weeks; monthly x3 months and quarterly thereafter by the Director of Nurses or designee and results presented to the monthly QAPI for follow-up as necessary. PPD information from the prior week is provided to the administrator for review and intervention as necessary.</p>		

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F 725	<p>Continued From page 70 to the bathroom, and at dining times.</p> <p>iii. On 11/8/18 at 10:07 AM, LPN #1 stated the restorative program ran 7 days a week. LPN #1 stated the RNAs worked daily from 6:00 AM to 2:30 PM, there was one RNA on each floor, and a float RNA. LPN #1 stated there were currently 81 residents on the restorative caseload. LPN #1 stated it was difficult for all the residents to receive restorative therapy daily.</p> <p>iv. On 11/8/18 at 10:07 AM, CNA #4 stated she was an RNA on one of the floors. CNA #4 stated it was difficult to get through all of her caseload each day and it was more difficult when she was reassigned to work the floor. CNA #4 stated if she was reassigned to work the floor, the restorative therapy was not always completed. CNA #4 stated she was reassigned to work the floor more over the last year. CNA #4 stated the facility could use more staff, so residents' restorative therapy could be completed.</p> <p>v. On 11/8/18 at 10:50 AM, CNA #3 said residents did not always receive the services of showers and incontinence care due to lack of staffing. CNA #3 stated the facility was generally shorter staffed during the evening and night shifts.</p> <p>vi. On 11/8/18 at 1:05 PM, CNA #5 stated she was an RNA and it was difficult to complete her caseload each day. CNA #5 stated she was reassigned to work the floor as a CNA multiple times due to staffing issues. CNA #5 stated if she was reassigned to work the floor restorative therapy was not completed for all residents.</p>	F 725			

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F 725	<p>Continued From page 71</p> <p>vii. On 11/8/18 at 1:14 PM, CNA #8 stated there were quite a few call-ins and other staff members would be reassigned to work the floor.</p> <p>viii. On 11/8/18 at 1:16 PM, CNA #2 stated she used to be a bath aide and there were times when she was reassigned to work the floor. CNA #2 stated she was still expected to complete all her showers on the days she was reassigned, and it was difficult to complete all the showers. CNA #2 stated the facility could utilize more staff.</p> <p>ix. On 11/8/18 at 1:21 PM, CNA #6 stated she was currently working as an RNA. CNA #6 stated it was difficult to complete her caseload daily. CNA #6 stated she was reassigned to work the floor often and was reassigned as a bath aide for most of October 2018. CNA #6 stated it depended on the day if the facility needed more staff. CNA #6 stated when she was working as a bath aide, residents complained about not receiving showers. CNA #6 stated there were days she could not complete all showers and she attempted to complete the residents' showers the following day of they missed one.</p> <p>x. On 11/8/18 at 3:10 PM, CNA #6 said sometimes the facility had a bath aide and sometimes they did not have a bath aide. She said the bath aide often got called to the floor to work. CNA #6 said residents' requiring the use of a Hoyer lift (equipment used to lift and transfer individuals, which requires two staff to operate safely) were the residents who were more likely to not receive baths consistently. CNA #6 stated in the afternoon at approximately 2:00 PM, during shift change, staff had to play "catch up" and change incontinent residents who were not</p>	F 725			

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F 725	<p>Continued From page 72</p> <p>changed at lunch. CNA #6 stated residents appeared to have been assisted to their rooms and left in their wheelchairs. CNA #6 stated she felt the facility was short staffed, and when concerns were expressed staff would hear, "We gotta do the best we can."</p> <p>xi. On 11/8/18 at 1:26 PM, CNA #9 stated she worked as a bath aide and she was reassigned to work the floor approximately two to three times a week during bad weeks. CNA #9 stated she was expected to complete the scheduled showers if she was reassigned and she could not always complete all the showers. CNA #9 stated she would have to complete approximately 40 showers a day. CNA #9 stated she tried to provide residents at least one shower a week and she ensured residents with skin or incontinence issues received their showers twice a week if she was reassigned to work the floor. CNA #9 stated she was not sure why the bath aide was reassigned, but she suspected it was due to a lack of staff.</p> <p>xii. On 11/8/18 at 1:29 PM, CNA #10 stated she worked the floor as a CNA and residents had complained to her about not receiving their restorative therapy and showers. CNA #10 stated the facility was short staffed when CNAs called in or did not show up for work. CNA #10 stated when call ins occurred replacements could not always be found.</p> <p>e. The facility's Shift Assignment sheets for 5/1/18 through 6/14/18 documented if a 1:1 staff member was assigned to a floor. The sheets did not document the assigned resident who required the 1:1 supervision, to ensure the resident</p>	F 725			

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F 725	<p>Continued From page 73</p> <p>received the 1:1 supervision. The staffing sheets and progress notes documented the following staffing concerns:</p> <p>* 5/1/18: a CNA worked the floor and provided baths.</p> <p>* 5/2/18, 5/5/18: a CNA worked extra hours because the facility was short staffed. It was unclear if the rest of the shift was covered.</p> <p>* 5/5/18: a scheduled CNA did not work and the schedule did not document a replacement was found.</p> <p>* 5/6/18: two CNAs did not show up to work and two CNAs stayed over to assist with getting residents out of bed in the morning. The schedule did not document how long the two CNAs stayed to assist. The schedule documented staffing agencies were called, however, they did not have CNAs available to assist the facility.</p> <p>* 5/8/18: one CNA was scheduled to work the night shift.</p> <p>* 5/12/18, 5/13/18, 5/14/18, 5/15/18, 5/17/18, 5/19/18, 5/20/18, 5/21/18, 5/22/18, 5/23/18, and 6/1/18: a CNA was assigned as a 1:1 for 8 hours during the evening shift. The schedule did not document the name of the resident that required the 1:1 supervision, to ensure the resident received the 1:1 supervision.</p> <p>* 5/21/18: two CNAs did not show up for work, one on day shift and one on evening shift. The schedule documented one CNA stayed over to</p>	F 725			

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F 725	<p>Continued From page 74</p> <p>assist with getting residents out of bed in the morning. The schedule did not document if replacements were found.</p> <p>* 5/24/18: a CNA was assigned as a 1:1 for 8 hours during the night shift. The schedule did not document the name of the resident requiring the 1:1 supervision, to ensure the resident received the 1:1 supervision.</p> <p>* 5/25/18: a CNA was assigned each shift to provide 1:1 supervision, to ensure 1:1 coverage for a 24 hour period. The schedule did not document the name of the resident requiring the 1:1 supervision, to ensure the resident received the 1:1 supervision.</p> <p>* 5/26/18: a CNA was assigned each shift to provide 1:1 supervision, to ensure 1:1 coverage for a 24 hour period. The schedule did not document the name of the resident requiring the 1:1 supervision, to ensure the resident received the 1:1 supervision. The CNA assigned to serve as the night shift 1:1 did not work. Two other CNAs did not work during the day shift and the schedule did not show if a replacement was found for one of the staff members.</p> <p>* 5/27/18: a CNA was assigned each shift to provide 1:1 supervision, to ensure coverage for a 24 hour period. The schedule did not document the name of the resident requiring the 1:1 supervision, to ensure the resident received the 1:1 supervision. Resident #261's care plan was updated on 5/26/18 to reflect the need for a 1:1 sitter. A Progress Note, dated 5/27/18 at 3:00 AM, documented Resident #261 woke up at 11:00 PM and was sitting on the edge of his bed.</p>	F 725			

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F 725	<p>Continued From page 75</p> <p>The note documented he was moved to the nurses' station due to his 1:1 sitter being "unavailable." The note documented a staff member volunteered to assist as Resident #261's 1:1 for 1-2 hours.</p> <p>* 5/28/18, 5/30/18, 6/2/18, 6/3/18, 6/4/18, 6/5/18, 6/6/18, 6/7/18, 6/8/18, 6/10/18, and 6/11/18: a CNA was assigned each shift to provide 1:1 supervision, to ensure coverage for a 24 hour period. The schedule did not document the name of the resident requiring 1:1 supervision to ensure the resident received the required level of supervision.</p> <p>* 5/29/18: a CNA was assigned each shift to provide 1:1 supervision, to ensure coverage for a 24 hour period. The schedule did not document the name of the resident requiring the 1:1 supervision to ensure the resident received the required level of supervision. The CNA assigned as the day shift 1:1 worked 7 hours. It was unclear if the resident was provided 1:1 supervision for the one remaining hour.</p> <p>* 5/31/18: a CNA on the evening shift and a CNA on the night shift were assigned to provide 1:1 supervision. The schedule did not document the name of the resident requiring the 1:1, to ensure the resident received the required level of supervision. The day shift did not document a 1:1 CNA was scheduled. A CNA assigned to bathe residents provided some assistance as a 1:1 for Resident #261 during the day shift in addition to providing showers. The schedule did not document the amount of time the CNA provided showers versus providing 1:1 supervision for Resident #261.</p>	F 725			

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F 725	Continued From page 76  * 6/1/18: a CNA was assigned as a 1:1 for the evening shift. The schedule did not document the name of the resident requiring the 1:1 supervision to ensure the resident received the required level of supervision. The day and night shifts did not document a 1:1 CNA was scheduled. A CNA assigned to bathe residents provided some assistance as a 1:1 for Resident #261 during the day shift in addition to assisting other residents with showers. The schedule did not document the amount of time the CNA provided showers versus providing 1:1 supervision.  * 6/9/18: a CNA was assigned each shift to provide 1:1 supervision, to ensure coverage for 24 hour period. The schedule did not document the name of the resident requiring the 1:1 to ensure the resident received the required level of supervision. The CNA assigned as the evening shift 1:1 worked 2 hours. The schedule documented one CNA was assigned to work the night shift. It was unclear how a resident was provided 1:1 supervision, and the other residents' needs met, when one CNA was assigned to work the shift.  * 6/12/18: a CNA was assigned each shift to provide 1:1 supervision, to ensure coverage for 24 hour period. The schedule did not document the names of the residents requiring the 1:1 supervision, to ensure 1:1 supervision was provided.  * 6/13/18 through 6/30/18 documented CNAs were scheduled to provide 1:1 supervision. The schedule did not document the name(s) of the	F 725			

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F 725	<p>Continued From page 77</p> <p>resident requiring the 1:1 supervision to ensure the resident received the required level of supervision.</p> <p>On 11/8/18 at 10:24 AM, the DON stated the staffing was difficult to manage and this was why the facility utilized staffing agencies. The DON stated when staff called in they could not always get replacements. The DON stated the staffing agencies did not always have staff available when she needed them. The DON stated the facility could utilize more staff when staff did not show up for work as scheduled.</p> <p>On 11/9/18 at 12:23 PM, the DON stated 1:1 staff were scheduled and there were occasions when the 1:1 staff did not show up for work. The DON stated her staffing schedule did not document the names of the residents, and she was unable to recall who required 1:1 supervision.</p> <p>On 11/9/18 at 2:48 PM, the Administrator stated the facility was consistently working on staffing issues through its quality assurance program. The Administrator stated the facility tried to place residents who required more assistance on a floor where more CNAs were scheduled to work. The Administrator stated RNAs got reassigned to work as bath aides if staff members called in.</p> <p>Also refer to F677 as it relates to the failure of the facility to ensure residents received baths or showers consistent with their need.</p> <p>Also refer to F688 as it relates to the failure of the facility to ensure residents received restorative therapy consistent with their needs.</p>	F 725			
F 758	Free from Unnec Psychotropic Meds/PRN Use	F 758		1/14/19	

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F 758 SS=G	Continued From page 78 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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F 758	<p>Continued From page 79</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 observation, staff interview, record review, and facility policy review, it was determined the facility failed to a) attempt GDR of psychotropic medications, b) monitor behavioral symptoms, c) obtain informed consents for the medications, and d) identify resident specific behaviors on the care plan. This was true for 4 of 6 residents (#2, #30, #87, and #261) reviewed for unnecessary medications. This resulted in harm to Resident #261 when he experienced increased somnolence, sedation, and a decline in ADL's as a result of multiple psychotropic medications. This deficient practice also had the potential for harm of other residents if they receive unnecessary psychotropic medications which were not adequately monitored. Findings include:</p> <p>A facility policy Mood and Behavior Medication Review Committee, undated, documented the committee identified and evaluated residents use of medication for behaviors or mood and the committee would determine the appropriate interventions and ensure consents, orders, and care plans were completed.</p>	F 758	<ol style="list-style-type: none"> <li>1. Resident #261 has expired. Resident's #2, #30, #87 care plans were updated with specific behaviors related to psychotropic medications. Resident #30 was reviewed in a Psychotropic Review committee for consideration for a Gradual Dose Reduction (GDR).</li> <li>2. All residents receiving psychotropic medications have the potential to be affected by the deficient practice. The care plans for residents receiving psychotropic medications were reviewed and revised as appropriate to include specific behaviors for which psychotropic medications are being administered. All residents who receive psychotropic medications have been reviewed in the Psychotropic Review Committee.</li> <li>3. The care plans for residents who are prescribed new orders for psychotropic medication and/or changes in medication dosage, will be evaluated and updated as appropriate to ensure behaviors are included for which the medication was</li> </ol>		

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F 758	<p>Continued From page 80</p> <p>The facility's ADL Behavior Monitor flowsheets documented the following behaviors for every resident in the facility, wandering, verbal abusive, physical abusive, socially inappropriate behavior, resistive or rejection of care.</p> <p>The facility's ADL Mood Symptoms Monitor flowsheets documented the following behavior for every resident in the facility, little interest or pleasure in doing things, feeling or appearing down/ depressed, trouble falling asleep or staying asleep, feeling tired, poor appetite or overeating, feeling bad about themselves, trouble concentrating, moving extremely slow and speaking slow so that others notice, suicidal ideation, and short tempered. The facility did not have resident specific behaviors for staff to monitor.</p> <p>a. Resident #261 was admitted to the facility on 6/19/17, with diagnoses including dementia with Lewy bodies (abnormal protein deposits in the brain) and behavioral disturbances, depression, and sleep disorder.</p> <p>A significant change MDS assessment, dated 6/7/18, documented Resident #261 was severely cognitively impaired and he was totally dependent or required extensive assistance from one to two staff members with cares. The MDS documented Resident #261 had signs and symptoms of mild depression and he exhibited delusions and hallucinations. The MDS documented Resident #261 had physical, verbal, and other behaviors 4-6 days a week. The MDS documented he did not wander or reject cares.</p> <p>i. Resident #261's May 2018 Physician Orders</p>	F 758	<p>ordered. Care plans are reviewed/ revised no less than quarterly. All physician orders are reviewed during the daily clinical meeting. Members of this meeting include the DON, nurse managers, social workers, activities, the Administrator and other IDT members as appropriate. The clinical meeting agenda sheet will be modified to include reviewing the care plan for all new psychotropic medication orders to ensure specific behaviors are present.</p> <p>New residents, or current residents who are newly prescribed psychoactive medications will have signed or documented verbal consents in the resident's chart prior to administration. Each unit's Social Worker will track consents to ensure documented verbal consents are followed up with signed consents. All licensed nurses will be educated to inform the social workers in the event a new psychoactive medication was ordered so that proper consents can be obtained. In PointClickCare, the "Order Progress Note" template was updated to include the need to obtain consent prior to administering newly ordered psychoactive medications. During non-business hours, the nurse taking the order from the physician will secure the verbal consent prior to medication administration.</p> <p>All residents receiving psychotropic medications are reviewed quarterly in the Psychotropic Review Committee. GDRs,</p>		

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F 758	<p>Continued From page 81 included the following scheduled and PRN medications:</p> <p>Scheduled Medications:</p> <ul style="list-style-type: none"> <li>- Depakote (anticonvulsant) 500 mg by mouth one time a day for Lewy bodies dementia with hallucinations and agitation, ordered on 5/31/18 and discontinued the same day.</li> <li>- Remeron (antidepressant) 15 mg at bedtime for depression and insomnia, ordered on 4/2/18 and discontinued on 6/1/18.</li> <li>- Seroquel (antipsychotic) 200 mg at bedtime for dementia with hallucinations, ordered on 4/24/18 and discontinued on 5/23/18.</li> <li>- Seroquel 100 mg two times a day for dementia with hallucinations, ordered on 4/27/18 and discontinued on 5/23/18.</li> <li>- Seroquel 300 mg at bedtime for dementia with hallucinations, ordered on 5/23/18 and discontinued on 5/31/18.</li> <li>- Topamax (anticonvulsant) 25 mg at bedtime for unstable mood, ordered on 3/30/18 and discontinued on 6/12/18.</li> <li>- Zolof (antidepressant) 200 mg one time a day for depression, ordered on 3/30/18 and discontinued on 6/1/18.</li> </ul> <p>PRN Medications:</p> <ul style="list-style-type: none"> <li>- Ativan (sedative and antianxiety) 1 mg intramuscularly (IM) one time only for extreme anxiety, ordered on 5/9/18.</li> <li>- Ativan 1 mg IM one time only for Lewy bodies dementia related to delirium, ordered on 5/23/18.</li> <li>- Ativan 1 mg IM one time only for Lewy bodies dementia related to delirium, ordered on 5/24/18.</li> <li>- Ativan 0.5 mg IM one time only for extreme</li> </ul>	F 758	<p>if appropriate, are recommended at that time or in consultation with the resident primary physician.</p> <p>The resident's specific behaviors related to a psychotropic medication will be care planned into a format that auto-populates into POC for daily/shift documentation by direct care nursing staff for review by social services staff and other pertinent facility staff. The POC information will be reviewed by the social workers for completeness and follow up as necessary. This information will also assist the Psychotropic Review Committee in determining appropriate GDRs for Residents. Nursing staff will be trained on using the newly revised targeted behavior process.</p> <p>4. The Director of Social Services or his designee once per month will print a report of residents on a specific unit who are receiving psychotropic medications to ensure they are included in the Psychotropic Review Committee. This list will be compared against the list reviewed in the Psychotropic Review Committee.</p> <p>The Director of Social Services/Designee will perform weekly audits of at least 10 percent of residents who received new psychoactive medications for the first four weeks, then monthly for the following 3 months, and quarterly thereafter, to verify consents are in place for all psychoactive medications the residents are prescribed. If any residents are found to not have</p>		

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F 758	<p>Continued From page 82</p> <p>anxiety, ordered on 5/27/18.</p> <ul style="list-style-type: none"> <li>- Ativan 1 mg intramuscularly every 24 hours PRN for agitation, ordered on 5/31/18 and discontinued on 6/4/18.</li> <li>- Oxycodone (narcotic) 5 mg every 6 hours PRN for pain, ordered on 5/21/18 and discontinued on 6/12/18.</li> <li>- Seroquel 100 mg one time only for dementia with hallucinations, ordered on 5/23/18.</li> <li>- Trazadone (sedative and antidepressant) 25 mg every 8 hours PRN for anxiety, ordered on 4/2/18 and discontinued on 5/23/18.</li> <li>- Trazadone 50 mg every 8 hours PRN for anxiety, ordered on 5/23/18 and discontinued on 6/12/18.</li> </ul> <p>Resident #261 received 2 antidepressant medications, Remeron and Zoloft, daily from 4/2/18 to 6/1/18, and 1 antipsychotic medication, Seroquel, daily from 4/24/18 to 5/31/18. Two medications, Seroquel and Depakote, were prescribed for hallucinations according to the MAR documentation. He also had orders for 2 antianxiety medications PRN, Ativan and Trazadone. Additionally, the medications Seroquel, Remeron, Trazadone, Ativan, and Oxycodone had sedative effects.</p> <p>Resident #261's June 2018 Physician Orders included the following scheduled and PRN medications:</p> <p>Scheduled Medications:</p> <ul style="list-style-type: none"> <li>- Ativan 1 mg/ml by mouth three times a day for agitation, ordered on 6/5/18 and discontinued on 6/6/18.</li> <li>- Ativan 1 mg/ml by mouth two times a day for</li> </ul>	F 758	<p>consents in place, the consents will be secured as soon as possible from the resident/responsible party. The results of these audits will be reported to the QA committee the following month.</p> <p>The Administrator or his designee will review the Clinical Meeting agenda to ensure a review of care plans developed in response to psychotropic medication changes has been done. The Administrator or his designee will initial the specific agenda item and will follow up as appropriate. This will occur weekly for four weeks, then monthly for three months, then quarterly thereafter. The results of this review will be presented to the QA Committee monthly.</p> <p>The Director of Social Services/Designee will review the POC to identify any "reds" (missing documentation) weekly for the first four weeks, monthly for the next three weeks, and quarterly thereafter and follow up as appropriate. The results of this audit will be reported to the QA Committee on a monthly basis.</p>		

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F 758	<p>Continued From page 83</p> <p>agitation, ordered on 6/6/18 and discontinued the same day.</p> <ul style="list-style-type: none"> <li>- Ativan 1 mg/ml by mouth every eight hours for agitation, ordered on 6/6/18 and discontinued on 6/14/18.</li> <li>- Clonazepam (antianxiety) 0.5 mg by mouth two times a day for comfort and seizure control, ordered on 6/1/18 and discontinued on 6/6/18.</li> <li>- Depakote extended release 500 mg by mouth at bedtime for Lewy bodies dementia with hallucinations and agitation, ordered on 6/1/18 and discontinued on 6/12/18.</li> <li>- Seroquel 50 mg two times a day for dementia with hallucinations, ordered on 5/23/18 and discontinued on 6/12/18.</li> <li>- Seroquel 200 mg at bedtime for dementia with hallucinations, ordered on 5/31/18 and discontinued on 6/12/18.</li> <li>- Topamax 25 mg at bedtime for unstable mood, ordered on 3/30/18 and discontinued on 6/12/18.</li> </ul> <p>PRN Medications:</p> <ul style="list-style-type: none"> <li>- Ativan 0.5 mg by mouth every 2 hours PRN for agitation, ordered on 6/1/18 and discontinued on 6/5/18.</li> <li>- Ativan 0.5 mg by mouth every hour PRN for agitation, ordered on 6/5/18 and discontinued on 6/14/18.</li> <li>- Ativan 1 mg IM every 24 hours PRN for agitation, ordered on 5/31/18 and discontinued on 6/4/18.</li> <li>- Ativan 1 mg IM every 24 hours PRN for agitation, ordered on 6/4/18 and discontinued on 6/14/18.</li> <li>- Morphine Sulfate (narcotic) 10 mg sublingually every 2 hours PRN for pain and air hunger, ordered on 6/1/18 and discontinued on 6/14/18.</li> </ul>	F 758			

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F 758	<p>Continued From page 84</p> <ul style="list-style-type: none"> <li>- Oxycodone 5 mg every 6 hours PRN for pain, ordered on 5/21/18 and discontinued on 6/12/18.</li> <li>- Trazadone 50 mg every 8 hours PRN for anxiety, ordered on 5/23/18 and discontinued on 6/12/18.</li> </ul> <p>Resident #261's antidepressants, Remeron and Zoloft, were discontinued and he had 2 antianxiety medications added to be taken daily, Ativan and Clonazepam. He also had PRN orders for Ativan, and a new order for Morphine Sulfate for pain. Additionally, the medications Ativan, Clonazepam, Seroquel, Morphine Sulfate, Oxycodone, and Trazadone had sedative effects.</p> <p>ii. Resident #261's 5/1/18 through 6/14/18 MAR documented he was administered a PRN psychotropic medication, Trazadone or Ativan, within 0 to 15 minutes of a PRN pain medication, Oxycodone or Morphine, being administered. Examples include:</p> <ul style="list-style-type: none"> <li>- Oxycodone and Trazadone were administered together on 5/23/18 at 2:25 PM and 10:06 PM, 5/24/18 at 3:45 PM, 5/30/18 at 12:33 AM, and 6/4/18 at 3:30 AM.</li> <li>- Oxycodone and Ativan were administered together on 6/2/18 at 1:12 PM, 6/3/18 at 10:45 AM, and 6/5/18 at 3:03 PM.</li> <li>- Morphine and Trazadone were administered together on 6/6/18 at 4:00 AM.</li> <li>- Morphine and Ativan were administered together on 6/1/18 at 1:30 PM, 6/3/18 at 1:40 PM, 6/3/18 at 4:10 PM, 6/4/18 at 6:30 AM, 9:35 AM, and 12:15 PM, 6/6/18 at 3:07 PM, 5:07 PM, and 9:15 PM, 6/10/18 at 10:01 PM, 6/11/18 at 3:32 PM, and 6/12/18 at 1:50 PM.</li> </ul>	F 758			

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F 758	<p>Continued From page 85</p> <p>According to the Nursing 2019 Drug Handbook, Ativan by IM injection takes 15-30 minutes to take effect and when given orally it takes 1 hour. Additionally, the Nursing 2019 Drug Handbook stated Ativan, Trazadone, and Oxycodone side effects include sedation, confusion, insomnia, dizziness, and drowsiness.</p> <p>This occurred 21 times on 12 days, from 5/23/18 to 6/12/18. The staff did not allow adequate time for the pain medication or the antianxiety medication administered to take effect. It was unclear if Resident #261 was anxious or in pain. According to the Nursing 2018 Drug Handbook the side effects for Ativan, Trazadone, Oxycodone, and Morphine Sulfate included sedation, confusion, insomnia, dizziness, and drowsiness.</p> <p>The progress notes for Resident #261 for the above listed dates and times included documentation he received Ativan or Trazadone PRN for agitation and/or anxiety. The progress notes did not include documentation of how Resident #261's agitation and/or anxiety presented or specific behaviors related to his agitation and/or anxiety.</p> <p>iii. Resident #261's May 2018 Behavior flowsheet documented he experienced the following behaviors:</p> <ul style="list-style-type: none"> <li>- Wandering- 3 episodes on 5/6/18, 5/17/18, and 5/20/18</li> <li>- Physically abusive- 1 episode on 5/21/18</li> <li>- Resistive or rejection of care- 2 episodes on 5/22/18 and 5/23/18</li> </ul>	F 758			

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

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F 758	<p>Continued From page 86</p> <p>Resident #261's 6/1/18 through 6/13/18 Behavior flowsheet documented he experienced the following behaviors:</p> <ul style="list-style-type: none"> <li>- Physically abusive- 1 episode on 6/3/18</li> <li>- Resistive or rejection of care- 1 episodes on 6/2/18</li> </ul> <p>Resident #261's progress notes did not correlate with his Behavior Monitoring flowsheets for May and June of 2018. Examples include:</p> <ul style="list-style-type: none"> <li>- A Progress note, dated 5/14/18 at 9:39 PM, documented Resident #261 was agitated and continued to ambulate without his wheelchair or assistance and a PRN Trazadone was provided at 2:53 PM. The note documented Resident #261 needed 1:1 staff supervision from 1:00 PM to 9:00 PM and a light duty staff member was only available from 4:00 PM to 6:00 PM. Resident #261's care plan was not updated to include the need for 1:1 staff supervision on 5/14/18, and it was unclear if he was to have a 1:1 CNA present for the duration of time between 1:00 PM and 9:00 PM.</li> <li>- Progress Notes, dated 5/23/18 at 2:25 PM, documented Resident #261 was provided a PRN Trazadone for anxiety and calling out and excessive movement in his wheelchair, PRN Oxycodone for pain, and Seroquel was given early to help with calming anxiety. There was no documentation of Resident #261 calling out or other behaviors related to anxiety in the behavior monitor flowsheet. Additionally, the progress note did not include a description how his anxiety presented.</li> </ul>	F 758			

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F 758	<p>Continued From page 87</p> <p>A subsequent Progress Note, at 11:05 PM on 5/23/18, documented Resident #261 woke up at 8:50 PM and was combative, agitated, and refused his bedtime medications by spitting them out at the nurse. The note documented Resident #261 was also kicking and hitting the nurse and CNAs. Resident #261 refused drink and food and was assisted to the common area to sit in a recliner for better observation by staff. The note documented he required 1:1 supervision because Resident #261 attempted to transfer himself and was constantly repositioning himself in the recliner. The note documented Resident #261 was anxious during most of the shift and rested for a few hours after dinner while his 1:1 supervision CNA was with him. The note documented IM Ativan was not initially effective and PRN Trazadone, Oxycodone, and Seroquel were administered to help settle his delirium/anxiety.</p> <p>The note did not include a description of how Resident #261 presented with delirium or anxiety. The Behavior Monitoring flowsheet documented Resident #261 was resistive to cares, there was no documentation related to his delirium, anxiety, or hitting and kicking at staff.</p> <p>The MAR documented he was administered a PRN dose of Ativan IM at 9:53 PM and at 10:06 PM, 13 minutes later, he was administered a dose of PRN Trazadone and PRN Oxycodone. At 10:13 PM, 7 minutes later, he was administered a dose of PRN Seroquel. The staff did not provide adequate time for the antianxiety medication to take effect before administering another 2 psychotropic medications and a pain medication.</p>	F 758			

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F 758	Continued From page 88  - A Progress Note, dated 5/24/18 at 10:53 PM, documented Resident #261 was pleasant and cooperative for most of the shift. The note documented he was administered a PRN pain and antianxiety medication for an "increase in symptoms/suspected pain, with successful result." The note documented at 6:45 PM, Resident #261 was restless, yelled and hit staff, and attempted to self-transfer out of his chair, and his scheduled Remeron, Seroquel, and Topamax did not decrease his anxiety. The note documented the physician ordered a one-time dose of IM Ativan which was given and he calmed down afterwards and was observed sleeping in a recliner chair. There was no documentation in his Behavior Monitoring flowsheet Resident #261 hit staff or he exhibited other behaviors.  - A Progress Note, dated 5/27/18 at 3:00 AM, documented Resident #261 woke up and he was calling out he wanted to use the bathroom and go home. Resident #261 was unable to stand up and comprehend instructions with using the mechanical lift and required 3 CNAs to assist with the transfer. He was given a dose of PRN Trazadone related to anxiety, which was ineffective. Resident #261 was moved to the nurses' station and continued to call out. The note documented a 1:1 sitter was not available for the night shift and a staff member assigned to a different unit volunteered to assist as Resident #261's 1:1 for 1-2 hours. Resident #261 was administered a PRN IM Ativan dose at 3:22 AM. There was no documentation describing how Resident #261's anxiety presented.	F 758			

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F 758	<p>Continued From page 89</p> <p>- A Progress Note, dated 6/4/18 at 10:41 AM, documented Resident #261 had increased confusion and was restless and picked up unseen items on the floor. The note documented he had a change in his previous normal pattern of behavior with an increase in negative behaviors and increased confusion and agitation. Resident #261's 6/4/18 MAR documented he was administered a dose of PRN Ativan and PRN Morphine at 12:15 PM, a dose of PRN Trazadone at 2:00 PM, and a dose of PRN IM Ativan at 2:40 PM. The Behavior Monitoring flowsheet did not include documentation of behaviors or an increase in behaviors. There was also no documentation in the Behavior Monitoring flowsheet about how Resident #261 exhibited agitation.</p> <p>iv. Resident #261's care plan did not include specific behaviors and did not identify or include depression and anxiety.</p> <p>Resident #261's care plan addressed cognition, dated 3/27/18, and documented he had impaired cognition related to Lewy body dementia and was rarely understood and had difficulty understanding. The care plan did not document how his dementia presented.</p> <p>Resident #261's care plan area addressed elopement risk, dated 4/13/18, and documented he verbalized wanting to leave the facility and wandered the facility. Interventions included Resident #261 had a roam alert bracelet on his wheelchair, dated 4/13/18, and staff were to provide 1:1 supervision until Resident #261 stopped attempting to leave the facility, dated 5/26/18. The care plan did not include</p>	F 758			

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F 758	<p>Continued From page 90</p> <p>identification of behaviors associated with the 1:1 intervention initiated on 5/26/18.</p> <p>The care plan area addressing Resident #261's behaviors and mood, dated 6/28/17, documented he was cognitively impaired and had dementia. The care plan documented he had behavioral issues with hallucinations and delusions. The care plan documented Resident #261 had suicidal ideation, hit staff, and screamed.</p> <p>Resident #261's care plan did not identify if Resident #261's hallucinations and or delusions were tactile [touch], visual, auditory, and olfactory [smell]), was not resident specific and did not document clearly how his hallucinations or delusions presented. The care plan did not document if his hallucinations or delusions were harmful to him.</p> <p>Resident #261 did not have a care plan for his anxiety or his depression. The facility did not identify how Resident #261's anxiety, agitation, or depression presented.</p> <p>v. Resident #261's MAR and Progress Notes documented his hours of sleep increased as medications were added.</p> <p>The care plan area addressing Resident #261's sleep cycle, dated 6/19/17, documented he was taking medications daily to assist him with sleep. The care plan documented staff were to monitor Resident #261's hours of sleep at night and staff were to encourage him to maintain his home routine of going to bed at 8:00 PM and waking at 6:00 AM.</p>	F 758			

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F 758	<p>Continued From page 91</p> <p>Resident #261's May 2018 MAR documented he was sleeping from 3 hours to 16 hours a day and averaged 9 hours daily. Examples include:</p> <ul style="list-style-type: none"> <li>- On 5/2/18, the MAR documented he slept 11 hours. A progress note, dated 5/2/18, documented Resident #261 was administered a PRN Trazadone as he was unable to sleep and settle down. Resident #261's Trazadone was ordered for anxiety, not sleep.</li> <li>- Resident #261's MAR documented he slept 9 hours during the 5/8/18 evening shift.</li> <li>- Resident #261's MAR documented for the night shift on 5/23/18 he slept 7 hours, and during the day shift on 5/24/18 he slept for 4 hours.</li> <li>- Resident #261's MAR documented for the night shift on 5/27/18 he slept 7 hours, and during the day shift on 5/28/18he slept for 4 hours.</li> <li>- Resident #261's MAR documented he slept for 10 hours on 5/29/18, on 5/30/18 he slept 7 hours, and on 5/31/18 he slept 10 hours during the 24 hour period.</li> </ul> <p>Resident #261's June 2018 MAR documented he was sleeping from 7 to 24 hours a day and averaging 15 hours daily. Examples include:</p> <ul style="list-style-type: none"> <li>- Resident #261's Sleep Monitor flowsheet for 6/4/18 documented he slept 8 hours during the 24 hour period.</li> <li>- Resident #261's Sleep Monitor flowsheet for 6/5/18 documented he slept 9 hours during the 24 hour period.</li> </ul>	F 758			

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F 758	<p>Continued From page 92</p> <p>- Resident #261's Sleep Monitor flowsheet for 6/6/18 documented he slept 16 hours during the 24 hour period.</p> <p>- Resident #261's Sleep Monitor flowsheet documented he slept 11 hours on 6/7/18, 16 hours on 6/8/18, 21 hours on 6/9/18, 16 hours on 6/10/18, 21 hours on 6/11/18, and 24 hours on 6/12/18 and 6/13/18.</p> <p>vi. Resident #261's GDR did not review specific behaviors or evaluate his sleeping habits.</p> <p>Resident #261's Quarterly GDR review, dated 6/6/18, documented Resident #261 was on Ativan, Trazadone, Seroquel, and Depakote. The GDR review documented he was on these medications for sleep and behavioral disturbances with Lewy Body Dementia. The review documented Resident #261 had hallucinations, increased paranoia, and was on hospice and the committee recommended no changes to his medication regime.</p> <p>The review did not evaluate Resident #261 for how many episodes/behaviors of hallucinations, depression, and or anxiety he experienced during the look back period. The GDR review did not include an evaluation of the increase in the hours he slept. The review did not include an evaluation what his hallucination or paranoia looked like or identify what other behaviors he was experiencing and how they were harmful to him.</p> <p>On 11/9/18 at 10:19 AM, LMSW #1 stated Resident #261 was actively delusional and paranoid of people "trying to do bad to him."</p>	F 758			

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F 758	<p>Continued From page 93</p> <p>LMSW #1 stated the medications were being managed by a Psychiatrist and he experienced hallucinations as well.</p> <p>b. Resident #30 was readmitted to the facility on 3/10/16, with diagnoses including dementia.</p> <p>A quarterly MDS assessment, dated 8/13/18, documented Resident #30 was severely cognitively impaired and had no signs and symptoms of depression. The MDS documented he did not exhibit inappropriate behaviors, hallucinations, delusions, rejection of cares, or wandering.</p> <p>Resident #30's October 2018 Physician Orders included:</p> <ul style="list-style-type: none"> <li>- Zyprexa 5 mg by mouth in the afternoon and evening for dementia, ordered 10/22/18.</li> <li>- Trazadone 100 mg at bedtime for insomnia, ordered 4/2/18.</li> <li>- Trazadone 25 mg in the afternoon for anxiety, ordered 10/19/18.</li> <li>- Oxycodone 5 mg twice daily for arthritis pain, ordered 9/28/18.</li> </ul> <p>The care plan area addressing Resident #30's sleep cycle, dated 3/9/17, documented he was taking medications daily to assist him with sleep. The care plan documented staff were to monitor Resident #30's hours of sleep at night.</p> <p>The care plan area addressing Resident #30's behaviors/cognition, revised 5/23/18, documented he was cognitively impaired and had dementia. The care plan documented Resident #30 was angry and frustrated at times. It did not</p>	F 758			

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F 758	<p>Continued From page 94 specifically describe how Resident #30's dementia presented.</p> <p>Resident #30's care plan did not include specific goals and interventions related to his anxiety and did not describe how his anxiety presented.</p> <p>Resident #30's Quarterly GDR review, dated 9/13/18, documented Resident #30 was receiving Zyprexa and Trazadone. The GDR review documented he was taking the medications for sleep and dementia. The review documented Resident #30 had poor safety awareness and had several falls. The review documented he exhibited anxiety by "leaning forward in his Broda chair." The review documented the committee recommended decreasing Resident #30's Zyprexa to 5 mg in the afternoon and 2.5 mg before bed. This was completed and then the medication was increased back to 5 mg twice daily on 10/29/18, when the physician discontinued another psychotropic medication (Lexapro, an antidepressant). Resident #30's GDR did not include a review of specific behaviors or evaluate his sleeping habits.</p> <p>Resident #30's 8/1/18 through 11/7/18 Behavior Monitoring flowsheets documented he did not exhibit behaviors. The review did not evaluate the number of behaviors and/or symptoms of anxiety Resident #30 experienced during the look back period, to assess the ongoing need for the medications.</p> <p>Resident #30's 10/1/18 through 11/6/18 MAR documented he was sleeping from 11 to 21 hours a day and averaging 16 hours daily.</p>	F 758			

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F 758	<p>Continued From page 95</p> <p>On 11/6/18 from 9:50 AM to 10:39 AM, Resident #30 was observed sitting in his Broda chair (tilt-in-space positioning chair) asleep and snoring. Resident 30 was observed asleep in his Broda chair on 11/6/18 at 2:28 PM, 11/7/18 at 11:00 AM and 4:20 PM, and 11/8/18 at 7:00 AM.</p> <p>On 11/9/18 at 9:56 AM, LMSW #1 stated Resident #30's specific behavior was wandering into other residents' rooms. LMSW #1 stated Resident #30's dementia presented as confusion and increased anxiety. LMSW #1 stated Resident #30 should have a care plan for anxiety and his dementia care plan should describe how his behaviors presented. LMSW #1 stated missing information in Resident #30's care plan made it difficult for contracted agency staff to observe for those behaviors and document them.</p> <p>c. Resident #2 was readmitted to the facility on 2/20/18, with multiple diagnoses including insomnia, dementia, PTSD (post-traumatic stress disorder), anxiety, depression, and Alzheimer's disease.</p> <p>Resident #2's quarterly MDS assessment, dated 7/21/18, documented his cognition was severely impaired, and family or representative participated in the assessment. The MDS documented Resident #2 received antipsychotic and antidepressant medications on a routine basis and documented target behaviors. The MDS target behaviors included delusions, physical, verbal, and other behaviors 1-3 days a week.</p> <p>Resident #2's care plan related to his behavior and mood, dated 5/3/17, did not identify resident</p>	F 758			

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F 758	<p>Continued From page 96</p> <p>specific behaviors or include interventions related to Resident #2's depression, PTSD, and anxiety. The care plan included Resident #2's dementia, dated 2/20/18, but did not document how his dementia presented or interventions related to the dementia.</p> <p>Resident #2's physician's orders, included Escitalopram Oxalate (antidepressant) 10 mg by mouth one time a day for depression/PTSD, ordered on 4/3/18; Risperdal 1 mg by mouth two times a day for unstable mood, ordered on 8/9/18; and Trazadone HCl 100 mg by mouth at bedtime for insomnia, ordered on 11/2/18. The orders included monitoring the number of hours of sleep every shift for insomnia, and to observe Resident #2 for side effects every shift related to the use of antidepressant and antipsychotic medications.</p> <p>Resident #2's Quarterly Mood/Behavior Medication Review, dated 8/7/18, listed his diagnoses for dementia and depression, it did not include his diagnoses for anxiety and PTSD. The review included a section for antidepressant medications and the date initiated. Under this section Escitalopram Oxalate and Trazadone were listed. The review documented Trazadone was used for anxiety and insomnia. Under another section for antipsychotic medications Risperdal was listed. The Trazadone was indicated for insomnia not anxiety according to his physician orders.</p> <p>The Quarterly Review documented Resident #2 had an increase in aggression directed toward other residents and staff over the past few weeks. There was no documentation how it was</p>	F 758			

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F 758	<p>Continued From page 97</p> <p>determined his aggression increased. The Quarterly Review documented the IDT was unable to determine other causes for Resident #2's increased aggression beyond dementia and psychosis. Resident #2's record did not include a diagnosis of psychosis.</p> <p>Resident #2's Behavior and Mood Monitoring Flowsheets, dated 10/1/18 through 11/8/18, monitored each shift for general behaviors and mood symptoms. The flowsheets included a section for response to interventions and effectiveness of the interventions, but they were not specific to Resident #2. The flowsheets did not document the effectiveness of Resident #2's use of psychotropic medications and did not identify the behaviors to monitor related to the use of psychotropic medications.</p> <p>d. Resident #87 was readmitted to the facility on 6/26/18, with diagnoses which included dementia, urinary issues, and cardiac issues.</p> <p>A Quarterly MDS assessment, dated 9/29/18, documented Resident #87 had severe cognitive impairment.</p> <p>Resident #87's physician orders, dated 11/7/18, documented his medication duloxetine (a medication used to treat depression and pain) was increased from 20 mg orally every day to 60 mg each day.</p> <p>Resident #87's current care plan documented he experienced pain, difficulty concentrating, fear of others causing him harm, and changes in sleep patterns. Resident #87's care plan lacked specific behaviors staff were to monitor Resident</p>	F 758			

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F 758	<p>Continued From page 98</p> <p>#87 for and lacked interventions related to the use of the psychoactive medication, duloxetine.</p> <p>On 11/8/18 at 1:25 PM, the Pharmacist confirmed the facility failed to develop and implement a resident specific care plan that described resident specific behaviors and included inventions related to Resident #87's use of duloxetine.</p> <p>On 11/8/18 at 10:44 AM, the DON stated she looked for resident specific behaviors and where they may be located. The DON stated residents' sleep habits were evaluated in the GDR meetings verbally and a resident's behaviors were discussed. The DON stated the current GDR form did not document the conversation that took place for the residents.</p> <p>On 11/9/18 at 10:19 AM, LMSW #1 stated he received alerts from staff when a resident was experiencing increased behaviors and the GDR committee evaluated trends from the alerts. LMSW #1 stated the CNA Behavior Monitoring flowsheets did not include hallucinations and delusions, but staff documented these in the MDS and throughout the progress notes when they were seen by staff. LMSW #1 stated psychotropic medications could increase a resident's fall risk and the facility did not provide PRN psychotropic medications when a 1:1 staff member was unavailable. LMSW #1 stated staff provided the PRN medications when a resident exhibited behaviors. LMSW #1 stated the specific behavior the resident exhibited should be documented in their clinical record for any PRN psychotropic medication administered. LMSW #1 stated the care plan should identify resident</p>	F 758			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135131</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/09/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>IDAHO STATE VETERANS HOME - BOISE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>320 COLLINS ROAD, 83702-4519 BOISE, ID 83707</b>		
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F 758	Continued From page 99 specific behaviors for dementia, hallucinations, and delusions and if they were harmful. LMSW #1 stated the current behavior monitors were helpful with gathering information in addition to the alerts he received and the MDS.  On 11/9/18 at 12:23 PM, the DON stated according to the care plan Resident #261 was to have a 1:1 staff member with him on 5/26/18. The DON stated he may have been provided a 1:1 for short durations before that. The DON stated the facility would not provide PRN psychotropic medications when a 1:1 staff member was unavailable, only when residents' behaviors increased. The DON stated the behavior monitors were not resident specific and the staff documented specific instances throughout the progress notes. The DON stated in the GDR meeting the team reviewed each residents' behaviors and evaluated items such as sleep, and what the team discussed was documented in the GDR note	F 758			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		1/14/19	

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F 880	Continued From page 100  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880			

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F 880	<p>Continued From page 101 by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on policy review, observation, and staff interview, it was determined the facility failed to ensure staff performed effective hand hygiene and implemented effective infection prevention measures related to urinary catheters. This was true for 9 of 22 residents (#2, #10, #15, #20, #28, #35, #95, #101, #103) reviewed for infection control. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include:</p> <p>a. The facility's Daily Catheter/Peri-Care Competency, undated, documented staff were to wash hands, put on gloves, perform peri-care, remove gloves after performing peri-care, use hand gel sanitizer and apply gloves, provide a clean brief, and then remove gloves and perform hand hygiene. This policy was not followed.</p> <p>On 11/5/18 beginning at 2:58 PM, CNA #16 and CNA #20 were observed assisting Resident #35</p>	F 880	<ol style="list-style-type: none"> <li>1. The Residents that were affected by the deficient practice did not suffer any adverse effects as a result of the deficient practice.</li> <li>2. All current and future Residents have the potential to be affected by the deficient practice. <ol style="list-style-type: none"> <li>a. All nursing staff were educated related to effective hand hygiene techniques per CMS guidelines and community standards.</li> <li>b. All nursing staff were observed in various Resident care scenarios to ensure competency with effective hand hygiene.</li> </ol> </li> <li>3. Systemic Changes to prevent recurrence: <ol style="list-style-type: none"> <li>a. Hand hygiene and Using Gloves procedures were revised and updated per CMS guidelines and community standards.</li> <li>b. Hand hygiene related to Peri-care,</li> </ol> </li> </ol>		

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F 880	<p>Continued From page 102</p> <p>on One East of the main room of the Secured Care Unit. Resident #35 was assisted from his recliner to his wheelchair, then from his wheelchair to his bed to perform peri-care. After cares he was then assisted from his bed to his wheelchair and helped to the dining room.</p> <p>CNA #16 and CNA #20 did not perform hand hygiene before they assisted Resident #35 to his room, and did not perform hand hygiene before, during, or after performing peri-care. CNA #20 and CNA #16 wore gloves during peri-care but did not change gloves or wash their hands until after Resident #35 was placed in his wheelchair to go to the dining room.</p> <p>CNA #20 stated she did not wash her hands before she put on the gloves or before she provided CNA #16 a pair of gloves. CNA #16 stated he knew he did not wash his hands before he put on gloves and knew he was supposed to but he was already too far into the care of changing the Resident #35's brief.</p> <p>b. The facility's policy Performing A Blood Glucose Test, dated August 2017, documented staff were to perform hand hygiene and apply gloves before the procedure, and remove gloves and perform hand hygiene after the procedure.</p> <p>On 11/6/18 at 2:50 PM, LPN #3 was observed measuring the blood glucose level of Resident #20 and did not perform hand hygiene after measuring Resident #20's blood glucose level. After LPN #3 removed his gloves, he was observed engaging in a conversation with another staff member and resident, and he touched the items on the medicine cart without</p>	F 880	<p>obtaining blood glucose levels, medication administration, Resident personal cares and Foley Catheter Care was incorporated into the LN and CNA competency skills checklists to ensure new hires were assessed for effective hand hygiene practices.</p> <p>c. All staff will be periodically assessed by the Staff Development Coordinator to ensure each staff member is able to demonstrate effective hand hygiene techniques.</p> <p>d. Competency checklist will be included in the new hire packet.</p> <p>4. Audit tool was developed and put into place to ensure effective hand hygiene is completed per procedure.</p> <p>a. Management staff, at the direction of the Director of Nursing, will conduct random observations of nursing staff hand hygiene techniques.</p> <p>b. The audit will include approximately 20 staff members and will be done weekly for 4 weeks; monthly for 3 months, and quarterly thereafter by the Director of Nurses or designee and results presented to the monthly QAPI for follow-up as necessary.</p>		

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F 880	<p>Continued From page 103</p> <p>performing hand hygiene. He then walked over to the nurses' station, touched the desk, picked up a binder and returned to the medicine cart without performing hand hygiene. LPN #3 stated he thought he had used the hand sanitizer after checking Resident #20's blood glucose.</p> <p>c. The facility's policy Hand Hygiene, dated August 2017, documented staff involved in direct contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The policy stated hand hygiene was performed between resident contact, after handling contaminated objects, before applying and after removing personal protective equipment (PPE) including gloves, before preparing or handling medications, after handling items potentially contaminated with body fluids, and when during resident care staff moved from a contaminated body site to a clean body site.</p> <p>The facility's policy Using Gloves, dated August 2017, documented staff were to perform hand hygiene after removing gloves.</p> <p>These policies were not followed. Examples include:</p> <p>- On 11/6/18 at 2:30 PM, CNA #15 was observed taking vital signs of residents on One East of the main room of the Secured Care Unit. CNA #15 took Resident #103's vital signs at 2:30 PM, Resident #20's vital signs at 2:34 PM, and Resident #28's vital signs at 2:36 PM. CNA #15 was then observed assisting Resident #95, from a sitting to standing position from his recliner to his walker. He did not perform hand hygiene</p>	F 880			

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F 880	<p>Continued From page 104</p> <p>before and after taking vital signs of each resident and did not perform hand hygiene before assisting Resident #95. CNA #15 stated he knew he should have washed his hands before and after taking the vital signs of each resident.</p> <p>- On 11/7/18 at 11:15 AM, CNA #11 and CNA #14 were observed helping Resident #10 get up from his recliner to his wheelchair to go to the bathroom. CNA #11 and CNA #14 did not perform hand hygiene before they assisted Resident #10.</p> <p>CNA #14 performed hand hygiene after he assisted Resident #10 on the toilet and left the room. CNA #14 returned to the room at 11:20 AM and put gloves on but did not perform hand hygiene before he put on gloves. CNA #14 performed hand hygiene after he helped Resident #10 from the toilet to the wheelchair.</p> <p>CNA #11 did not perform hand hygiene after she removed her gloves, she did not wash her hands before she returned the clean supply items back into the cabinet, and then replaced the dirty garbage bag. CNA #11 then washed her hands and Resident #10's hands and assisted him to the dining room.</p> <p>- On 11/7/18 at 11:33 AM, CNA #14, was observed assisting Resident #2 from the couch to his wheelchair on One East of the main room to the dining room of the Secured Care Unit for lunch. CNA #14 did not perform hand hygiene before assisting Resident #2 to the dining room.</p> <p>- On 11/7/18 at 11:35 AM, CNA #11 was observed assisting Resident #28 to the dining</p>	F 880			

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F 880	<p>Continued From page 105</p> <p>room. CNA #11 did not perform hand hygiene before and after assisting Resident #28. CNA #11 then left the dining room and went to Resident #15's room and made his bed. CNA #11 then assisted Resident #35 from his recliner to his wheelchair and helped him to the dining room and did not wash her hands until after she left the dining room.</p> <p>On 11/7/18 at 12:52 PM, CNA #14 stated he knew he was to wash his hands between taking care of residents, before and after peri-care, and touching equipment. He thought he washed his hands each time but did not realize he sometimes missed opportunities.</p> <p>On 11/7/18 at 12:54 PM, CNA #11 stated she knew she was to wash her hands before and after cares and between each resident. CNA #11 stated she knew she washed her hands after she moved the clean supplies in the cupboard and stated she should have washed her hands before she moved the clean supplies.</p> <p>d. The Centers for Disease Control and Prevention (CDC) website, updated October 24, 2016, accessed on November 12, 2018, included recommendations for proper techniques for urinary catheter maintenance. One recommendation stated not to rest the catheter bag on the floor.</p> <p>The facility's policy Foley Catheter Maintenance, dated March 2006, documented a Foley catheter was a potential source of infection. The policy documented when the resident was up, staff were to make sure the bag was not dragging on the floor area.</p>	F 880			

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F 880	Continued From page 106  Resident #101's care plan, dated 1/12/18, included interventions for an indwelling catheter which documented to keep the catheter bag and tubing off the floor.  On 11/6/18 at 1:50 PM, Resident #101 was observed in bed and the catheter bag was on the floor.  On 11/9/18 at 11:45 AM, CNA #7 stated catheter bags and tubing were not supposed to be on the floor.  On 11/9/18 at 4:00 PM, the DON, stated staff were to make sure catheter bags and tubing were not on the floor.  On 11/7/18 at 4:08 PM, the Infection Control Nurse stated hand hygiene should be performed before and after performing care for residents, between cares with each resident, and catheters should not be on the floor. The Infection Control Nurse stated senior CNAs were assigned to survey other CNAs for hand hygiene but was unsure if they were reporting if there were issues because they did not want to "tell on each other". The Infection Control Nurse stated she monitored for infection control. She stated training for hand hygiene and infection control was completed for new employees when they were first hired, annually, and when necessary.	F 880			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001313</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/09/2018</b>
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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the State licensure survey conducted at the facility from November 5, 2018 to November 9, 2018.</p> <p>This report reflects changes of the Informal Dispute Resolution conducted on January 17, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Coordinator Wendi Gonzales, RN</p>	C 000		
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  12/17/18
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IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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June 20, 2019

Rick Holloway, Administrator  
Idaho State Veterans Home - Boise  
320 Collins Road, Po Box 7765  
Boise, ID 83702

Provider #: 135131

Dear Mr. Holloway:

On **November 9, 2018**, an unannounced on-site complaint survey was conducted at Idaho State Veterans Home - Boise. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00007839**

ALLEGATION #1:

Call bells were not answered timely by staff.

FINDINGS #1:

An unannounced on-site recertification and complaint survey was conducted from 11/5/18 to 11/9/18. During the investigation 23 residents were observed and six resident records, which included a closed record, were reviewed for call light concerns. Interviews were conducted with residents and family members. Multiple staff members were interviewed and observed regarding call light times. Facility abuse allegations, grievances, and Resident Council minutes were reviewed.

During the investigation observations were conducted for call lights and resident and family members were interviewed.

Rick Holloway, Administrator  
June 20, 2019  
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During observations of call light response times, no concerns were identified. The call lights were answered within minutes and residents' needs were taken care of before call lights were turned off throughout the survey.

Resident Council Meeting minutes and Grievances from October to November 2018 documented that call light response times were not an issue.

Several residents and two family members said call lights were answered in a timely manner. CNAs and nurses said call lights were answered timely. The Director of Nursing said call lights were answered timely.

#### CONCLUSIONS:

The allegation was unsubstantiated due to lack of evidence of long call light response times.

#### ALLEGATION #2:

The facility was too understaffed to meet all the residents needs.

#### FINDINGS #2:

Twenty-two residents were observed for quality of care services, such as staff interaction with residents, restorative nursing programs, showers, and supervision. The facility's grievance files and resident council meeting minutes were reviewed. Eleven residents records were reviewed for staffing concerns related to their restorative nursing programs, showers, supervision, and psychotropic medication use. Residents and staff were interviewed regarding various quality of care issues.

One resident said he did not receive showers as he should. The resident stated it was due to the facility being short staffed and it "irks" him when he does not receive his scheduled shower twice weekly. The resident stated he had spoken with staff about his concerns often and nothing had changed.

Two resident records documented they did not receive their showers as scheduled, and three residents stated the facility needed more staff to meet the needs of the residents because they did not receive showers as scheduled. One resident stated the call lights were answered but their needs were not met when the lights were answered.

One resident's family member said she often found her loved one wet with urine that "soaked" through his clothing, bedding, and wheelchair pad. The family member said the facility frequently failed to provide bathing for the resident, due to "lack of staffing."

Rick Holloway, Administrator  
June 20, 2019  
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A grievance documented an anonymous resident complained of not receiving a shower for 7-10 days.

The facility tracked baths on a secondary document titled the Bath List. The April through June 2018 Bath List documented multiple days when the bath aide was reassigned to work the floor. The October 2018 Bath List documented multiple days when the bath aide was reassigned to work the floor.

Three resident records documented they did not receive their restorative nursing program as ordered, and two residents stated they did not receive their restorative nursing because of staffing issues.

Multiple staff stated their job duties were reassigned depending on the day. The staff stated the shower aides and the restorative nursing assistants were reassigned to work the floor often and the facility could use more staff to meet the needs of the residents.

Review of the facility's Shift Assignment sheets for 5/1/18 through 6/14/18 documented if a 1:1 staff member was assigned to a floor. The sheets did not document the assigned resident who required the 1:1 supervision, to ensure the resident received the 1:1 supervision, and had open shifts where a staff member was not assigned.

One resident's record, admitted June 2017, included physician orders and medication administration records which documented the resident had eight different medications ordered that increased his sleepiness throughout his stay at the facility. The resident's record documented the facility failed to provide adequate supervision for the resident and provided him with excess medications to keep the resident from eloping and being aggressive with staff. The resident subsequently experienced multiple falls after the facility changed the medications and it was unclear whether a 1:1 staff member was provided when needed.

Progress notes between 5/27/18 and 6/5/18 documented the resident experienced more falls, could not comprehend directions, his 1:1 was unavailable, he required more staff assistance with ADL's, and was sleeping more.

The DON stated the facility did not provide PRN psychotropic medications when a 1:1 staff member was unavailable, only when residents' behaviors increased.

The DON stated the staffing was difficult to manage and this was why the facility utilized staffing agencies. The DON stated when staff called in they could not always get replacements. The DON stated the staffing agencies did not always have staff available when she needed them. The DON stated the facility could utilize more staff when staff did not show up for work as scheduled.

The Administrator stated the facility was consistently working on staffing issues through its quality assurance program. The Administrator stated the facility tried to place residents who required more assistance on a floor where more CNAs were scheduled to work. The Administrator stated RNAs got reassigned to work as bath aides if staff members called in.

#### CONCLUSIONS:

Based on the results of the investigation, the allegation was substantiated. Deficiencies were cited at F605, F677, F688, F725, and F758 as it relates to the failure of the facility to ensure resident needs were met with sufficient staff.

#### ALLEGATION #3:

Multiple residents experienced falls and the facility did not implement interventions to prevent the falls.

#### FINDINGS #3:

During the investigation three residents were observed and four resident records, which included one closed record, were reviewed for accidents and falls. Interviews were conducted with residents and family members. Staff members were also interviewed regarding supervision and falls.

All four residents' records were reviewed for accidents and supervision, including residents admitted to the facility in June 2015 and June 2017.

One resident, admitted June 2015, included documentation in the record he/she experienced multiple falls while at the facility. The record did not contain documentation the facility investigated the falls in May 2018 for causality and implemented interventions to protect the resident from further injury. The resident's record did not document the care plan was updated after the falls. The resident did not experience falls from October 2018 through November 2018.

Another resident, admitted June 2017, had documentation he/she experienced multiple falls while at the facility. The record did not contain documentation the facility investigated the falls in April and May 2018 for causality and implemented interventions to protect the resident from further injury.

Another resident, admitted November 2015, had documentation in their record they experienced multiple falls without injury in October 2018 and November 2018.

The facility self-identified falls as a concern and developed a plan of correction for the falls prior

to survey.

CONCLUSIONS:

Based on the results of the investigation, the allegation was substantiated, however no deficiency was cited due to the facility correcting the issue prior to survey.

ALLEGATION #4:

There is not enough staff assistance in the dining room for dependent residents and weight loss occurred.

FINDINGS #4:

Three resident records were reviewed for weight loss and eating assistance, family members were interviewed, and residents were observed eating in the dining room.

Three of three resident records did not document a concern regarding weight loss or assistance with eating. The three resident records documented the type of assistance the residents required for eating. Resident Council minutes and Grievances did not document concerns with weight loss and/or assisting residents with eating.

During the review of the record for one resident, admitted June 2015, weights were documented and did vary some in April and May 2018 and the resident's weight stabilized between June 2018 to November 2018, back to his original weight. The resident's record documented the dietitian addressed the weight loss and implemented interventions to assist with weight gain. Meal monitors were documented and no concerns were identified. The resident was assisted with his meals by staff members on multiple observations.

During the survey, 8 residents were observed for meal assistance for four meals and staff assisted them as needed and as their care plans directed. Several other residents received assistance with their meals during the four meals and no concerns were identified.

CONCLUSIONS:

The allegation was not substantiated due to lack of evidence regarding lack of assistance with meals and weight loss.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Rick Holloway, Administrator  
June 20, 2019  
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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. One of the allegations was substantiated, but not cited. No response is necessary to this findings letter, as cited deficiencies 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,

A handwritten signature in black ink, appearing to read "Laura Thompson". The signature is written in a cursive style and is positioned above the typed name.

LAURA THOMPSON, RN, Supervisor  
Long Term Care Program

LT/slj