



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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November 29, 2018

Patrick McNabb, Administrator
Ivy Court
2200 Ironwood Place
Coeur d'Alene, ID 83814-2610

Provider #: 135053

Dear Mr. McNabb:

On **November 9, 2018**, a survey was conducted at Ivy Court 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.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 10, 2018**. Failure to submit an acceptable PoC by **December 10, 2018**, may result in the imposition of civil monetary penalties by **January 15, 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*.

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

Denial of payment for new admissions effective February 9, 2019

- Civil money penalty

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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.

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)

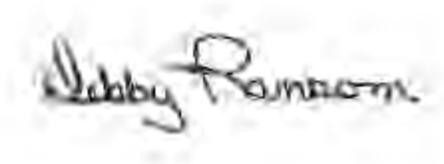
[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **December 9, 2018**. If your request for informal dispute resolution is received after **December 9, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

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

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

dr/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/09/2018
NAME OF PROVIDER OR SUPPLIER IVY COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814		
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from November 5, 2018 to November 9, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, LSW, Team Coordinator Linda Kelly, RN Karen George, RN</p> <p>Survey Abbreviations: AA = Acting Administrator ADL = Activity(ies) of Daily Living cm = Centimeters CNA = Certified Nursing Assistant COO = Chief Operating Officer I&A = Incident and Accident IDON = Interim Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PPD = Per Patient Day RCM = Resident Care Manager TAR = Treatment Administration Record</p>	F 000			
F 661 SS=D	<p>Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)</p> <p>§483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</p>	F 661		12/14/18	

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

TITLE

(X6) DATE

Electronically Signed

12/07/2018

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 661	<p>Continued From page 1</p> <p>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to complete the discharge summary for 1 of 4 residents (Resident #67) whose closed records were reviewed. This failure created the potential for harm and inappropriate care following discharge due to incomplete documentation. Findings include:</p> <p>Resident #67 was discharged home from the facility on 8/9/18.</p> <p>The record did not include a completed recapitulation of Resident #67's stay.</p> <p>On 11/9/18 at 3:10 PM, the IDON said a recapitulation or discharge summary was not</p>	F 661	<p>This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions in the Departments inspection report.</p> <p>F-661 Discharge Summary</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #67 is no longer at the facility.</p>		

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

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

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F 661	Continued From page 2 completed when Resident #67 was discharged.	F 661	How you will identify other resident who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents residing at the facility have the potential to be affected by this practice. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Social Services and unit managers have been educated on completing discharge summaries and recapitulation of stay for anticipated discharges. How the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained: Audits of residents discharging from the facility will be done by the ADON/DON daily Monday through Friday X 12 weeks to ensure compliance. Findings will be reviewed at QAPI monthly X 3 for further educational opportunities. DON/designee is responsible for compliance		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff	F 677	F-677 ADL Care Provided for Dependent	12/14/18	

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F 677	<p>Continued From page 3</p> <p>interview, and record review, it was determined the facility failed to ensure nail care was provided consistent with a resident's needs. This was true for 1 of 7 residents (Resident #4) who were reviewed for ADL care. The failure created the potential for Resident #4 to experience skin impairment and a negative effect to her psychosocial well-being when her toenails were longer than she liked. Findings include:</p> <p>Resident #4 was admitted to the facility on 2/8/18, with multiple diagnoses including dementia, multiple sclerosis, abnormal gait and mobility, and generalized muscle weakness.</p> <p>Resident #4's quarterly MDS assessment, dated 11/4/18, documented her cognition was severely impaired, she required extensive assistance with personal hygiene, and she had functional limitation in range of motion in both of her lower extremities.</p> <p>Resident #4's care plan, revised 5/18/18, documented an ADL deficit and included interventions for 2 staff to assist with personal hygiene. Her care plan did not specifically address nail care.</p> <p>On 11/6/18 at 11:35 AM, Resident #4 was observed laying on her bed with her bare feet uncovered. Her toenails were painted and the nail polish had grown out approximately 1/8 of an inch. Her toenails on her left great toe, third toe, fourth toe, and all of the toenails on her right foot were 1/8 to 1/4 inch longer than the other toenails. She said her toenails were long and she used to cut them but she was unable to cut them now. Moments later, CNA #7 and CNA #9</p>	F 677	<p>Residents</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #4 has had nail care completed and care plan updated to reflect nail care needs.</p> <p>How you will identify other resident who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents have been evaluated for nail care needs with any negative findings addressed and corrected.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Licensed staff were educated by unit managers on completing non-diabetic nail care. Nail care will be added to the TAR as weekly task to ensure compliance. Facility is contracting with Podiatrist to address residents with additional needs.</p> <p>How the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained: Unit managers will complete weekly nail checks and related documentation x 12 weeks. Audits will be presented at QAPI monthly X 3 to identify further educational opportunities</p> <p>DON/designee is responsible for compliance</p>		

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F 677	<p>Continued From page 4</p> <p>entered the room. CNA #9 said she did not know who trimmed Resident #4's toenails and she did not know if Resident #4 was diabetic or not. Resident #4 stated that she was not diabetic.</p> <p>On 11/8/18 at 10:24 AM, the AA said that nail care was documented in the MAR or the TAR.</p> <p>On 11/8/18 at 10:26 AM, Resident #4's October 2018 and November 2018 MARs and TARs were reviewed and there was no documentation of nail care.</p> <p>On 11/8/18 at 10:32 AM, RCM #1 and RCM #2 both said nail care for diabetic residents was documented in the MAR or the TAR but they were not sure where nail care for non-diabetic residents was documented. RCM #2 said she would look to see if the CNAs documented nail care in the Electronic Medical Record (EMR).</p> <p>On 11/8/18 at 10:40 AM, RCM #2 said personal hygiene was documented in the EMR but there was nothing specific about nail care, and there was no other place to document nail care. RCM #2 accompanied the surveyor to Resident #4's room. With Resident #4's permission, RCM #2 uncovered her feet and removed her socks. RCM #2 said the toenails on Resident #4's left big toe, third toe, fourth toe, and the toenails on her right foot were "quite long." RCM #2 told Resident #4 she was going to get a nail kit to trim and file her toenails right away.</p> <p>11/8/18 2:30 PM, the AA said the only place to document nail care for non-diabetic residents was in the EMR under personal hygiene, but it was not specific about nail care. She said there</p>	F 677			

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F 677	Continued From page 5	F 677			
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, review of I&A reports, policy review, and staff interview, it was determined the facility failed to ensure professional standards of practice related to neurological status assessment after a fall were followed for 2 of 5 residents (#38 and #53) who were reviewed for falls; and to obtain weekly weights as ordered for 1 of 18 residents (Resident #21) whose records were reviewed. The failure created the potential for harm if changes in the residents' neurological status or weight went undetected and untreated. Findings include:</p> <p>1. The facility's policy Episodic Documentation, effective June 2018, documented to include a neurological assessment using the Neurological Assessment Flowsheet as applicable or if a head injury was known or suspected.</p> <p>A Neurological Assessment Flowsheet, attached to the Episodic Documentation policy, documented neurological assessments included</p>	F 684	<p>F-684 Quality of Care</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 38 and #53 had no negative outcomes as a result of incomplete neurological status assessments. Resident #21 is no longer at the facility.</p> <p>How you will identify other resident who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents residing at the facility have the potential to be affected by this deficient practice. Residents who have had recent unwitnessed falls have been reviewed to ensure neurological status assessments were complete with any negative finding corrected.</p>	12/14/18	

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F 684	<p>Continued From page 6</p> <p>vital signs, pupil (eye) reaction, motor function, level of consciousness, and pain response. The flowsheet documented the assessments were to be done every 15 minutes times 4 until stable, then every 30 minutes times 4 until stable, then every hour times 4 until stable, then every 4 hours times 4 until stable, then every 8 hours.</p> <p>a. Resident #38 was admitted to the facility on 6/30/16, with multiple diagnoses including dementia and repeated falls.</p> <p>I&A reports for Resident #38 documented he had unwitnessed falls on 9/24/18 at 1:00 AM, 9/26/18 at 10:30 AM and 5:30 PM, and on 10/1/18 at 4:01 AM.</p> <p>The Neurological Assessment Flowsheet related to the fall on 9/24/18 at 1:00 AM documented his neurological status was not assessed hourly for 4 hours from 4:45 AM to 7:45 AM. At 10:00 AM and 2:00 PM Resident #38's vital signs were completed, but there were no vital signs documented after 2:00 PM. His last neurological assessment was documented at 3:45 AM on 9/24/18.</p> <p>There was no documented evidence Resident #38's neurological status was assessed using the Neurological Assessment Flowsheet after his unwitnessed falls on 9/26/18 at 10:30 AM and 5:30 PM. The I&A report for 9/26/18 at 5:30 PM documented Resident #38 was found lying on his floor by the sink and he had an abrasion to his right upper forehead.</p> <p>There was no documented evidence Resident #38's neurological status was assessed using the</p>	F 684	<p>Resident have had their weights reviewed to ensure completion per physician orders and appropriate documentation requirements.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Licensed Nurses have been in serviced by the DON on the policy for episodic documentation including completing neurological status assessments after unwitnessed falls. Licensed staff have been in serviced by DON on obtaining weights per physician orders with timely and complete documentation.</p> <p>How the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained: Resident incident reports including, but not limited to unwitnessed falls, will be reviewed daily Monday through Friday x 12 weeks to ensure compliance to episodic documentation. Unit managers will audit daily Monday through Friday x 12 weeks for missed weight entries with negative findings corrected at that time. Audits will be reviewed at QAPI monthly X 3 for further educational/corrective opportunities.</p> <p>DON/designee is responsible for compliance</p>		

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F 684	<p>Continued From page 7</p> <p>Neurological Assessment Flowsheet after his unwitnessed fall on 10/1/18.</p> <p>On 11/9/18 at 2:40 PM, RCM #1 said a resident's neurological status should be assessed after an unwitnessed fall. RCM #1 reviewed the I&A reports for Resident #38 and said his neurological status was not consistently assessed after the unwitnessed fall on 9/24/18 and there was no documentation his neurological status was assessed after the unwitnessed falls on 9/26/19 and 10/1/18.</p> <p>b. Resident #53 was admitted to the facility on 10/18/17, with multiple diagnoses including vascular dementia and repeated falls.</p> <p>I&A reports for Resident #53 documented he had unwitnessed falls on 3/24/18 at 11:55 AM, 3/26/18 at 1:09 AM, 8/9/18 at 11:02 PM, 9/3/18 at 10:24 AM, and 9/18/18 at 2:10 PM.</p> <p>On 3/24/18 at 11:55 AM, Resident #53 was found sitting on the floor by his bed with a 3 cm laceration near his right eye. He was transferred to an emergency room for evaluation after the fall. A Progress Note, dated 3/24/18 at 4:50 PM, documented he had returned to the facility from the hospital. The Neurological Assessment Flowsheet documented the first neurological assessment was completed at 10:00 PM on 3/24/18, five and a half hours after he returned to the facility, then every 4 hours for a total of 4 times, then one time 8 hours after that.</p> <p>The Neurological Assessment Flowsheet related to Resident #53's unwitnessed fall on 3/26/18 at 1:09 AM, documented his neurological status</p>	F 684			

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F 684	<p>Continued From page 8</p> <p>was not assessed as directed at 7:15 AM, 11:15 AM, and 3:15 PM. Resident #53 was also not neurologically assessed every 8 hours as directed.</p> <p>There was no documentation Resident #53's neurological status was assessed using the Neurological Assessment Flowsheet after his unwitnessed falls on 8/9/18, 9/3/18, and 9/18/18.</p> <p>On 11/9/18 at 2:40 PM, RCM #1 said a resident's neurological status should be assessed after unwitnessed falls because of the possibility for head injury. RCM #1 reviewed the I&A reports for Resident #53 and said his neurological status was not consistently assessed after the unwitnessed falls on 3/24/18 and 3/26/18 and there was no documentation he was assessed after the unwitnessed falls on 8/9/18, 9/3/18, and 9/18/18.</p> <p>2. Resident #21 was admitted to the facility on 3/28/14, with multiple diagnoses including Alzheimer's disease.</p> <p>Resident #21's physician order, dated 3/7/18, directed staff to weigh her weekly.</p> <p>Resident #21's nutrition evaluation, dated 9/11/18, documented she had a history of weight loss.</p> <p>Resident #21's nutrition progress note, dated 9/18/18, documented she was to remain on weekly weights.</p> <p>Resident #21's weight on 10/16/18, documented she weighed 141.8 pounds. There were no other</p>	F 684			

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F 684	Continued From page 9 documented weights from 10/17/18 to 11/8/18, 3 weeks. On 11/8/18 at 10:27 AM, the AA said there were no weights documented for Resident #21 since 10/16/18. On 11/8/18 at 1:43 PM, CNA #3 said after residents' were weighed, the weights were documented on a weight sheet and either given to the AA or slipped under her office door to be recorded.	F 684			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, review of I&A reports, and policy review, it was determined the facility failed to ensure residents did not develop avoidable pressure ulcers. This was true for 1 of 6 residents (Resident #40) reviewed for pressure ulcers. Resident #40 was harmed when an avoidable	F 686	F-686 Treatment/Svcs to Prevent/heal Pressure Ulcer. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #40 is receiving	12/14/18	

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F 686	<p>Continued From page 10</p> <p>facility acquired right heel pressure ulcer was identified and worsened. Findings include:</p> <p>The facility's Pressure Ulcer Prevention/Treatment policy, effective July 2018, documented the need to manage friction and shear and to select appropriate interventions to stabilize, reduce, or remove underlying risk factors. For residents at high risk to develop a pressure ulcer, interventions included supplementing turning with small shifts in body position and to reduce pressure to the heels. The procedure included managing pressure by off-loading heel pressure and to manage friction and shear with heel protection if they were being exposed to friction.</p> <p>Resident #40 was admitted to the facility on 8/29/18, with a septic (infected) left knee following knee surgery, severe malnutrition, toxic metabolic encephalopathy (impaired brain function related to infection, toxins, or organ failure), and uncontrolled pain.</p> <p>A History and Physical (H&P), dated 8/31/18, documented Resident #40 was admitted to the facility from a local hospital following a fall at home. Resident #40 fell and was not found down at his home for 2 days. The H&P documented he had multiple necrotic (dead tissue or skin) skin lesions but did not describe where the lesions were located. The H&P documented he was being followed by a wound clinic for the lesions.</p> <p>An admission MDS assessment, dated 9/5/18, documented Resident #40's cognition was severely impaired but he was able to express ideas and wants, make himself understood, and</p>	F 686	<p>weekly skin checks with accurate documentation, necessary treatment and services consistent with professional standards of practice to the right heel pressure area. Care plan has been updated to reflect resident refusals and interventions. His wound is healing.</p> <p>How you will identify other resident who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents who have been admitted in the past 30 days, have been reviewed for skin assessment, risk for pressure ulcer development, appropriate interventions based on etiology, refusals of care, and completion of documentation with care plan updates as indicated. Residents who have skin issues have been reviewed to ensure appropriate interventions based on etiology are identified and reflected in their care plan.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Licensed staff will be educated by the DON on admission assessments to include skin assessment/evaluation, implementation of interventions/treatments and the need for IDT/resident/representative involvement for residents with refusals of Care.</p> <p>How the facility plans to monitor performance to ensure the corrective action are effective and compliance is</p>		

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F 686	<p>Continued From page 11</p> <p>understood others; he did not reject evaluations or cares; he required 2-person total assistance for bed mobility, dressing, toilet use, and personal hygiene; pain was "almost constantly" at 6 on a scale from 0-10 (0 = no pain, 10 = worst pain); he had surgical wounds and skin tears and he was at risk for developing a pressure ulcer.</p> <p>A pressure ulcer Care Area Assessment (CAA) triggered by the MDS assessment, dated 9/5/18, identified Resident #40 was at an increased risk for pressure ulcers related to his surgical wounds to the left knee and left shoulder and multiple trauma wounds to the left eye/temple area, left hand/elbow/arm, left chest/shoulder, left lateral knee, left hip, and the right medial metatarsal (end of the foot by the toes).</p> <p>Resident #40's Braden Scale assessment (a tool for predicting pressure ulcer risk), dated 8/29/18, documented he was at high risk for developing a pressure ulcer.</p> <p>Resident #40's care plan included the following concerns and associated interventions:</p> <p>* ADL self care performance deficit:</p> <ul style="list-style-type: none"> - Required a mechanical lift and the assistance of 2 staff for transfers, revised on 9/3/18. - Totally dependent on the assistance of 2 staff for repositioning and turning in bed, initiated on 9/3/18. <p>* Safety device: air mattress with internal bolsters:</p> <ul style="list-style-type: none"> - Apply safety device while in bed, initiated on 	F 686	<p>sustained:</p> <p>Results of new admission skin assessments will be validated at the clinical meeting daily Monday through Friday ongoing with follow up as indicated. New skin issues will be investigated to identify root cause and ensure appropriate interventions are in place and reflected on the care plan. Unit managers will audit the TAR daily Monday through Friday x 12 weeks for validation that weekly skin checks/treatments/interventions were initiated and implemented with accurate documentation.</p> <p>Wound/skin audits will continue to be conducted weekly ongoing to ensure implementation of wound/skin program. Audits will be reviewed at QAPI monthly X 3 for further corrective opportunities.</p> <p>DON is responsible for compliance</p>		

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F 686	<p>Continued From page 12 9/3/18.</p> <p>* Actual pressure ulcer and potential for pressure ulcer:</p> <ul style="list-style-type: none"> - Needs pressure relieving mattress and "pillows under calves (as he allows) to protect the skin while in bed," initiated and revised on 9/3/18. - Notify nurse immediately of any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily care, initiated on 9/3/18. - Assist with turning and repositioning at least every 2 hours, and as needed or requested, initiated on 9/3/18. - If treatment was refused, confer with Resident #40, the Interdisciplinary Team, and family to determine why and try alternative methods to gain compliance. Document alternative methods. These interventions were initiated on 9/3/18. - "Keep heels off of bed by placing calves on pillow as resident allows, Sage [protective padded boots] boots to b/l [bilateral] feet," initiated on 9/3/18 and revised on 9/7/18. <p>A Nursing Progress Note, dated 8/29/18 at 2:41 PM, documented Resident #40 refused a skin assessment.</p> <p>A Nursing Progress Note, dated 8/29/18 at 7:41 PM, documented staff was unable to complete a skin assessment due to Resident #40 refusing.</p> <p>A Therapy Progress Note, dated 8/31/18 at 7:29 AM, documented Resident #40 was at high risk for skin breakdown due to him refusing position changes or mobility with therapy.</p>	F 686			

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F 686	<p>Continued From page 13</p> <p>A Nursing Progress Note, dated 9/2/18 at 9:49 PM, documented Resident #40 continued to refuse re-positioning. There was no documentation regarding his wounds or skin.</p> <p>A Nursing Progress Note, dated 9/3/18 at 11:19 AM, documented Resident #40 "Arrived with 7 previously documented wounds including pressure areas as well as trauma injuries." There was no documentation where the 7 wounds were located or a description of the wounds. The note documented an air mattress with bolsters was in place and skin and positioning programs were also in place. The note documented these were effective because there were no new skin issues since admission.</p> <p>A Nursing Progress Note, dated 9/5/18 at 10:14 AM, documented Resident #40 was bed bound and required the assistance of 2 staff for bed mobility and cares. The note documented the dressings to his wounds were intact and changed the previous day. There was no documentation of a description of the wounds which were dressed or where they were located.</p> <p>A Nursing Progress Note, dated 9/6/18 at 6:51 PM, documented Resident #40 stated his pain was uncontrolled and he wanted to go to the hospital. The note documented the on-call physician was contacted and an order was received to send Resident #40 to the hospital for evaluation and treatment.</p> <p>A Nursing Progress Note by RCM #1, dated 9/7/18 at 2:30 PM, documented Resident #40 had a fluid filled blister on his right heel which measured 8cm by 7cm. Staff from the hospital's</p>	F 686			

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F 686	<p>Continued From page 14</p> <p>Emergency Department (ED) identified the wound. RCM #1 documented the wound was cleansed with normal saline, covered with a dressing, and wrapped in gauze. RCM #1 documented the physician was notified and treatment orders were requested. She also documented Sage boots were applied to both feet and were added to Resident #40's care plan.</p> <p>An I&A report, dated 9/7/18 at 2:10 PM, documented Resident #40 returned from the ED and the ED staff called the facility to report a blister to his right heel. The report documented ED staff informed the facility they had drained the fluid from the blister. RCM #1 documented his right heel was assessed by herself and another nurse and they found a large blister measuring 8 cm by 7 cm. Immediate action taken included cleansing and dressing the heel pressure ulcer and they applied Sage boots to both feet.</p> <p>Resident #40's September 2018 TAR documented weekly skin assessments were to be done every Wednesday and to document "(-)" for no area of impairment or "(+)" for area of impairment. The area to document the weekly skin check on Wednesday 9/5/18 contained a set of initials and the space to document (-) or (+) was blank. The remaining weekly skin assessments for September 2018 were left blank.</p> <p>Resident #40's wound assessment flowsheet documented his right heel pressure ulcer was initially identified on 9/7/18, as a Stage II and it was 8 cm by 7 cm, with scant drainage and it was not present on admission. A Stage II pressure ulcer is defined as partial thickness skin</p>	F 686			

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F 686	<p>Continued From page 15</p> <p>loss and may present as an abrasion, blister, or shallow crater according to the National Pressure Ulcer Advisory Panel, website accessed on 11/28/18.</p> <p>Subsequent wound assessment documentation included the following:</p> <p>* 9/14/18 - Stage II pressure ulcer, unchanged in size, and heavy serosanguineous (a yellowish fluid with small amounts of blood) drainage. Comments included "No change, unstageable D/T [due to] fluid filled blister."</p> <p>* 9/21/18 - The pressure ulcer stage was blank, the width increased to 8 cm, and the ulcer had a scant amount of serosanguineous drainage. Comments included "...Unruptured blister. [No] pain noted with wound care. Updated resident on wound status."</p> <p>* 9/28/18 - The pressure ulcer stage was left blank, the size decreased to 7.2 cm by 6.6 cm. No drainage was documented, and the color was described as pink and black. Comments included "25% epithelial [new tissue], 75% eschar [dead tissue]. Wound improving..."</p> <p>* 10/5/18 - The pressure ulcer was documented as unstageable and the size decreased to 7.0 cm by 6.6 cm. No drainage was documented, and the color was described as pink and black but, in the comments, it documented the ulcer was "100% eschar."</p> <p>* 10/12/18 - The pressure ulcer was documented as unstageable and the size increased to 7.5 cm by 7.0 cm. Comments included "...95% eschar,</p>	F 686			

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F 686	<p>Continued From page 16</p> <p>5% granulation" with a small amount of purulent (containing pus) discharge.</p> <p>* 10/19/18 - The pressure ulcer stage was blank, the size decreased to 7.0 cm by 5.0 cm wide, with a light amount of serosanguineous drainage, and the color was described as red and black. Comments included "Improving [with] 10% granulation, 90% slough [dead tissue which is yellow in color] ..."</p> <p>* 10/26/18 - The pressure ulcer stage was blank, the size increased to 7.4 cm by 5.4 cm wide, with light serosanguineous drainage, and the color was described as red and black. Comments included, "Improving - measured by different provider so measurements different...Refer to chart for [name of wound care provider] notes."</p> <p>* 11/2/18 - The pressure ulcer stage was blank, the size decreased to 3.8 cm by 3.8 cm, with light serosanguineous drainage, and the color was described as red and black. Comments included "Improving...75% eschar, 25% granulation..."</p> <p>The wound care provider's notes, dated 10/26/18, documented this was the initial encounter for the right heel pressure ulcer and described the ulcer as "Obscured full-thickness skin and tissue loss" with light serosanguineous drainage. The pressure ulcer wound was further described as necrotic tissue with 51-75% eschar and 1-25% pink granulation tissue, and it measured 7.4 cm by 5.4 cm. The provider note dated 11/2/18, documented the pressure ulcer was unchanged in appearance and had decreased in size to 3.8 cm by 3.8 cm.</p>	F 686			

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F 686	<p>Continued From page 17</p> <p>Resident #40 was observed lying in bed with the Sage boots on both feet on 11/5/18 at 10:15 AM, 11:10 AM, and 11:25 AM, and again on 11/6/18 at 11:18 AM and 3:49 PM.</p> <p>On 11/7/18 at 12:45 PM, RCM #1 said Resident #40 went to an ED on 9/6/18, for uncontrolled pain and the right heel pressure ulcer was found while he was in the ED. RCM #1 said whole body skin checks were to be done weekly and documented in the TAR. RCM #1 reviewed Resident #40's record then said she would go to medical records to find his TARs for September and August 2018.</p> <p>On 11/7/18 at 3:04 PM, RCM #1 said she was very familiar with Resident #40 and he frequently refused to be repositioned because of pain. RCM #1 reviewed his record and found progress notes which documented he refused to get out of bed or to be repositioned on 9/6/18 at 10:51 AM and he was uncooperative with cares on 9/5/18 at 2:05 AM. She said she did not find documentation staff had provided him education about the risks associated with the refusals. RCM #1 said an air mattress was implemented on 9/3/18, 6 days after he was admitted to the facility, and Sage boots were added after he returned to the facility on 9/7/18. She said Resident #40 went to the ED on 9/6/18 at 10:30 PM and he returned to the facility at 1:20 AM on 9/7/18, less than 3 hours later. RCM #1 also reviewed his September 2018 and October 2018 MARs and TARs and said the weekly skin check on 9/5/18 was incomplete. She said it did not document if there was or was not a new skin issue. RCM #1 said the remaining weekly skin checks for September 2018 were not done and</p>	F 686			

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F 686	<p>Continued From page 18</p> <p>weekly skin checks were not consistently done in October 2018.</p> <p>On 11/8/18 at 1:40 PM, LPN #7 was observed as she performed wound care and a dressing change to Resident #40's right heel pressure ulcer. When LPN #7 removed the old dressing, 3 distinct wound areas were observed at the medial (inside) and posterior (back) aspect of the right heel. LPN #7 did not measure the wounds. The largest wound was about 2.5 cm by 3 cm long and 3.5 cm by 4 cm wide and covered with 100% eschar. The two smaller open wounds had beefy red wound beds. One of the small wounds was about 1 cm long by 1.5 cm wide and the other small wound was about 0.5 cm long by 0.5 cm wide. There was approximately 0.5 cm to 1 cm of intact skin between all of the wounds. When asked about the 3 distinct wounds, LPN #7 said the smaller open areas had become evident as the overall size of the pressure ulcer decreased in size.</p> <p>On 11/14/18 at 12:47 PM, the Bureau of Facility Standards received a 2 page fax (including a cover sheet) from the facility. The fax was a letter by the wound care provider from the wound clinic, dated 11/12/18. The Physician Assistant Certified (PA-C) stated "Based on the review of documentation before our initial visit on November 5th, it appears his pressure injury was more than a clear fluid-filled blister (stage two) and indeed included blood. In this case this [Resident #40's name] right heel presented as a more severe Deep Tissue Pressure Injury (DTPI), which represents a much deeper area of ischemia and tissue damage. DTPI's also have a high likelihood of evolving into an open wound,</p>	F 686			

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F 686	Continued From page 19 which in this case it has." The facility was aware Resident #40, who was admitted with uncontrolled pain and multiple areas of skin breakdown, including lesions, was at high risk of developing a pressure ulcer. He was harmed when the facility failed to implement interventions to minimize, reduce, or prevent pressure to his right heel, or to monitor his skin for potential breakdown and he developed a Stage II pressure ulcer to his right heel that had to be drained and was determined to be an unstageable DTPI according to the wound clinic.	F 686			
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 accordance with the facility assessment required at §483.70(e). §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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725		12/14/18	

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F 725	<p>Continued From page 20</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. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, resident representative interview, staff interview, review of Nurse Staff information, review of Shift Assignment sheets, review of Resident Council Minutes, review of facility grievances, policy review, and review of the Facility Assessment, it was determined the facility failed to ensure there was sufficient staffing to provide care and meet the needs of the residents. This was true for 12 of 21 residents (#4, #6, #10, #17, #19, #27, #34, #37, #38, #40, #53 and #63) who were reviewed for concerns related to staffing, 11 of 14 residents in the group interview and all other residents in the facility. This deficient practice created the potential for physical and psychosocial harm if residents did not receive appropriate care or the care was delayed. Findings include:</p> <p>The facility's staffing policy, effective October 2017, stated "To ensure staffing needs for direct care nursing are individualized based on the Center's specific population, and tools are utilized which take into account the resident's individual needs and rely on more than ranges and fixed staffing models, staff to resident ratios, or prescribed patient formulas." The policy also stated staff were to assess resident's individual needs through tools and staff interviews, and adjust deployment of staff based on resident acuity.</p>	F 725	<p>F725- Sufficient Nursing Staff</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Residents # 4,6,10,17,19,27,34,37,38,40,53,and 63 have been interviewed to ensure all care needs and services have been met. Resident #38 does have a scheduled 1:1 for each shift.</p> <p>How you will identify other resident who have the potential to be affected by the same deficient practice and what corrective action will be taken: Through the facility's resident advocate system, residents were interviewed and evaluated for appropriate call light response times and to ensure care needs and services have been met. Any negative findings were immediately corrected through facility's grievance/concern process.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Care needs/acuity were evaluated with additional staff hours added to enhance care delivery/services. The facility will continue with recruitment and retention</p>		

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F 725	<p>Continued From page 21</p> <p>The Facility Assessment, dated 3/27/18, directed staff:</p> <ul style="list-style-type: none"> * To ensure staffing needs were based on individualized needs. * To rely on more than ranges and fixed staffing models, staff to resident ratios, or prescribed patient formulas. * To review acuity based staffing levels and to adjust accordingly. <p>a. Resident Council Meeting minutes, dated 8/7/18, documented concerns of lack of staff on the weekends and in the evening during the week.</p> <p>Resident Council Meeting minutes and grievance reports for Resident #6, Resident #19, and Resident #63, dated 10/2/18, documented concerns of long call light response times due to lack of staff, residents had trouble finding a staff member at the nurse's station who could help them, staff ignored call lights, and restorative aides were pulled from their assigned duties to work the floor. The grievances documented the staff were educated to answer call lights as quickly as possible, be available to residents, and to pay more attention to residents who tried to get their attention.</p> <p>Grievances for Resident #10, dated 10/5/18 and 10/11/18, documented concerns of long call light response times and not enough staff. A call light audit attached to the grievance for Resident #10, documented the average wait time was six minutes, with one 30 minute wait time on the evening shift of 10/17/18.</p>	F 725	<p>measures to promote hiring and retaining of staff. Cornerstone Health Care's internal float pool will be used as needed to supplement staff.</p> <p>The retention and recruitment efforts will be discussed in resident council monthly.</p> <p>How the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained:</p> <p>Staffing levels will be reviewed daily for staffing needs and/or changes Monday-Friday x 4 weeks then weekly x 8 weeks by DON. Random resident interviews will be conducted daily Monday-Friday x 12 weeks by assigned care advocates to ensure needs of residents are met. Audits will be reviewed through QAPI monthly x 3 for further corrective actions and opportunities</p> <p>DON is responsible for compliance</p>		

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F 725	<p>Continued From page 22</p> <p>Resident Council Meeting minutes, dated 10/16/18, documented concerns restorative aides were repeatedly pulled to work on the floor.</p> <p>Resident Council Meeting minutes, dated 11/6/18, documented concerns with staff not answering call lights.</p> <p>b. Resident #38 was admitted to the facility on 6/30/16, with multiple diagnoses including squamous cell carcinoma (cancer), benign prostatic hyperplasia (enlarged prostate), osteoarthritis, and incontinence.</p> <p>I&A reports documented Resident #38 had 6 unwitnessed falls between 8/18/18 and 10/11/18.</p> <p>Resident #38's care plan documented he was at risk for falls and injury. The care plan, revised on 10/12/18, included the intervention for 1:1 supervision when he was awake and asleep.</p> <p>Resident #38's Progress Notes documented he was not provided 1:1 supervision as documented in his care plan. Examples include:</p> <p>* 10/15/18 at 9:24 AM - "...Staff providing 1:1 and when 1:1 not available resident at nursing station where he can be seen at all times..."</p> <p>* 10/24/18 at 11:06 AM - "Resident remains on 1:1 for his safety...spoke with...VA [Veteran's Administration], inquiring about extra help with 1:1...VA does not provide or pay for extra assistance in this matter. Facility to continue to ensure his safety and provide 1:1 care as needed..."</p>	F 725			

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F 725	<p>Continued From page 23</p> <p>* 10/29/18 at 2:03 AM - "Resident remains 1:1 with staff. Had to wheel resident's bed out by nurses [sic] station to provide visual supervision related to not having a 1:1 available..."</p> <p>Facility Shift Assignment sheets and the October 2018 Nursing Schedule documented Resident #38 was not provided 1:1 supervision due to lack of staff. Examples include:</p> <p>* A Hospitality Aide (HA) #1 did not show up for work for the night shift on 10/28/18. HA #1 was assigned to Resident #38 as his 1:1 staff for the night. The remaining night shift staff consisted of 2 nurses and 2 CNAs for 69 residents.</p> <p>* On 10/29/18, HA #1 did not show up for the night shift. HA #1 was assigned to Resident #38 as his 1:1 staff for the night. The remaining night shift staff consisted of 2 nurses and 2 CNAs for 68 residents.</p> <p>* On 10/31/18, HA #1 did not show up for the night shift. HA #1 was assigned to Resident #38 as his 1:1 staff for the night. The remaining night shift staff consisted of 2 nurses and 2 CNAs for 70 residents.</p> <p>* I&A reports documented that Resident #38 had two unwitnessed falls; on the nightshift, 9/26/18 at 1:00 AM and 10/1/18 at 4:01 AM and 1 unwitnessed fall on the evening shift 9/26/18 at 5:30 PM.</p> <p>c. Resident #53 was admitted to the facility on 10/18/17, with multiple diagnoses including vascular dementia and repeated falls. I&A reports documented that Resident #52 had one</p>	F 725			

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F 725	<p>Continued From page 24</p> <p>unwitnessed falls during the night shift on 3/26/18 at 1:09AM and one unwitnessed fall on the evening shift 8/9/18 at 11:02 PM.</p> <p>c. On 11/6/18 at 10:45 PM, the posted Daily Nurse staffing form documented 2 nurses and 3 CNAs were scheduled for 73 residents in 3 different halls. During that time, 2 nurses and 2 CNAs were observed to be available for the residents while a third CNA was the 1:1 staff for Resident #38. The facility's Shift Assignment sheet for the night shift of 11/6/18, documented 2 nurses and 3 CNAs were scheduled.</p> <p>d. Residents and their family members stated during interviews there were not enough staff at the facility to meet their care needs. Examples include:</p> <p>On 11/6/18 at 9:40 AM, Resident #37 said there was not always enough CNA staff to turn him every 2 hours while he was in bed and he was not provided range of motion exercises the previous day because the restorative aide was pulled to work the floor. He said it normally took about 20 minutes for his call light to be answered.</p> <p>On 11/6/18 at 10:25 AM, Resident #10 said there were not enough CNAs or nurses and it took anywhere from 10 minutes to an hour to have his call light answered, even though he had filed grievances about these issues. He said he was not provided range of motion exercises the previous day because the restorative aide was pulled to work the floor.</p> <p>On 11/6/18 at 10:32 AM, Resident #4 stated she</p>	F 725			

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F 725	<p>Continued From page 25</p> <p>sometimes waited up to an hour for help and it could happen any time.</p> <p>On 11/6/18 at 11:12 AM, Resident #63 said the facility needed more help, especially for residents who require transfers using mechanical equipment. He said sometimes he waited a long time because two people were needed to transfer him. He added there was a communication problem and staff did not tell each other "stuff."</p> <p>On 11/6/18 at 11:22 AM, Resident #40 said the facility needed more help.</p> <p>On 11/6/18 at 1:15 PM, Resident #27's family member said there was a lack of consistent staff in the facility. She said she had seen Resident #27's catheter bag stay full of urine several times because they were short staffed and the staff working were too busy to empty it.</p> <p>On 11/6/18 at 11:22 AM, a family member said Resident #34's clothing, bedding, and wheelchair were often wet with urine because there were not enough staff to care for all of the residents.</p> <p>On 11/7/18 at 10:00 AM, Resident #17's spouse said there were always issues with staffing and frequently Resident #17 had to wait a long time for help, especially when only 1 CNA was on the hall during mealtimes. The spouse said the night shift was the worst and there was almost never enough help on the night shift. The spouse said a couple days ago at about 8:00 AM, when the day shift staff provided care to Resident #17 they found a large urine stain on the sheet because the night shift had changed his incontinence brief but not his sheet.</p>	F 725			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 725	<p>Continued From page 26</p> <p>On 11/7/18 at 3:18 PM, during the Resident Group Interview, 11 of 14 residents said there were not enough CNAs, they felt rushed when the staff provided care, and sometimes it took too long for the call lights to be answered.</p> <p>e. Staff interviewed stated there were not enough staff to meet the needs and cares of the residents.</p> <p>On 11/6/18 at 10:45 PM, LPN #1 stated "99%" of the time there were not enough staff on all shifts, especially the night shift. LPN #1 said it was not a new issue and administration was aware of the problem.</p> <p>On 11/6/18 at 10:48 PM, CNA #1 said the facility was usually "pretty short staffed" which made it hard to take care of residents in a timely manner. CNA #1 said the staff are usually half an hour to an hour behind doing rounds. CNA #1 said she had talked to the AA several times about the staffing problem.</p> <p>On 11/6/18 at 10:50 PM, LPN #2 said the facility does not have enough staff. She said the IDON and AA have been told about the staff shortage on the evening and night shifts and they have told staff to work harder rather than adding more staff to the schedule. LPN #2 said the staff worked very hard to take care of the residents. LPN #2 said one of the residents required a 1:1 staff member and when staff called in sick the other residents' cares suffered. LPN #2 said she was concerned about resident safety due to the lack of supervision when residents who were</p>	F 725			

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F 725	<p>Continued From page 27 prone to falling experienced increased behaviors.</p> <p>On 11/6/18 at 10:55 PM, CNA #8 said 2 CNAs and 2 nurses during the night shift was not enough staff to take care of all the residents' needs. CNA #8 said the hardest part was trying to assist the residents who required 2 person assistance with the current staff levels. CNA #8 said she worked through her breaks in order to get everything done.</p> <p>On 11/6/18 at 11:05 PM, CNA #2 said night shift was always short staffed and the residents' cares were not always completed on time. CNA #2 said residents who needed to be turned or those who needed their incontinence brief checked every two hours were often completed late due to the lack of staff.</p> <p>On 11/6/18 at 11:10 PM, LPN #1 said about 2 weeks ago Resident #38 needed 1:1 staff but there were only 2 nurses and 2 CNAs scheduled. LPN #1 said she called administration and was told to move Resident #38 to the nurses' station. LPN #1 said the staff took turns "keeping an eye" on him while he was by the nurses' station. LPN #1 said the staff do the best they can but residents were probably not getting the care they needed.</p> <p>On 11/7/18 at 10:29 AM, CNA #3 said there was not enough staff, especially on night shift. CNA #3 said residents who needed to be turned every two hours were frequently delayed. She said sometimes when she started rounds right after shift change she found some residents in very soiled and wet incontinence briefs.</p>	F 725			

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F 725	<p>Continued From page 28</p> <p>On 11/7/18 at 12:48 PM, LPN #7 said when staff did not come to work it made it tough to meet the residents' needs, especially when no one else covered the shift.</p> <p>On 11/7/18 at 2:47 PM, Restorative Aide #1 said she was pulled to the floor on 11/5/18 because the facility was short staffed. She said other than eating exercises, no range of motion exercises were provided on 11/5/18.</p> <p>On 11/7/18 at 4:56 PM, LPN #8 said there were not enough staff in the evenings.</p> <p>On 11/8/18 at 10:50 AM, CNA #3 said there was not enough staff, especially on the evening and night shift.</p> <p>On 11/8/18 at 10:57 AM, CNA #4 said there was not enough staff for the facility. CNA #4 said shower aides were often reassigned to work on the floor when they were short staffed.</p> <p>On 11/8/18 at 11:37 AM, RCM #1 said maintaining staffing levels was challenging. She said when staff called off, then other staff came in and sometimes the restorative aides were pulled to work the floor. RCM #1 said call light response times were longer when the facility was short on staff. She said night shift normally had 2 CNAs but 3 CNAs was better to meet the residents' needs.</p> <p>On 11/8/18 at 3:10 PM, CNA #6 said the facility was short staffed and after shift change she had "to play catch up" on the care not completed by the previous shift, which included changing residents' wet incontinence briefs. CNA #6 said</p>	F 725			

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F 725	<p>Continued From page 29</p> <p>she recently found Resident #34's brief soaked with urine.</p> <p>On 11/9/18 at 9:47 AM, the Staffing Coordinator (SC) said she tried to staff night shift with 3 CNAs, one for each hall, with additional staff when a resident required 1:1 coverage. She said if any shift was short or someone called off, then the AA was notified and an RCM came in to work. The SC said if an RCM was not available then a restorative aide or shower aide was pulled to cover the floor. She said the facility also used float pool staff when needed. She said the corporate office provided her with a Per Patient Day (PPD) number to complete the daily CNA staffing assignments. The SC said she used a formula given to her that was based on the number of residents in the facility to determine the number of CNAs she scheduled. She said she was not aware of individual residents' acuity levels or needs, other than when a resident required a 1:1 staff.</p> <p>On 11/9/18 at 11:06 AM, the IDON said the facility used an acuity tool based on resident needs to score their acuity level. He said the facility was staffed appropriately and when staff called off the charge nurse worked with the RCMs and the SC to find a replacement. The IDON said the shower aides were pulled to the floor when needed but they tried not to do that. He said the night shift staff were able to get all their work done because they helped one another.</p> <p>On 11/9/18 at 12:55 PM, the AA said the facility periodically used an acuity tool based on resident needs and it was completed by the floor staff.</p>	F 725			

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F 725	Continued From page 30 She said the last time the acuity tool was completed was about 2 months ago and she had shredded those results. The AA said the facility's PPD number and staffing level had not changed since November of 2017 and she felt there were enough staff to meet the residents' needs. She said if she needed to increase staff levels she let the COO know. The AA said the night shift could complete the work with 2 nurses and 2 CNAs, but 3 CNAs on the night shift was "nice." She said when call offs happened the facility tried not to pull the restorative aides to the floor. On 11/9/18 at 2:18 PM, the COO said the facility budget was based on resident acuity levels. He said the PPD was based on information sent from the facility to the corporate office then back to the facility's SC. The COO said the facility could request more staff, especially for 1:1 coverage. He said the facility had not requested extra staff lately, until the survey, and that additional staffing for 1:1 coverage was approved.	F 725			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 732		12/14/18	

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F 732	<p>Continued From page 31</p> <p>vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to post daily nurse staffing information. This deficient practice created the potential for minimal harm for 73 of 73 residents living in the facility, their family members, and/or visitors who wanted to know the facility's staffing levels. Findings include: The facility's daily nurse staffing policy, dated June 2018, directed staff to post the nurse staffing information in a visible area at the</p>	F 732	<p>F- 732- Posted Nurse Staffing Information</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: No affected residents identified. The staffing information was immediately posted.</p> <p>How you will identify other resident who have the potential to be affected by the</p>		

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F 732	Continued From page 32 beginning of each shift. On 11/5/18 at 10:30 AM, 12:13 PM, 2:04 PM, and 2:59 PM, the daily nurse staffing information was not found in the facility. On 11/5/18 at 2:59 PM, the AA said the daily nurse staffing information should have been posted on the wall next to the nurses' station and it was not. On 11/5/18 at 3:03 PM, the Staffing Coordinator said she did not know why the daily nurse staffing information was not posted.	F 732	same deficient practice and what corrective action will be taken: Residents residing at the facility have the potential to be affected by this deficient practice. Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Facility scheduler has been educated by the DON on daily posting requirements. How the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained: DON/designee will monitor that the daily staffing is posted 7 days a week x 4 weeks then monthly x 3.		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761	DON is responsible for compliance	12/14/18	

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F 761	<p>Continued From page 33 personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to securely store or dispose of controlled medications. This was true for 1 of 1 resident (Resident #24) whose medications were observed during inspection of 1 of 1 medication storage rooms. The failed practice created the potential for harm if the controlled medications were diverted. Findings include: The facility's policy Pharmacy Services and Procedures, dated 2013, directed staff to:</p> <ul style="list-style-type: none"> * Store Schedule II controlled substances in a separate compartment within the locked medication cart with a different key or access device. * Double lock controlled substances in a locked cabinet in a locked room or a double locked cabinet. * Waste controlled medications with two licensed nurses and document. This would also apply to unused doses wasted for any reason. * Return unused medication brought to the facility by residents or their representatives. The 	F 761	<p>F- 761 Label/Store Drugs and Biologicals</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #24's discontinued medications were immediately destroyed.</p> <p>How you will identify other resident who have the potential to be affected by the same deficient practice and what corrective action will be taken: Medication room was reviewed with no other unused medications, including unsecured controlled substances, brought in by families/residents noted.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Education was provided to licensed nurses on policy/procedure on storage of medications including timely return/destruction of medications brought in from home and ensuring controlled</p>		

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F 761	<p>Continued From page 34</p> <p>medication should be placed in a secured location until picked up or destroyed after 30 days.</p> <p>On 11/6/18 at 8:53 AM, the medication storage room was observed with RN #1 and RCM #2 present. A bucket with miscellaneous medications and supplies belonging to residents was found in an unlocked cupboard under the sink. RCM #2 said the medications were brought to the facility by the residents or their family members. She said the medications could not be stored in residents' rooms and the families had not taken the medications home yet.</p> <p>Among the medications found under the sink, in a sealed clear plastic bag, were eight bottles of medication belonging to Resident #24 who was admitted to the facility 3/7/18. One of the medication bottles for Resident #24 was labeled as Tramadol HCL 50 mg and 3 tablets were in the bottle. Tramadol is in a class of medications called opiate (narcotic) analgesics. The plastic bag was sealed, and the information regarding the medication was gathered by viewing through the sealed bag.</p> <p>On 11/6/18 at 9:18 AM, RCM #2 said the facility practice for the storage of controlled substances was all narcotics were brought in by the pharmacy and triple checks were conducted before the narcotics were placed in the medications carts. RCM #2 said she did not know how Resident #24's Tramadol ended up under the sink and she did not know how long it was stored there. She said the Tramadol for the facility was kept in the narcotic drawer in the medication cart. She said all nurses had keys to</p>	F 761	<p>substances are secured.</p> <p>How the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained: Medication room audits will be done daily by the Resident Care Manager (Registered Nurse) Monday through Friday x 12 weeks to ensure compliance.</p> <p>Findings will be reviewed at QAPI monthly x 3 for further educational opportunities.</p> <p>The DON/designee is responsible for compliance</p>		

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F 761	Continued From page 35 the medication storage room. The facility's Record of Product Destruction, dated 11/6/18 at 2:11 PM, documented the destruction of eight medications belonging to Resident #24, including three Tramadol. On 11/7/18 at 11:50 AM, the AA said typically when a resident brought medications from home the facility held the medications for them. She said the facility policy was to dispose of the medications after 30 days.	F 761			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, Resident Group interview, test tray evaluation, review of Resident Council Minutes, and staff interview, it was determined the facility failed to ensure palatable food was served. This affected 5 of 19 residents (#4, #10, #29, #53, and #57) who were reviewed for dietary concerns, 12 of 14 residents in a Resident Group interview. This failed practice created the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include:	F 804	F-804 Nutritive Value/Appear, Palatable/Prefer Temp What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #57 is no longer at the facility. How you will identify other resident who have the potential to be affected by the same deficient practice and what	12/14/18	

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F 804	<p>Continued From page 36</p> <p>The facility's Resident Council Minutes, dated 9/18/18, documented residents had concerns about the variety of the menu. Resident Council Minutes, dated 11/6/18, documented residents had concerns about the temperature of the food.</p> <p>On 11/5/18 at 10:27 AM and 12:40 PM, Resident #29 said the food served in the dining room was cold and the pork was tough that day.</p> <p>On 11/5/18 at 10:34 AM, Resident #4 said her food was sometimes cold when she got it and that could happen at all meal times.</p> <p>On 11/5/18 at 12:15 PM, Resident #57, who was eating in her room, said the food that day was better than normal but the taste of the food was not always very good.</p> <p>On 11/5/18 from 12:19 PM to 12:34 PM, 5 individual lunch plates were placed uncovered on a rolling cart in the kitchen and the cart was rolled to the dining room, which was adjacent to the kitchen, and served to residents.</p> <p>On 11/6/18 at 10:16 AM, Resident #10 said the food was horrible all of the time.</p> <p>On 11/6/18 at 10:48 AM, Resident #53 said the food was cold when asked about food temperature and palatability.</p> <p>On 11/7/18 from 12:08 PM to 12:13 PM, 5 individual lunch plates were covered with lids and placed on a rolling cart in the kitchen then the cart was rolled to the adjacent dining room where the meals were served to residents.</p>	F 804	<p>corrective action will be taken: Resident #4, 10, 29, and 53 were interviewed to ensure food served is palatable and at the right temperature.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Nutrition services staff were educated by dietary manager on following recipes, seasoning food to taste, as well as ensuring food temperature within acceptable range for each meal service before it has been served.</p> <p>Meals served to residents in the main dining room are covered to better preserve meal temperatures: The facility also holds a monthly "Food Committee" meeting between residents and the Dietary Manager to discuss any menu items served or any food concerns that residents may have.</p> <p>The facility has also implemented a Resident Meal Satisfaction survey to obtain feedback from residents on the meal quality. These surveys are conducted randomly with residents eating in the main dining room and for those residents eating meals in their rooms. The feedback is then used to address any quality concerns that may be identified.</p> <p>How the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained:</p>		

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F 804	<p>Continued From page 37</p> <p>On 11/7/18 at 12:40 PM, Resident #4 said the meal was better and it was warm.</p> <p>On 11/7/18 at 3:15 PM, during the Resident Group Interview, 12 of 14 residents said the food did not taste good and 10 of them said the food was cold. Five of the 14 residents said they had told staff before the food was cold but the food was not covered with a lid until 11/6/18.</p> <p>On 11/8/18 at 11:03 AM, Dietary Aide #1 said the food trays on the cart were not covered prior to 11/6/18.</p> <p>On 11/8/18 at 11:05 AM, Dietary Aide #2 said the food trays on the cart were not covered prior to 11/6/18.</p> <p>On 11/8/18 at 11:07 AM, the Certified Dietary Manager (CDM) said individual resident meals served in the dining room were served without lids to make the meal service more homelike. She said the facility started covering individual meals after the residents complained the food was cold and they suggested covering the plates during the 11/6/18 Resident Council meeting.</p> <p>On 11/9/18 at 8:33 AM, a breakfast meal test tray was evaluated by two surveyors and the CDM. The inner mound of the scrambled eggs had a temperature of 132-degrees Fahrenheit. The eggs were determined to be mushy, cool outside of the mound, and did not taste palatable. The CDM said the eggs were fresh liquid eggs. She said residents complained about cold food in the past and she thought it was addressed.</p> <p>On 11/9/18 at 9:04 AM, Cook #1 said the facility</p>	F 804	<p>Dietary manager continues to monitor tray line during meal service to ensure recipes are followed/ food is seasoned to taste and that food temperature is per standard.</p> <p>Dietary manager or designee to complete a quality validation test tray 2x a week on random meals x 8 weeks then weekly thereafter.</p> <p>RD will complete a quality validation test tray 2 x a month on random meals x 8 weeks then monthly thereafter.</p> <p>Results of audits will be reviewed at QAPI monthly x 3 for further educational/corrective opportunities.</p> <p>The Dietary Manager and Registered Dietitian will be responsible for compliance.</p>		

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F 804	Continued From page 38 used warming pellets under the plates in the past and she was not sure why they did not use them anymore.	F 804			
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, review of Resident Council Minutes, policy review, review of the facility assessment, and resident, residents' family, and staff interview, it was determined the Administration failed to ensure available resources were utilized in an effective manner. This was true for 73 of 73 residents living in the facility, including 19 of 19 residents (#3, #4, #5, #10, #16, #17, #21, #24, #25, #27, #28, #34, #37, #38, #40, #42, #53, #57, and #63) who were reviewed. This failure created the potential for harm if residents' cares and needs were not met. Findings include: The facility's staffing policy, effective October 2017, directed staff to adjust the assignment of staff based on resident acuity and draft a budget that includes input from direct care staff related to assignment workload and residents' needs. The Facility Assessment, dated 3/27/18, directed staff to ensure staffing needs were based on individualized needs and to review acuity based staffing levels and adjust accordingly.	F 835	F-835 Administration What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 3, 4, 5, 10, 16, 17, 24, 25, 27, 34, 37, 38, 40, 42, 53, and 63 were interviewed to ensure all care needs and services have been met. Resident #21, 28, and 57 are no longer at facility. How you will identify other resident who have the potential to be affected by the same deficient practice and what corrective action will be taken: Through the facility's resident advocate system, residents were interviewed and evaluated for appropriate call light response times and to ensure that care needs/services have been met, any negative findings were immediately corrected through facility's grievance/concern process.	12/14/18	

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F 835	<p>Continued From page 39</p> <p>The facility was previously cited at F725 on 2/26/18, during a complaint investigation survey related to staffing concerns.</p> <p>a. Resident Council Meeting minutes dated 8/7/18, 10/2/18, 10/5/18, 10/11/18, 10/16/18, and 11/6/18 documented concerns of not enough staff and call lights not being answered in a timely manner. Examples include:</p> <ul style="list-style-type: none"> - On 8/7/18, under Departmental Issues for Nursing, the minutes documented staffing was an issue and there were not enough staff working the weekends. - On 10/2/18, under Departmental Issues for Nursing, the minutes documented call lights were "worse" and there was not enough staff. The minutes also documented residents were having trouble finding staff and restorative aides were being pulled from their assignment to work on the floor. - On 10/16/18, under New Discussion, the minutes documented restorative aides continued to be pulled from their assignments to work on the floor. - On 11/6/18, under New Discussion, the minutes documented residents had to make their own beds, they felt "rushed" and staff was not taking time with them. The minutes also documented aides were ignoring call lights and the call lights were not in reach. <p>b. Residents and their family members stated during interviews there were not enough staff at</p>	F 835	<p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Care needs/acuity were evaluated with additional staff hours added to enhance care delivery/services and ensure that the highest practicable physical, mental, and psychosocial well-being of each resident is maintained.</p> <p>The AA applied for and received an Administrator Designee agreement through the Idaho Bureau of Occupational Licenses. As a part of this agreement, an Idaho licensed administrator is acting as a consultant to the AA in accordance with this agreement and is available to assist AA when needed. The consultant administrator communicates regularly with the AA and visits the facility to assure that AA has the necessary support needed.</p> <p>How the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained: Random resident interviews will be conducted daily Monday-Friday x 12 weeks by assigned care advocates to ensure needs and services of residents are met.</p> <p>Staffing levels will be reviewed daily for additional needs/ changes Monday-Friday x 4 weeks then weekly x 8 by DON.</p> <p>The consultant administrator will be</p>		

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F 835	<p>Continued From page 40</p> <p>the facility to meet their care needs. Examples include:</p> <p>On 11/6/18 at 9:40 AM, Resident #37 said there was not always enough CNA staff to turn him every 2 hours while he was in bed and he was not provided range of motion exercises the previous day because the restorative aide was pulled to work the floor. He said it normally took about 20 minutes for his call light to be answered.</p> <p>On 11/6/18 at 10:25 AM, Resident #10 said there were not enough CNAs or nurses and it took anywhere from 10 minutes to an hour to have his call light answered, even though he had filed grievances about these issues. He said he was not provided range of motion exercises the previous day because the restorative aide was pulled to work the floor.</p> <p>On 11/6/18 at 10:32 AM, Resident #4 stated she sometimes waited up to an hour for help and it could happen any time.</p> <p>On 11/6/18 at 11:12 AM, Resident #63 said the facility needed more help, especially for residents who require transfers using mechanical equipment. He said sometimes he waited a long time because two people were needed to transfer him. He added there was a communication problem and staff did not tell each other "stuff."</p> <p>On 11/6/18 at 11:22 AM, Resident #40 said the facility needed more help.</p> <p>On 11/6/18 at 1:15 PM, Resident #27's family member said there was a lack of consistent staff</p>	F 835	responsible for compliance.		

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F 835	<p>Continued From page 41</p> <p>in the facility. She said she had seen Resident #27's catheter bag stay full of urine several times because they were short staffed and the staff working were too busy to empty it.</p> <p>On 11/6/18 at 11:22 AM, a family member said Resident #34's clothing, bedding, and wheelchair were often wet with urine because there were not enough staff to care for all of the residents.</p> <p>On 11/7/18 at 10:00 AM, Resident #17's spouse said there were always issues with staffing and frequently Resident #17 had to wait a long time for help, especially when only 1 CNA was on the hall during mealtimes. The spouse said the night shift was the worst and there was almost never enough help on the night shift. The spouse said a couple days ago at about 8:00 AM, when the day shift staff provided care to Resident #17 they found a large urine stain on the sheet because the night shift had changed his incontinence brief but not his sheet.</p> <p>On 11/7/18 at 3:18 PM, during the Resident Group Interview, 11 of 14 residents said there were not enough CNAs, they felt rushed when the staff provided care, and sometimes it took too long for the call lights to be answered.</p> <p>c. Staff interviewed stated there were not enough staff to meet the needs and cares of the residents and administration was aware of these problems. Examples include:</p> <p>On 11/6/18 at 10:45 PM, LPN #1 stated "99%" of the time there were not enough staff on all shifts, especially the night shift. LPN #1 said it was not a new issue and administration was aware of the</p>	F 835			

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

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F 835	<p>Continued From page 42 problem.</p> <p>On 11/6/18 at 10:48 PM, CNA #1 said the facility was usually "pretty short staffed" which made it hard to take care of residents in a timely manner. CNA #1 said the staff are usually half an hour to an hour behind doing rounds. CNA #1 said she had talked to the AA several times about the staffing problem.</p> <p>On 11/6/18 at 10:50 PM, LPN #2 said the facility does not have enough staff. She said the IDON and AA have been told about the staff shortage on the evening and night shifts and they have told staff to work harder rather than adding more staff to the schedule. LPN #2 said the staff worked very hard to take care of the residents. LPN #2 said one of the residents required a 1:1 staff member and when staff called in sick the other residents' cares suffered.</p> <p>On 11/6/18 at 11:10 PM, LPN #1 said about 2 weeks ago Resident #38 needed 1:1 staff but there were only 2 nurses and 2 CNAs scheduled. LPN #1 said she called administration and was told to move Resident #38 to the nurses' station. LPN #1 said the staff took turns "keeping an eye" on him while he was by the nurses' station. LPN #1 said the staff do the best they can but residents were probably not getting the care they needed.</p> <p>On 11/8/18 at 11:37 AM, RCM #1 said maintaining staffing levels was challenging. She said when staff called off, then other staff came in and sometimes the restorative aides were pulled to work the floor. RCM #1 said call light response times were longer when the facility was short on</p>	F 835			

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F 835	<p>Continued From page 43</p> <p>staff. She said night shift normally had 2 CNAs but 3 CNAs was better to meet the residents' needs.</p> <p>Administration was aware of the concerns related to staffing levels from communication with residents and staff during the previous 4 month period. There was no documentation changes were made by Administration related to staffing levels to address these concerns.</p> <p>On 11/6/18 at 3:44 PM and 11/9/18 at 12:55 PM, the AA said she was not licensed or trained to be an Administrator. She said the facility periodically used an acuity tool based on resident needs, which was completed by the floor staff. She said the last time the acuity tool was completed was about 2 months ago and she had shredded those results. The AA said the facility's Per Patient Day (PPD) number and staffing level had not changed since November 2017, and she felt there was sufficient staff to meet the residents' needs. She said after the 2/26/18 complaint survey the facility did not add new staff but had shifted staff to hallways which needed more help. She said if she needed to increase staff levels then she let the COO know.</p> <p>On 11/9/18 at 9:47 AM, the Staffing Coordinator (SC) said she tried to staff night shift with 3 CNAs, one for each hall, with additional staff when a resident required 1:1 coverage. She said if any shift was short or someone called off, then the AA was notified and an RCM came in to work. The SC said if an RCM was not available then a restorative aide or shower aide was pulled to cover the floor. She said the facility also used float pool staff when needed. She said the</p>	F 835			

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F 835	Continued From page 44 corporate office provided her with a Per Patient Day (PPD) number to complete the daily CNA staffing assignments. The SC said she used a formula given to her that was based on the number of residents in the facility to determine the number of CNAs she scheduled. She said she was not aware of individual residents' acuity levels or needs, other than when a resident required a 1:1 staff. On 11/9/18 at 2:18 PM, the COO said the facility budget was based on the acuity levels of the residents. He said the PPD was based on information the facility sent to the corporate office and then they would send the PPD to the facility's Staffing Coordinator. The COO said the facility could request more staff, especially for 1:1 coverage but the facility had not requested extra staff lately, until the week of survey, and additional staff for a 1:1 coverage was approved.	F 835			
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: §483.80(a)(1) A system for preventing,	F 880		12/14/18	

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F 880	<p>Continued From page 45</p> <p>identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p>	F 880			

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F 880	<p>Continued From page 46</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure urinary catheter bags and catheter tubing were kept off the floor. This was true for 3 of 5 residents (#25, #27, #53, and #166) who were reviewed for urinary catheter use. This failure created the potential for more than minimal harm by exposing residents to the risk of infection and cross-contamination. Findings include:</p> <p>1. Resident #27 was admitted to the facility on 9/6/18, with multiple diagnoses including obstructive and reflux uropathy (urine flowing back towards the kidneys).</p> <p>Resident #27's physician order, dated 9/6/18, documented he had an indwelling catheter.</p> <p>On 11/5/18 from 1:10 PM to 1:22 PM, Resident #27 was in his wheelchair in the hallway outside his room. His catheter privacy bag and 4 inches of the catheter tubing were sitting on the floor. At 1:22 PM, CNA #7, accompanied by two Nursing</p>	F 880	<p>F-880 Infection Prevention &Control</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 25, 27, 53, and 166 have their catheter bags and tubing secured properly and are not touching the floor.</p> <p>How you will identify other resident who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents with urinary catheters have been assessed, and have their urinary bags and tubing off the floor per infection control requirements.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Staff have been educated by the infection control specialist on infection control</p>		

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F 880	<p>Continued From page 47</p> <p>Assistant students, asked him if he wanted to lay down. He said he did not. At 1:27 PM, RN #2 and Nursing Assistant Instructor #1 assisted Resident #27 into his room and repositioned him in his wheelchair, then brought him back into the hallway where his spouse took him to an activity. The catheter privacy bag and tubing were continuously touching the floor while he was in his wheelchair.</p> <p>On 11/5/18 at 1:53 PM, CNA #7 said she had not noticed anything unusual about Resident #27's catheter.</p> <p>On 11/5/18 at 1:55 PM, Nursing Assistant Instructor #1 said she saw Resident #27's catheter tubing was connected but she had not noticed anything unusual.</p> <p>On 11/5/18 at 1:58 PM, RN #2 said she had not noticed the position of the urinary privacy bag or tubing. At 1:59 PM, RN #2 viewed the catheter privacy bag and tubing and said it was on the floor. RN #2 said the bag and tubing should not be on the floor.</p> <p>2. Resident #25 was readmitted to the facility on 2/12/18, with multiple diagnoses including neuromuscular dysfunction of the bladder.</p> <p>Resident #25's physician order, dated 6/28/18, documented he had a suprapubic indwelling catheter (a surgically created area to drain urine from the bladder).</p> <p>On 11/5/18 at 2:46 PM, Resident #25 was observed in his bed and his catheter bag was laying on the floor. He said it should not be on</p>	F 880	<p>policy and procedure including care of Foley bags and proper tubing placement.</p> <p>How the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained: Audits will be done by the infection control specialist to ensure Foley bag and tubing placement is correct 3 X a week X 12 weeks. Audits will be reviewed at QAPI for further corrective measures as indicated</p> <p>The DON/designee is responsible for compliance</p>		

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F 880	<p>Continued From page 48</p> <p>the floor and asked if someone could get it off the floor.</p> <p>On 11/5/18 at 2:47 PM, RCM #2 said the catheter bag was on the floor and it should not be on the floor.</p> <p>3. Resident #53 was admitted to the facility on 10/18/17, with multiple diagnoses including obstructive and reflux uropathy (urine flowing back towards the kidneys).</p> <p>His current physician orders and care plan included an indwelling urinary catheter for urinary retention related to obstructive uropathy.</p> <p>On 11/5/18 at 2:20 PM, Resident #53 was observed laying on his bed and his uncovered catheter bag was on the floor on the left side of his bed. LPN #6, was sitting by his roommate's bed and faced Resident #53's bed and the catheter bag on the floor. At 2:24 PM, LPN #6 asked Resident #53 if he was okay, but did not attempt to elevate his catheter bag or summon another staff to elevate the catheter bag.</p> <p>At 2:31 PM, CNA #5 entered Resident #53's room and squatted by his bed and talked with him. Resident #53 said he wanted to get up and said something about an appointment. CNA #5 told Resident #53 he would check to see if he was scheduled for an appointment. CNA #5 did not move Resident #53's catheter bag off the floor.</p> <p>At 2:36 PM, CNA #5 returned and explained to Resident #53 he was not scheduled for an appointment. CNA #5 did not move the catheter</p>	F 880			

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F 880	<p>Continued From page 49</p> <p>bag off the floor. At 2:39 PM, CNA #5 returned and explained to Resident #53 his wife may have scheduled an appointment and he assisted him with calling his wife. CNA #5 did not move the catheter bag off the floor.</p> <p>On 11/5/18 at 2:40 PM, CNA #5 returned to Resident #53's room and was asked about Resident #53's uncovered catheter bag on the floor, CNA #5 said he noticed the catheter bag was on the floor and he was going to get a privacy cover. LPN #6, who was still sitting by the roommate's bed, said she had not noticed Resident #53's urine collection bag on the floor. CNA #5 returned to Resident #53's room a minute later with a dense plastic type privacy bag and said it would keep his urine bag from direct contact with the floor.</p> <p>On 11/6/18 at 8:48 AM, Resident #53 was observed moving about the East hallway in his wheelchair and a section of his catheter tubing was in contact with the floor. At 8:50 AM, he went into his room and CNA #7 was sitting next to the roommate's bed. Resident #53 began to stand up from the wheelchair and CNA #7 left the roommate's bedside and went to help Resident #53. CNA #7 told Resident #53 she needed to get help and when he sat back in his wheelchair his catheter tubing was again in contact with the floor. While waiting for help, CNA #7 said the catheter tubing should not have been on the floor.</p> <p>4. Resident #166 was admitted to the facility on 10/31/18, with multiple diagnoses including urinary tract infection (UTI) and an indwelling urinary catheter.</p>	F 880			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 880	Continued From page 50 On 11/7/18 at 4:50 PM, Resident #166's catheter tubing was observed dragging on the floor under his wheelchair as he propelled himself in his room. On 11/07/18 at 4:57 PM, LPN #4 said the catheter tubing was on the floor and it should not have been on the floor.	F 880			

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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, LSW, Team Coordinator Linda Kelly, RN</p>	C 000		
C 105	<p>02.100,02 ADMINISTRATOR</p> <p>02. Administrator. The governing body, owner or partnership shall appoint a licensed nursing home administrator for each facility who shall be responsible and accountable for carrying out the policies determined by the governing body. In combined hospital and nursing home facilities, the administrator may serve both the hospital and nursing home provided he is currently licensed as a nursing home administrator. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an Administrator was appointed to the facility and responsible for facilitating the effective use of resources. This was true for 18 of 18 residents (#3, #4, #5, #10, #16, #17, #21, #24, #25, #27, #28, #34, #37, #38, #40, #42, #53, and #57) and 55 other residents who resided in the facility. This deficient practice created the potential for residents to not receive appropriate services and treatment in the facility. Findings include:</p> <p>The facility's list of key personnel documented the Acting Administrator (AA) was the acting in house Executive Director (Administrator).</p>	C 105	<p>C-105 Administrator</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident # 3, 4, 5, 10, 16, 17, 24, 25, 27, 34, 37, 38, 40, 42, 53, and 63 were interviewed to ensure appropriate services and treatments are received. Resident #21, 28, and 57 are no longer at facility.</p> <p>How you will identify other resident who have the potential to be affected by the same deficient practice and what</p>	12/14/18

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 12/07/18
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C 105	<p>Continued From page 1</p> <p>On 11/5/18 at 10:01 AM, and on 11/6/18 at 8:25 AM and 3:44 PM, the AA said she was not licensed or trained as an Administrator. She said the corporation's Chief Executive Officer (CEO) had told her an Administrator of a sister facility nearby was the Administrator of record for this facility and he was available by phone or he was able to come to the facility when she needed him there. The AA said the COO was also available by phone if she needed additional support. The AA said she had been the AA for a couple of weeks and she was under the impression she could be the AA until a new Administrator was hired. She said she had taken vacation time the week prior and had come in a few times to help the IDON.</p> <p>On 11/6/18 at 3:52 PM, the sister facility Administrator said he was not the Administrator of record for this facility but he was available for the AA when she had questions.</p> <p>On 11/9/18 at 2:06 PM, the COO said he was not the Administrator of record for this facility and he was not licensed in the state. He said the company had hired a new Administrator for this facility and the Administrator was possibly available to start working by mid November 2018.</p>	C 105	<p>corrective action will be taken: Residents have the potential to be affected by this deficient practice. The AA applied for and received an Administrator Designee agreement.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: The AA applied for and received an Administrator Designee agreement.</p> <p>How the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained: Cornerstone Health Care COO will continue to recruit for a permanent licensed nursing home Administrator until one is found.</p>	
C 762	<p>02.200,02,c,ii When Average Census 60-89 Residents</p> <p>ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) patients/residents a registered professional nurse shall be on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.)</p>	C 762		12/14/18

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C 762	<p>Continued From page 2</p> <p>and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift.</p> <p>This Rule is not met as evidenced by: Based on review of the nursing schedule and staff interview, it was determined the facility did not meet the State requirement for RN (Registered Nurse) coverage when the resident occupancy rate was between 60 and 89 residents. Inadequate RN coverage had the potential to negatively affect all residents living in the facility. Findings include:</p> <p>The three-week nursing schedule for 10/14/18 through 11/3/18 for RN coverage on the Day Shift (approximately 7:00 AM to 3:00 PM) and the Evening Shift (approximately 3:00 PM to 11:00 PM) documented the following:</p> <p>* 10/14/18 - An RN worked from 9:45 PM on 10/13/18 to 7:03 AM on 10/14/18. There was no RN coverage for the Day or Evening Shift hours. The resident census was 68.</p> <p>* 10/20/18 - An RN worked from 5:15 AM to 1:56 PM, 5:43 AM to 3:24 PM, and 10:00 PM to 6:23 AM. There was no RN coverage from 3:24 PM to 10:00 PM, 6 hours and 36 minutes. The resident census was 69.</p> <p>* 10/21/18 - An RN worked from 5:43 AM to 2:55 PM, and from 6:04 AM to 1:55 PM. There was no RN coverage for the Evening Shift hours. The resident census was 69.</p> <p>* 10/27/18 - An RN worked from 5:28 AM to 2:39 PM, and from 12:28 PM to 1:07 PM. There was</p>	C 762	<p>C-762 When Average census 60-89 Residents:</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: There were no affected residents named.</p> <p>How you will identify other resident who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents have the potential to be affected by this deficient practice.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Facility will continue to recruit for registered nurses through online postings on INDEED, local newspaper, and corporate recruiter.</p> <p>Staffing coordinator was educated on State RN coverage requirements.</p> <p>The Director of Nursing (AA) and Interim Director of Nursing are available for after hours and weekend consults with licensed nursing staff.</p> <p>The facility will continue to utilize</p>	

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C 762	Continued From page 3 no RN coverage for the Evening Shift hours. The resident census was 69. On 11/9/18 at 9:47 AM, the Staffing Coordinator said there was no RN coverage on the above mentioned shifts. She said she was not aware of the RN coverage requirements.	C 762	corporate float pool to assist in meeting this RN staffing requirement. If the facility after making reasonable attempts to recruit and hire Registered Nurses is unsuccessful, the facility will then submit a waiver request to the State for a variance in this requirement. How the facility plans to monitor performance to ensure the corrective action are effective and compliance is sustained: Facility leadership will review daily census and staffing ongoing for appropriate RN coverage per state requirements. DON is responsible for compliance	



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
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P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

June 12, 2019

Joan Martellucci, Administrator
Ivy Court
2200 Ironwood Place
Coeur d'Alene, ID 83814-2610

Provider #: 135053

Dear Ms. Martellucci:

On **November 5, 2018** through **November 9, 2018**, an unannounced recertification and complaint survey was conducted at Ivy Court. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007866

ALLEGATION #1:

The facility neglected a resident.

FINDINGS #1:

The clinical records of 18 residents were reviewed. Facility policies and procedures, Grievance files, Resident Council minutes, Incident & Accident (I&A) reports, and investigations of allegations of Abuse and Neglect were also reviewed. Interviews were conducted with 5 individual residents and 14 residents in a Resident Group. Several staff were also interviewed, including 9 Certified Nursing Assistants, 8 nurses, 2 unit managers, a Hospitality Aide, the Staffing Coordinator, the Interim Director of Nursing, and the Acting Administrator. The staff were observed as they responded to residents needs and requests in general and when they provided direct care to seven individual residents.

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The residents' clinical records, Grievance files, Resident Council minutes, I&A reports, and investigations of allegations of Abuse and Neglect did not document issues regarding neglect.

Five individual residents and 14 residents in the Resident Group said they had not been neglected. They said the facility was understaffed but the staff who were there did all they could under the circumstances. The facility staff said the same.

Based on the investigative findings, neglect was not identified and the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility did not provide the care and services necessary to prevent pressure ulcers.

FINDINGS #2:

The clinical records of 6 residents were reviewed for pressure ulcers. Grievance files, Resident Council minutes, Incident & Accident (I&A) reports, and investigations of allegations of Abuse and Neglect were also reviewed. Interviews were conducted with several individual residents and 14 residents in a Resident Group. Interviews were also conducted with 9 Certified Nursing Assistants (CNA), 8 nurses, 2 Unit Managers, the Interim Director of Nursing (IDON), the Acting Administrator. The staff were observed as they responded to residents needs and requests in general and when they provided direct care to seven individual residents.

One resident's clinical record documented an avoidable Stage II heel pressure ulcer developed and worsened while he was in the facility. His record contained documentation that preventative interventions were not implemented and his skin was not consistently monitored for potential breakdown.

Based on the investigative findings, the allegation was substantiated and deficient practice was cited at F606.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility did not adequately manage a resident's pain.

FINDINGS #3:

The clinical records of 7 residents were reviewed regarding pain. Grievance files, Resident Council minutes, Incident & Accident (I&A) reports, and investigations of allegations of Abuse and Neglect were also reviewed. Interviews were conducted with 5 individual residents and 14 residents in a Resident Group. Nine Certified Nursing Assistants, 8 nurses, 2 unit managers, and the Interim Director of Nursing were also interviewed. The staff were observed as they responded to residents needs and requests in general and when they provided direct care to seven individual residents.

The residents' clinical records contained documentation that the staff appropriately assessed, monitored, and intervened regarding their pain. Grievances, Resident Council minutes, I&A reports, and investigations of allegations of Abuse and Neglect did not document issues regarding unmanaged pain.

Five individual residents and 14 residents in the Resident Group said their pain was adequately managed.

Based on the investigative findings, the allegation was not substantiated as there was evidence the facility managed the residents' pain adequately.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility did not have adequate nursing staff on all shifts.

FINDINGS #4:

The clinical records of 18 residents were reviewed. Grievance files, Resident Council minutes, Incident & Accident (I&A) reports, investigations of allegations of Abuse and Neglect, and staffing records were also reviewed. Interviews were conducted with 5 individual residents and 14 residents in a Resident Group. Several staff were also interviewed, including 9 Certified Nursing Assistants (CNA), 8 nurses, 2 unit managers, a Hospitality Aide, the Staffing Coordinator, the Interim Director of Nursing, the Acting Administrator, and the Chief Operating Officer. The staff were observed as they responded to residents needs and requests in general and when they provided direct care to seven individual residents.

The Grievance files and Resident Council minutes documented issues regarding inadequate staffing. The staffing records documented the facility did not consistently provide staff for one-to-one supervision for 2 residents and the RN (Registered Nurse) coverage did not meet the State's minimum requirement.

Five individual residents and 11 of 14 residents in the Resident Group said the facility was frequently understaffed and the staff who were there had to work harder to meet their needs. Three family members said the same. Nine CNAs and 8 nurses said they were frequently understaffed.

Based on the investigative findings, the allegation was substantiated and the facility was cited for the deficient practice at F725.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

A resident had unplanned weight loss.

FINDINGS #5:

The clinical records of 4 residents were reviewed regarding their nutritional status. Grievances and Resident Council minutes were also reviewed. Two meal services were observed. Several residents and staff were interviewed.

One resident's clinical record documented she was malnourished when she was admitted to the facility and she was evaluated by a Registered Dietitian (RD) who closely monitored her nutritional status. Nutritional interventions included a regular diet, large protein portions, vitamins and probiotics, all of which were implemented. Her meal intake was 25% to 50% and she usually refused snacks. She developed gastrointestinal issues and lost 5 pounds, which was significant for her. Nutritional supplements were added, with her approval and acceptance. As her gastrointestinal problems improved, so did her nutritional status, and she regained 4.2 pounds.

There were no concerns about unplanned weight loss documented in Grievances or Resident Council minutes.

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During lunch meal service observations in the dining rooms and resident rooms on 11/5/18 and 11/7/18, the staff were attentive to the residents' needs and requests, and they provided assistance to the residents who needed assistance.

The residents said their food and drink choices were honored and they could request something different if they did not like what they were served. All of the residents denied unplanned weight loss. The staff said they had enough staff to serve and pass meal trays and they tried to be attendant to the residents' needs and requests.

Based on the investigative findings, the facility appropriately assessed and monitored residents' nutritional status and the allegation was not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The facility did not provide the necessary care and services to maintain residents' functional abilities.

FINDINGS #6:

The clinical records of 8 residents were reviewed for activities of daily living (ADL). Incident and Accident (I&A) reports, Grievances, and Resident Council minutes were also reviewed. Several staff were observed as they provided direct care, including ADL assistance, for 5 residents. Interviews were conducted with several residents, several Certified Nursing Assistants, 2 Unit Managers, and the Acting Administrator.

One resident's clinical record documented she had lived in the facility for over 6 months and she required extensive assistance with personal hygiene. There was no documented evidence her fingernails and toenails were being trimmed. Eight of her toenails were observed to be much longer than the other 2 toenails. She said her toenails were long and needed to be trimmed but she could no longer do it. Two Certified Nursing Assistants said they did not know who trimmed her toenails. One of Unit Managers said her toenails were long and needed to be trimmed, the Unit Manager trimmed her toenails.

Based on the investigative findings, the allegation was substantiated and the facility was cited for the deficient practice at F677.

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CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,

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

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj