



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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December 6, 2018

Gerald Bosen, Administrator  
Life Care Center of Treasure Valley  
502 North Kimball Place  
Boise, ID 83704-0608

Provider #: 135123

Dear Mr. Bosen:

On **November 9, 2018**, a survey was conducted at Life Care Center of Treasure Valley 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal 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) and on or before the "Opportunity to Correct." **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 17, 2018**. Failure to submit an acceptable PoC by **December 17, 2018**, may result in the imposition of penalties by **January 8, 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 24, 2018 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **February 7, 2019**. A change in the seriousness of the deficiencies on **December 24, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **February 9, 2019** includes the following:

Denial of payment for new admissions effective **February 9, 2019**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 9, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, 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>

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

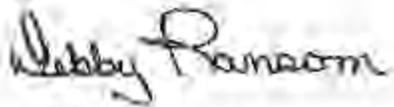
- BFS Letters (06/30/11)

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

This request must be received by **December 17, 2018**. If your request for informal dispute resolution is received after **December 17, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

DR/lj

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

PRINTED: 01/25/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/09/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF TREASURE VALLEY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>502 NORTH KIMBALL PLACE BOISE, ID 83704</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from November 5, 2018 to November 9, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Cecilia Stockdill, RN Kathi Davis, RN Susette Mace, RN</p> <p>Abbreviations include:</p> <p>CNA = Certified Nursing Assistant DNR = Do not resucitate DON = Director of Nursing LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set Mg = milligrams POST = Physician Orders for Scope of Treatment RN = Registered Nurse TAR = Treatment Administration Record UMA = Unit Manager for Station A UMD = Unit Manager Station D</p>	F 000			
F 550 SS=D	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p>	F 550		12/24/18	

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

TITLE

(X6) DATE

Electronically Signed

12/17/2018

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

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F 550	Continued From page 1  §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.  §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.  §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and resident and staff interviews, it was determined the facility failed to ensure an environment was	F 550	This Plan of Correction required under Federal and State Regulations and statutes applicable to		

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F 550	<p>Continued From page 2</p> <p>maintained that enhanced a resident's dignity and respect when staff placed a clothing protector on a resident without the resident's permission. This was true for 1 of 8 residents (#21) observed in the Ponderosa dining room. This failed practice created the potential for psychosocial harm if a resident experienced embarrassment or a lack of self-esteem due to being observed wearing a clothing protector. Findings include:</p> <p>The facility's policy and procedure for dignity, last revised 6/17/08, documented the following:</p> <p>* "All residents are treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality." * "Social Services staff promote staff interactions with residents to maintain their dignity, including promoting resident's independence and dignity in dining."</p> <p>Resident #21 was admitted to the facility on 8/8/17 with multiple diagnoses, including unspecified dementia without behavioral disturbance.</p> <p>On 11/7/18 at 12:02 PM, Resident #21 was sitting at a dining table in the Ponderosa dining room. LPN #2 placed a clothing protector on Resident #21 without asking her if she would like to wear one.</p> <p>On 11/7/18 at 12:07 PM, Resident #21 said she did not like to wear a clothing protector and wished she did not have to.</p>	F 550	<p>long-term care providers. This Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</p> <p>F 550</p> <p>Corrective Action: Resident #21 will be offered a clothing protector at each meal before staff will put one on her and only if she says yes to wanting one. At times she does want one and at other times she does not.</p> <p>Identification: All residents that eat their meals in the facility's Dining Rooms are identified as potentially being affected by this deficiency. All residents will be offered a clothing protector before and say they want one before staff will put one on.</p> <p>Systemic Changes: 1. Education to be provided to all staff regarding the facility policy and procedure</p>		

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F 550	Continued From page 3 On 11/7/18 at 12:11 PM, CNA #2 said staff were to ask residents first before applying a clothing protector, and if the resident refused, one would not be placed on the resident.  On 11/7/18 at 12:12 PM, LPN #2 said staff usually ask the resident first before applying a clothing protector, and if the resident said no then she would not apply it. LPN #2 said she applied Resident #21's clothing protector and she did not ask her first.  On 11/9/18 at 8:11 AM, the DON said staff offered a clothing protector, and if a resident wanted one then they would get one. The DON said staff were expected to ask the resident if a clothing protector was wanted, and if so, place one on the resident.	F 550	concerning placement and use of clothing protectors. 2. Education provided to all Staff regarding that residents may choose to not wear clothing protectors and staff must ask before placing a clothing protector.  Monitor: 1. ED or Designee to audit 10 random residents during meal service in the dining room to ensure compliance. 2. Audits to be conducted at the following frequencies: a. Weekly for four (4) weeks b. Monthly for three (3) months 3. Findings to be reviewed and reported to QA Committee  Completion Date: 12/24/2018		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		12/24/18	

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F 578	Continued From page 4 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and family and staff interview, it was determined the facility failed to ensure residents received information and assistance to exercise their right to formulate an Advance Directive, and if one was developed, the facility requested a copy for the resident's record and care planning. This was true for 4 of 19 residents (#56, #65, #77, and #87) reviewed for advance directives. The deficient practice created the potential for harm should residents' wishes regarding end of life or emergent care not be honored when they are	F 578	F 578  Corrective Action: 1. Resident #77 was discharged. 2. Residents #65, #87, #56 and / or family representatives have received education regarding advanced directives.  Identification: 1. A facility-wide audit will be conducted of all residents for advanced directives and / or documentation of education		

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F 578	<p>Continued From page 5 incapacitated. Findings include:</p> <p>The facility's policy for Advanced Directives, revised in February 2018, documented the following:</p> <p>* An Advance Directive is defined as a written instruction regarding care and treatment, such as a living will (a document that specifies a resident's preferences about measures used to sustain life) or a durable power of attorney for health care, recognized under state law in relation to the provision of such care when the resident is incapacitated.</p> <p>* Each time the resident is admitted to the facility, quarterly, after a significant change, and as needed, Social Services should review the Advance Directive information for accuracy with the resident or representative, and document these findings in the progress notes.</p> <p>* Each quarter the care plan team reviews with the resident his or her Advance Directives to ensure that they are still the wishes of the resident.</p> <p>* If the resident is discharged from and readmitted to the facility, the Do Not Resuscitate (DNR) [code] status must be reviewed to determine if it is still appropriate and desired by all parties involved. A new order for DNR is obtained at that time."</p> <p>The Centers for Medicare/Medicaid Services State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, Revision 173, dated 11/22/17, defines</p>	F 578	<p>provided regarding advanced directives.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> <li>1. Education provided to staff regarding resident's right to formulate advanced directives.</li> <li>2. Admission staff educated regarding requesting a copy of an advanced directive, upon admission, from the resident and/or resident's responsible party. Education also to include discussing information regarding advanced directives with the resident and/or responsible party. If family desires further help or education the family will be referred to our Social Services staff.</li> <li>3. At Resident Care Plan Conference, IDT will review current advanced directive if a copy has already been provided to the facility. If the facility does not have a copy of the resident's advanced directive, the IDT will inquire of the resident / responsible party for a copy of such to include in the resident record if one exists. If the resident / responsible party does not have an advanced directive, education will be provided regarding advanced directives, and documentation will be made in the resident record regarding the education provided and that the resident did not have an advanced directive at that time.</li> <li>4. Advanced Directive tab in the hard copy of Resident Record will include Advanced Directive (if initiated) and the POST.</li> </ol>		

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F 578	<p>Continued From page 6</p> <p>an "Advance directive" as "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." It also states "Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form" is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an Advance Directive.</p> <p>1. Resident #65 was admitted to the facility on 8/7/18 with multiple diagnoses, including Parkinson's Disease.</p> <p>Resident #65's admission MDS assessment, dated 8/14/18, documented he was cognitively impaired.</p> <p>An undated Resident Admission Agreement Acknowledgement requested information as to whether Resident #65 had executed an Advance Directive or would like information to complete advance directives prior to admission. A response by Resident #65 was not documented.</p> <p>Resident #65's completed Physician's Order for Scope of Treatment (POST/POLST) was signed by his daughter on 8/13/18 and by the physician on 8/13/18. The POST was found under the Advance Directive tab in his chart. The POST documented Resident #65's code status was</p>	F 578	<p>Monitor:</p> <ol style="list-style-type: none"> <li>1. DNS or Designee to audit admission and Resident Care Conference documentation to ensure compliance.</li> <li>2. 5 random residents will be audited and audits to be conducted at the following frequencies: <ol style="list-style-type: none"> <li>a. Weekly for four (4) weeks</li> <li>b. Monthly for three (3) months</li> </ol> </li> <li>3. Findings to be reviewed by Administrator and reported to QA Committee</li> </ol> <p>Completion Date: 12/24/2018</p>		

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F 578	<p>Continued From page 7</p> <p>DNR, provide comfort measures only, and he chose not to have a feeding tube, IV fluids, or blood products. Resident #65 chose to have antibiotics as needed.</p> <p>On 11/6/18 at 12:45 PM, Resident #65's daughter and Power of Attorney, stated he had completed a Living Will. Resident #65's daughter stated the facility had not requested a copy of the Living Will.</p> <p>On 11/7/18 at 11:25 AM, the Director of Admissions reviewed Resident #65's Admission Agreement Acknowledgement. She stated the question as to whether Resident #65 had executed an Advance Directive or would like information to complete advance directives prior to admission, should have been marked "no" as an Advance Directive was not executed.</p> <p>2. Resident #87 was admitted to the facility on 7/17/18 with multiple diagnoses including a cerebral infarct (stroke.)</p> <p>Resident #87's quarterly MDS assessment, dated 10/17/18, documented she was cognitively impaired.</p> <p>An undated Resident Admission Agreement Acknowledgement documented that prior to admission, Resident #87 had executed an Advance Directive.</p> <p>Resident #87's completed POST was signed by her husband on 7/7/18 and by the physician on 7/9/18. The POST was found under the Advance Directive tab in her record. The POST documented Resident #87's code status was</p>	F 578			

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F 578	<p>Continued From page 8</p> <p>DNR, provide comfort measures only, and she chose to have a feeding tube, IV fluids, and blood products as needed. Resident #87 chose not to receive antibiotics.</p> <p>On 11/5/18 at 3:50 PM, Resident #87's husband stated Resident #87 did not have Advance Directives. He stated the facility did not ask if Resident #87 had an Advance Directive and did not offer help to complete one. When informed Resident #87's record documented "prior to admission, I have executed an Advance Directive" Resident #87's husband stated perhaps by him telling facility staff Resident #87's wishes, the staff thought she had formulated Advance Directive.</p> <p>On 11/7/18 at 11:25 AM, the Director of Admissions stated she was not sure why Resident #87's Admission Agreement Acknowledgement was not marked correctly.</p> <p>3. Resident #77 was admitted to the facility on 11/28/17 with multiple diagnoses which included jaw reconstruction for removal of abnormal tissue or growth.</p> <p>A quarterly MDS assessment, dated 8/6/18, documented Resident #77 was cognitively intact.</p> <p>Resident #77's medical record did not document evidence the facility had discussed or provided him with the information needed to formulate an Advance Directive.</p> <p>On 11/5/18 at 10:28 AM, Resident #77 stated he did not have a Living Will or other Advance Directive. Resident #77 stated he would like one</p>	F 578			

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

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F 578	<p>Continued From page 9 but was not sure how to go about getting one.</p> <p>On 11/8/18 at 10:10 AM, the Unit Manager for Unit A (UMA) produced an unsigned, undated document that indicated Resident #77 had a Living Will. UMA stated there was not a copy of a living will or other Advance Directive in Resident #77's record. UMA stated she could not find documentation Advance Directives had been discussed with Resident #77.</p> <p>4. Resident #56 was admitted to the facility on 6/14/18 with multiple diagnoses including acute respiratory failure with hypoxia (low oxygen levels).</p> <p>Resident #56's quarterly MDS assessment, dated 10/4/18, documented severe cognitive impairment.</p> <p>Resident #56's November 2018 physician orders documented a POST with a code status of DNR was ordered on 6/14/18.</p> <p>Resident #56's current care plan documented she had an Advance Directive with a code status of DNR and directed staff to honor her wishes per her POST.</p> <p>On 11/6/18 at 8:37 AM, Resident #56's clinical record documented a letter of guardianship/ conservatorship. There was no documentation of an Advance Directive, Living Will, or Power of Attorney.</p> <p>A Care Plan Conference Record, dated 9/27/18, did not document the Advance Directive status was addressed with Resident #56 or her</p>	F 578			

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F 578	Continued From page 10 representative.	F 578			
F 622 SS=D	<p>On 11/8/18 at 8:32 AM, the Licensed Social Worker (LSW) said Resident #56 had a guardian and was not able to complete an Advance Directive. The LSW said residents were asked on admission if they had an Advance Directive and it was reviewed quarterly. The care plan meeting note related to the 9/27/18 care conference did not address Advance Directives.</p> <p>Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)</p> <p>§483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements-</p> <ul style="list-style-type: none"> <li>(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- <ul style="list-style-type: none"> <li>(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;</li> <li>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</li> <li>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;</li> <li>(D) The health of individuals in the facility would otherwise be endangered;</li> <li>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a</li> </ul> </li> </ul>	F 622		12/24/18	

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F 622	<p>Continued From page 11</p> <p>resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c) (1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)</p>	F 622			

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F 622	<p>Continued From page 12</p> <p>(A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility policy review, and record review, it was determined the facility failed to ensure completed transfer information was provided to the receiving hospital for emergent transfers. This was true for 1 of 2 residents (Resident #17) reviewed for transfers. This deficient practice had the potential to cause harm if the resident was not treated appropriately or in a timely manner due to a lack of information. Findings include:</p> <p>The facility's policy and procedure for Transfers and Discharges, last revised 9/1/17, directed staff to complete the Resident Transfer Form, copy any part of the clinical record necessary to care for the resident, and send the original Resident Transfer Form and the parts of the clinical record</p>	F 622	<p>F 622</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> <li>Resident #17 is in the facility and we are following her plan of care.</li> <li>If resident #17 needs to go out to the hospital her Transfer/Discharge Form will be completed as directed by our policy.</li> </ol> <p>Identification: All residents who have to may have to discharge in an emergency or have a facility initiated discharge are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes:</p>		

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F 622	<p>Continued From page 13</p> <p>that were copied. The minimum information sent with the resident should include the following:</p> <ul style="list-style-type: none"> <li>* Face sheet</li> <li>* Medication List</li> <li>* Contact information of the healthcare provider responsible for the resident's care.</li> <li>* Resident representative information including contact information.</li> <li>* Advanced Directive information.</li> <li>* All special instructions or precautions for ongoing care.</li> <li>* Comprehensive care plan goals.</li> <li>* Any other information to make sure a safe and effective transfer of care related to meeting the resident's needs, which may include: Resident status, including baseline and current mental, behavioral, and functional status; reason for transfer, recent vital signs, diagnoses and allergies, medications, (to include the last time received), most recent pertinent labs and other diagnostic tests, recent immunizations, and resident's consent to share information.</li> </ul> <p>Resident #17 was re-admitted to the facility on 10/27/18 with multiple diagnoses including acute kidney failure and paroxysmal atrial fibrillation (irregular heart rhythm).</p> <p>Resident #17's annual MDS assessment, dated 10/12/18, documented severe cognitive impairment.</p> <p>Resident #17's Progress Notes documented the following:</p> <ul style="list-style-type: none"> <li>* 10/24/18 at 1:47 PM: 911 was called and transport was on the way. Two family members were called and messages left.</li> </ul>	F 622	<ol style="list-style-type: none"> <li>1. Education provided to nursing staff regarding filling out the Transfer/Discharge form completely including during an emergency transport.</li> </ol> <p>Monitor:</p> <ol style="list-style-type: none"> <li>1. DNS or Designee to audit Transfer/Discharge documentation to ensure compliance.</li> <li>2. Up to 5 residents who are discharged will have their Transfer/Discharge documentation audited and audits to be conducted at the following frequencies:             <ol style="list-style-type: none"> <li>a. Weekly for four (4) weeks</li> <li>b. Monthly for three (3) months</li> </ol> </li> <li>3. Findings to be reviewed by Administrator and reported to QA Committee</li> </ol> <p>Completion Date: 12/24/2018</p>		

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F 622	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>* 10/24/18 at 11:02 PM: Resident #17 was sent to a named hospital and was admitted to the hospital.</li> <li>* 10/25/18 at 6:32 AM: A late entry for 10/24/18 at 2:00 PM. The physician was called regarding Resident #17's condition, and orders were received to transport her to the hospital. Paramedics arrived at 2:15 PM.</li> <li>* 11/5/18 at 3:24 PM: Resident #17 complained of chest pain and difficulty breathing. The physician was notified and an order was received to send her to the hospital.</li> </ul> <p>On Resident #17's Transfer Summary, dated 10/24/18, the following areas were left blank:</p> <ul style="list-style-type: none"> <li>* The section for Family Notified of Transfer and Contact Name</li> <li>* The Transfer Vital Signs</li> <li>* Skin Conditions and Diet Regimen</li> </ul> <p>On Resident #17's Transfer Summary, dated 11/5/18, the following areas were left blank:</p> <ul style="list-style-type: none"> <li>* Does Medication Need to be Crushed?</li> <li>* Skin Conditions and Diet Regimen</li> <li>* The Activities of Daily Living section which included ambulation, transfer, bladder control, bowel control, bathing, dressing, feeding, sight, speech, and hearing.</li> <li>* The History section which included Medical History, Social History, and Family History.</li> </ul> <p>On 11/5/18 at 1:28 PM, Resident #17's family member said she was hospitalized during the previous month due to dehydration.</p> <p>On 11/7/18 at 11:12 AM, UMD said he was aware</p>	F 622			

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F 622	Continued From page 15 of Resident #17 being hospitalized during the previous month and being transferred to the hospital on 11/5/18.  On 11/7/18 at 11:30 AM, when asked to provide documentation of Resident #17's recent transfers to the hospital, UMD provided copies of the Transfer Summaries dated 10/24/18 at 1:58 PM and 11/5/18 at 3:11 PM. UMD said that was the documentation as it was completed at the time, along with copies from the clinical record as indicated on the Transfer Summaries.	F 622			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.  §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		12/24/18	

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F 623	<p>Continued From page 16</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for</p>	F 623			

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F 623	<p>Continued From page 17</p> <p>the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on a resident's family member interview and staff interview, facility policy review, and record review, it was determined the facility failed to ensure transfer notices were provided in writing to a resident and the local ombudsman. This was true for 2 of 2 residents (#11 and #17)</p>	F 623	<p>F 623</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> <li>1. Resident #11 has been discharged</li> <li>2. Resident #17 and/or her family will be provided a copy of the Notice of Resident</li> </ol>		

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F 623	<p>Continued From page 18</p> <p>reviewed for transfers and had the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's policy and procedure for Transfers and Discharges, last revised 9/1/17, documented the following:</p> <ul style="list-style-type: none"> <li>* Transfers and discharges will be handled appropriately to ensure proper notification and assistance to residents and families in accordance with federal and state-specific regulations.</li> <li>* The facility makes certain systems are carried out to provide written notification to residents and resident representatives prior to transfer. The written notification would be provided on the Notice of Discharge or Transfer form.</li> <li>* The written notification would include the following: <ul style="list-style-type: none"> <li>- The reason for the transfer and effective date.</li> <li>- Location of where the resident is being transferred or discharged.</li> <li>- A statement of the resident's appeal rights, including the name, address, and phone number of the entity who receives the request and information regarding how to obtain an appeal form and assistance with completing the form and submitting the appeal hearing request.</li> <li>- Name, address, and phone number of the Office of the State Long-Term Care Ombudsman</li> </ul> </li> </ul>	F 623	<p>Transfer or Discharge form upon any facility initiated discharge.</p> <p>3. Ombudsman will also be given a copy of the Notice of Resident Transfer or Discharge form upon any facility initiated discharges.</p> <p>Identification: All residents who have a facility initiated discharged including an emergency are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: 1. Nursing staff educated regarding using Notice Resident Transfer or Discharge form for all facility initiated discharges including emergency situations. 2. Nursing staff will fill out the Notice of Resident Transfer or Discharge form for all facility initiated discharges and provide the resident or family/responsible party with a copy. 3. Medical records will send a copy of the Notice of Resident Transfer or Discharge form to the state Ombudsman upon any facility initiated discharges.</p> <p>Monitor: 1. DNS or designee to conduct audit the documentation of any facility initiated discharges. 2. Audits to be conducted at the following frequencies: a. Weekly for four (4) weeks b. Monthly for three (3) months to 3. Findings to be reviewed by</p>		

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F 623	<p>Continued From page 19 and other individuals or agencies required by the state.</p> <ul style="list-style-type: none"> <li>- When applicable, the name, address, and phone number of the protection and advocacy agencies for individuals with intellectual and developmental disabilities, mental disorders, or other related disabilities would be provided.</li> <li>- A copy of the notice of transfer/discharge would be sent to the Office of the State Long-Term Care Ombudsman for all facility-initiated transfers or discharges.</li> <li>- When a resident is transferred on a temporary, emergent basis to an acute care facility, notice of the transfer may be provided to the resident and their representative as soon as practicable. Copies of emergency transfers must also be sent to the ombudsman and may be sent as soon as practicable, such as a list that is sent on a monthly basis.</li> <li>- Residents who are emergently sent to the hospital are considered facility-initiated transfers.</li> </ul> <p>1. Resident #17 was re-admitted to the facility on 10/27/18 with multiple diagnoses including acute kidney failure and paroxysmal atrial fibrillation (irregular heart rhythm).</p> <p>Resident #17's annual MDS assessment, dated 10/12/18, documented severe cognitive impairment.</p> <p>Resident #17's Progress Notes documented the following:</p>	F 623	<p>Administrator and reported to QA Committee</p> <p>Completion Date: 12/24/2018</p>		

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F 623	<p>Continued From page 20</p> <p>* 10/24/18 at 1:47 PM: 911 was called and transport was on the way. Two family members were called and messages left.</p> <p>* 10/24/18 at 11:02 PM: Resident #17 was sent to a named hospital and was admitted to the hospital.</p> <p>* 10/25/18 at 6:32 AM: A late entry for 10/24/18 at 2:00 PM. The physician was called regarding Resident #17's condition, and orders were received to transport her to the hospital. Paramedics arrived at 2:15 PM.</p> <p>On Resident #17's Transfer Summary, dated 10/24/18, the section for Family Notified of Transfer and Contact Name were left blank</p> <p>There was no documentation in Resident #17's clinical record that she or her representative were provided written notification of her transfer to the hospital on 10/24/18.</p> <p>On 11/5/18 at 1:28 PM, Resident #17's family member said Resident #17 was hospitalized during the previous month due to dehydration.</p> <p>On 11/7/18 at 11:12 AM, UMD said he was aware of Resident #17 being hospitalized during the previous month.</p> <p>On 11/7/18 at 11:30 AM, when asked to provide documentation of Resident #17's recent transfers to the hospital, UMD provided copies of the Transfer Summaries dated 10/24/18 at 1:58 PM and 11/5/18 at 3:11 PM. UMD said that was the documentation as it was completed at the time, along with copies from the clinical record as indicated on the Transfer Summaries.</p>	F 623			

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F 623	<p>Continued From page 21</p> <p>On 11/7/18 at 11:50 AM, when asked if facility staff notified the ombudsman of transfers to the hospital, UMD said it depended on the circumstance. When asked who would notify the ombudsman, UMD said he would go ask.</p> <p>On 11/7/18 at 3:58 PM, UMD said he was not aware the facility was to provide written notification of transfers to the resident, their representative, and the ombudsman. The LSW said Medical Records staff notified the ombudsman of discharges monthly, but she was not sure if notification of transfers was provided.</p> <p>On 11/7/18 at 4:02 PM, the Health Information Management (HIM) Director said she sent a copy of the facility's discharge list to the ombudsman at the end of every month. The HIM Director said the facility did not notify the ombudsman of transfers to the emergency room. The HIM Director provided a list of facility discharges dated October 2018 that was sent to the ombudsman. The list did not include residents who were transferred.</p> <p>On 11/7/18 at 4:21 PM, the DON said if a resident was transferred, the nurse notified the physician, resident's family, and the unit manager (UM), and the UM notified her and the Executive Director. The DON said the facility did not provide written notification of transfers, but notification was done by a phone call.</p> <p>2. Resident #11 was admitted to the facility on 12/11/11, and readmitted on 10/11/18, with multiple diagnoses which included aspiration pneumonia and paraplegia unspecified.</p>	F 623			

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F 623	Continued From page 22 A physician's order, dated 10/8/18, documented Resident #11's transfer to the hospital was for further work up and evaluation due to complaints of shortness of breath. There was no evidence of written notification to Resident #11 or her family of the transfer to the hospital.	F 623			
F 625 SS=D	On 11/9/18 at 8:17 AM, UMD stated written documentation was not provided to Resident #11 or her family regarding the transfer and admission to the hospital. Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing	F 625		12/24/18	

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F 625	<p>Continued From page 23</p> <p>facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interview, and policy review, it was determined the facility failed to ensure written notification of the facility's bed-hold agreements were provided to residents. This was true for 2 of 2 residents (#11 and #17) reviewed for transfers. The deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include:</p> <p>The facility's policy for bed hold/reservation of room, revised on 1/28/16, documented:</p> <p>* The facility will provide written information to the patient or patient representative regarding bed holds before the patient transfers to a hospital or the patient goes on therapeutic leave.</p> <p>* Bed hold policies will be provided and explained to the patient upon admission and explained to the patient before each temporary absence.</p> <p>* Before the patient transfers to a hospital or the patient goes on therapeutic leave, the facility will provide:</p> <ul style="list-style-type: none"> <li>- Written information to the patient or patient representative specifying the duration of the state bed-hold policy, if any, during which the patient is permitted to return and resume residence in the nursing facility.</li> <li>- The reserve bed payment policy in the state</li> </ul>	F 625	<p>F 625</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> <li>1. Resident #11 has been discharged.</li> <li>2. Resident #17 and/or family have been educated on the facility bed hold policy. If Resident #17 were to have a temporary discharge with the intent to return the bed hold policy would be given to them.</li> </ol> <p>Identification:</p> <p>All residents who discharge from the facility are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> <li>1. Education provided to Admissions staff, Social Services, and Licensed Nursing staff regarding the facility's bed hold policy.</li> <li>2. Upon any Resident discharge with the likelihood of return a written copy of the facility bed hold policy will be given to the Resident and/or Family.</li> <li>3. For emergency discharges the bed hold policy will be given to the resident and/or family within 24 hours of the discharge. Staff will document that the bed hold policy has been given to the resident and/or family in the resident's medical chart.</li> </ol>		

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F 625	<p>Continued From page 24 plan, if any.</p> <p>- The facility policies regarding bed-hold.</p> <p>* In cases of emergency transfer, notice at the time of transfer means the family, surrogate, or patient representative are provided with written notification within 24 hours of the transfer.</p> <p>1. Resident #11 was readmitted to the facility on 10/11/18 with multiple diagnoses including aspiration pneumonia and paraplegia.</p> <p>A physician's order, dated 10/8/18, directed staff to transfer Resident #11 to the hospital for further work up and evaluation due to complaints of shortness of breath. There was no documentation in Resident #11's medical record that written notification of the facility's bed-hold policy was provided to her or her family at the time of transfer or within 24 hours of the transfer to the hospital.</p> <p>On 11/9/18 at 8:17 AM, UMD stated a written notice of the facility's bed-hold policy was not provided to Resident #11 or her family at the time she transferred or within 24 hours of the emergency transfer.</p> <p>2. Resident #17 was readmitted to the facility on 10/27/18 with multiple diagnoses including acute kidney failure and paroxysmal atrial fibrillation (irregular heart rhythm).</p> <p>Resident #17's annual MDS assessment, dated 10/12/18, documented severe cognitive impairment.</p> <p>Resident #17's Transfer Summary, dated</p>	F 625	<p>Monitor:</p> <ol style="list-style-type: none"> <li>DNS or Designee to audit Transfer/Discharge documentation to ensure compliance.</li> <li>Up to 5 residents who are discharged will have their Transfer/Discharge documentation audited and audits to be conducted at the following frequencies: <ol style="list-style-type: none"> <li>Weekly for four (4) weeks</li> <li>Monthly for three (3) months</li> </ol> </li> <li>Findings to be reviewed by Administrator and reported to QA Committee</li> </ol> <p>Completion Date: 12/24/2018</p>		

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F 625	<p>Continued From page 25 10/24/18, documented the following:</p> <ul style="list-style-type: none"> <li>* She was transferred to a named hospital by ambulance on that day due to a change in condition and low blood pressure.</li> <li>* The section for Bed Hold Information Provided was blank.</li> </ul> <p>Resident #17's Transfer Summary, dated 11/5/18, documented the following:</p> <ul style="list-style-type: none"> <li>* She was transferred to a named hospital by ambulance on that day due to chest pain and decreased heart rate.</li> </ul> <p>On 11/7/18 at 11:12 AM, UMD said he was aware of Resident #17 being hospitalized during the previous month and being transferred to the hospital on 11/5/18.</p> <p>There was no documentation in Resident #17's record of a bed hold form being offered or signed.</p> <p>On 11/7/18 at 4:18 PM, the Business Office Manager said if a resident was being transported emergently the resident would not be awakened and asked to sign a bed hold form. The Business Office Manager said if a bed hold form was offered it would be documented in the nurses' notes.</p> <p>On 11/7/18 at 4:21 PM, the Executive Director said if a resident was being transferred out of the facility then a bed hold form was offered. The DON said if a resident was being transferred out of the facility, the nurses had been asked to offer a bed hold form. If the resident was admitted to</p>	F 625			

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F 625	Continued From page 26 the hospital, the facility would make a phone call to offer the bed hold form within 24 hours and document it in the nurse's note.	F 625			
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff and resident interviews, it was determined the facility failed to: a) provide supervision of medication administration to ensure a resident's medications were taken as ordered by the physician, b) ensure Prevalon boots (boots to protect skin) were in place as ordered by the physician, and c) ensure a dressing was in place as ordered by the physician. This was true for 2 of 19 residents (Residents #11 and #53) reviewed. This deficient practice had the potential for harm if residents did not receive medications ordered by the physician and if residents experienced a decline in skin condition due to lack of wearing Prevalon boots (a boot to protect skin) and protective dressings. Findings include:  1. Resident #53 was admitted to the facility on 10/14/17 with multiple diagnoses including Stage IV pressure ulcer of the left heel and Alzheimer's	F 684	F 684  Corrective Action: 1. Resident #53 and #11 have been discharged.  Identification: 1 Facility wide audit of residents with orders for Prevalon boots was completed and that they are being applied as ordered. 2 Education for all licensed nurses on supervision of medication administration completed.  Systemic Changes: 1. Education provided to LN staff regarding supervision of medication administration and properly caring for and using wound dressings. 2. Education provided to facility staff	12/24/18	

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F 684	<p>Continued From page 27</p> <p>disease. The National Pressure Ulcer Advisory Panel website, accessed on 12/4/18 describes a Stage IV pressure ulcer a full-thickness skin and tissue loss with exposed or directly palpable fascia (a thin sheath of fibrous tissue enclosing a muscle or other organ), muscle, tendon, ligament, cartilage or bone in the ulcer.</p> <p>Resident #53's quarterly MDS assessment, dated 10/11/18, documented the following:</p> <ul style="list-style-type: none"> <li>* Severe cognitive impairment.</li> <li>* Extensive assistance of 2 persons with bed mobility and dressing, functional limitation in range of motion in one upper extremity and one lower extremity.</li> <li>* Application of non-surgical dressings.</li> </ul> <p>Resident #53's November 2018 physician orders documented the following:</p> <ul style="list-style-type: none"> <li>* Place Prevalon boots on resident while in bed, remove and check integrity of skin each shift, ordered on 10/14/17.</li> <li>* Apply Allevyn dressing (a dressing to protect skin) to resident's left heel for weekly prevention and protection, ordered 1/8/18.</li> </ul> <p>Resident #53's current care plan directed staff to do the following:</p> <ul style="list-style-type: none"> <li>* Place Prevalon boots to legs per current physician's order.</li> <li>* Monitor left heel for skin breakdown each day.</li> </ul> <p>Resident #53's November 2018 TAR documented the following:</p>	F 684	<p>regarding use of Prevalon boots and proper use.</p> <p>Monitor:</p> <ol style="list-style-type: none"> <li>1. DNS or Designee to conduct audit of 5 random residents to observe if wound dressings are properly placed and if they have Prevalon boots that they are being used properly. DNS or Designee will also conduct a medication pass audit on 5 random residents to ensure medications are not left unsupervised with residents.</li> <li>2. Audits to be conducted at the following frequencies: <ol style="list-style-type: none"> <li>a. Weekly for four (4) weeks</li> <li>b. Monthly for three (3) months</li> </ol> </li> <li>3. Findings to be reviewed by Administrator and reported to QA Committee</li> </ol> <p>Completion Date: 12/24/2018</p>		

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F 684	<p>Continued From page 28</p> <p>* The Allevyn dressing was placed to the left heel on 11/3/18.</p> <p>* Prevalon boots while in bed were applied each day from 11/1/18-11/7/18.</p> <p>On 11/7/18 at 2:25 PM, Resident #53 was in bed with her feet on two pillows and non-skid socks were in place. The Prevalon boots were not in place and no dressing was in place to Resident #53's left heel. CNA #1 said Resident #53 wore boots in bed at night and her heels were floated sometimes. CNA #1 said it had been awhile since Resident #53 had a dressing on her heel and her heels were good. CNA #1 said Resident #53 had a wound on her heel and it was healed.</p> <p>On 11/7/18 at 2:43 PM, UMD said Resident #53 came to the facility with bad feet and she had a pressure ulcer.</p> <p>On 11/7/18 at 2:45 PM, UMD said Resident #53's Allevyn dressing could have come off during a transfer or some other activity, and it may have been there for protection. The UMD said he had looked at Resident #53's heels and they looked good, and he thought the order for the Allevyn dressing could be discontinued.</p> <p>On 11/7/18 at 2:50 PM, UMD said he would expect Resident #53's Prevalon boots to be on anytime she was in bed and staff needed re-education.</p> <p>On 11/7/18 at 2:56 PM, LPN #3 said she applied Resident #53's Allevyn dressing four days earlier.</p> <p>On 11/7/18 at 2:58 PM, UMD came out of Resident #53's room holding her Prevalon boot,</p>	F 684			

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F 684	Continued From page 29 and a dressing was stuck inside of the boot. UMD said he was going to apply the Prevalon boot for Resident #53.  2. The facility's policy for Medication Administration, revised 4/2/13, directed staff to remain with the resident to ensure medication was swallowed.  Resident #11's current physician orders documented she was to receive cranberry juice powder 425 milligram (mg) capsule twice daily for supplement, one Fish Oil 1,000 mg capsule by mouth daily, and ginger root 550 mg 2 tablets by mouth daily for supplement.  On 11/5/18 at 8:26 AM, Resident #11 was observed with a medication cup containing several pills in her right hand. Resident #11 stated, "The nurse left them with me. She gave me the important ones." The nurse was not in the room at the time of the observation. RN #2 walked into the room and stated she had left the medications with Resident #11. She also stated, "I am not supposed to leave any medications with the resident." RN #2 said the medications in the cup were two ginger root tablets, one cranberry pill, and one fish oil capsule.	F 684			
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii)  §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's	F 687		12/24/18	

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F 687	<p>Continued From page 30</p> <p>medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, facility policy review, and record review, it was determined the facility failed to ensure residents received proper treatment and care to maintain good foot health. This was true for 1 of 7 residents (#53) reviewed for foot care. This failed practice created the potential for harm should residents experience complications from their medical condition related to the lack of proper foot care. Findings include:</p> <p>The facility's policy and procedure for Foot Care, dated 8/28/18, documented the following:</p> <p>* The facility would make sure foot care was provided consistent with professional standards of practice and foot care would include treatment to prevent complications from conditions such as diabetes, peripheral vascular disease, and immobility.</p> <p>* The facility would make sure foot care included assisting residents to make needed appointments with healthcare providers such as podiatrists and arranging transportation to and from the appointments.</p> <p>Resident #53 was admitted to the facility on 10/14/17 with multiple diagnoses including Stage IV pressure ulcer of the left heel and Alzheimer's disease. The National Pressure Ulcer Advisory Panel website, accessed on 12/4/18, describes a</p>	F 687	<p>F 687</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> <li>1. Resident #53 has been reviewed by the facility and is currently receiving proper foot and nail care.</li> </ol> <p>Identification:</p> <p>All other residents have been reviewed to ensure they are receiving proper foot and nail care.</p> <p>Systemic Changes:</p> <ol style="list-style-type: none"> <li>1. Reeducated nursing staff on proper foot care including proper nail care.</li> <li>2. When appropriate resident will be referred to a Podiatrist.</li> </ol> <p>Monitor:</p> <ol style="list-style-type: none"> <li>1. DNS or designee to audit 5 random residents to monitor whether foot care including proper nail care is being completed to ensure compliance.</li> <li>2. Audits to be conducted at the following frequencies: <ol style="list-style-type: none"> <li>a. Weekly for four (4) weeks</li> <li>b. Monthly for three (3) months to</li> </ol> </li> <li>3. Findings to be reviewed and reported to QA Committee</li> </ol>		

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F 687	<p>Continued From page 31</p> <p>Stage IV pressure ulcer a full-thickness skin and tissue loss with exposed or directly palpable fascia (a thin sheath of fibrous tissue enclosing a muscle or other organ), muscle, tendon, ligament, cartilage or bone in the ulcer.</p> <p>Resident #53's quarterly MDS assessment, dated 10/11/18, documented the following:</p> <ul style="list-style-type: none"> <li>* Severe cognitive impairment.</li> <li>* Extensive assistance of 2 persons with bed mobility and dressing, and functional limitation in range of motion in one upper extremity and one lower extremity.</li> </ul> <p>Resident #53's current care plan directed nursing staff to provide Activities of Daily Living care to make sure the resident's daily needs were met.</p> <p>Resident #53's clinical record did not document foot care or toenail care.</p> <p>On 11/7/18 at 2:25 PM, Resident #53 was in bed with her feet on 2 pillows, and her toenails were long. CNA #1 said Resident #53 needed to go to the podiatrist if her toenails were too thick. CNA #1 said she tried to cut Resident #53's toenails a month ago, but she was able to trim only the small nails and could not trim her large nails. CNA #1 said she thought she told the nurse about Resident #53's toenails. CNA #1 said if she could trim a resident's toenails she would provide nail care once a week.</p> <p>On 11/7/18 at 2:43 PM, UMD said nail care depended on the resident, but his expectation would be residents' nails would be looked at least once a week, and if staff could not take care of</p>	F 687	Completion Date: 12/24/2018		

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

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F 687	Continued From page 32 them then a referral needed to be made.  On 11/7/18 at 2:56 PM, LPN #3 said she needed to notify hospice about Resident #53's toenails because her nails were hard to cut. There was nothing documented on the MAR/TAR about nail care being done, and the facility did not have a podiatry referral list.  On 11/7/18 at 4:25 PM, UMD said he looked at Resident #53's feet and did not see any need for a podiatry referral, and an order was never made for her to see a podiatrist. The UMD said the nurses should be able to take care of Resident #53's toenails.	F 687			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)  §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and  §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia,	F 693		12/24/18	

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F 693	<p>Continued From page 33</p> <p>diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and review of clinical records and facility policy, it was determined the facility failed to ensure adequate care and treatment was provided to 1 of 2 residents (Resident #38) reviewed for feeding tubes. This failure created the potential for harm if complications developed from improper feeding tube practices. Findings include:</p> <p>The facility's policy and procedure for Administering PO (oral) Medications through an Enteral Feeding Tube, dated 6/26/06, directed staff to rinse the feeding tube with 20-30 ml (milliliters) of warm water before giving medications in the tube and after giving the last medication.</p> <p>Resident #38 was re-admitted to the facility on 10/2/17 with multiple diagnoses including gastrointestinal hemorrhage and dysphagia (a swallowing disorder).</p> <p>Resident #38's 9/3/18 quarterly MDS assessment documented the following:</p> <ul style="list-style-type: none"> <li>* Severe cognitive impairment.</li> <li>* Feeding tube while a resident.</li> <li>* 501 cc (cubic centimeters) per day or more average fluid intake per day by IV (intravenous) or tube feeding.</li> </ul> <p>Resident #38's November 2018 physician orders documented the following:</p>	F 693	<p>F693</p> <p>Corrective Action: 1. Resident #38 is still in the facility and her enteral feeding orders per feeding tube are appropriate.</p> <p>Identification: All other residents with feeding tubes have been reviewed to maintain proper feeding tube care.</p> <p>Systemic Changes: 1. Reeducated nursing staff on facility procedures for proper use of feeding tube.</p> <p>Monitor: 1. DON or designee to audit 3 random residents with feeding tubes to monitor to ensure compliance. 2. Audits to be conducted at the following frequencies: a. Weekly for four (4) weeks b. Monthly for three (3) months to 3. Findings to be reviewed and reported to QA Committee</p> <p>Completion Date: 12/24/2018</p>		

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F 693	Continued From page 34 * Water bolus 300 cc per g-tube (feeding tube) four times daily, ordered on 10/24/17. * Flush feeding tube with 50 cc water before and after each medication pass and 300 ml of water between medications to equal 1200 ml four times daily, ordered on 10/25/17.  Resident #38's current care plan documented the following:  * Administer tube feeding formula and flushes as ordered * Water flushes per current physician order  Resident #38's MAR documented the feeding tube was flushed with water each day from 11/1/18 - 11/8/18.  On 11/6/18 at 7:47 AM, LPN #2 discontinued Resident #38's tube feeding solution and flushed the feeding tube with 50 cc of water by pushing the water through a syringe. LPN #2 said feeding tubes were flushed by whatever works for the patient, and Resident #38's feeding tube did not work by gravity very well.  On 11/8/18 at 8:37 AM, the UMD said water or medications through a g-tube should generally be given by gravity flow.  On 11/9/18 at 8:11 AM, the DON said water and medications should flow in by gravity into a g-tube.	F 693			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		12/24/18	

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F 695	<p>Continued From page 35</p> <p>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, facility policy review, and staff interviews, it was determined the facility failed to ensure staff changed residents' oxygen cannulas (tubing that delivers oxygen) and humidifier per physician orders and facility policy. This was true for 3 of 6 sample residents (#14, #17, and #38) reviewed for oxygen therapy. This failure created the potential for harm from respiratory infections due to the growth of pathogens (organisms that cause illness) in oxygen cannulas and humidifiers. Findings include:</p> <p>The facility's policy and procedure for Oxygen Administration/Safety/Storage/Maintenance, last revised 11/29/17, documented the following:</p> <ul style="list-style-type: none"> <li>* Change oxygen supplies every week and whenever visibly soiled.</li> <li>* Humidifier bottles should be dated and changed every 7 days, regardless of the water level.</li> <li>* Licensed healthcare providers and responsible to ensure that oxygen equipment/supplies are set up and cared for as documented in the policy.</li> </ul> <p>1. Resident #14 was re-admitted to the facility on 8/25/17 with multiple diagnoses including end stage renal (kidney) disease.</p>	F 695	<p>F 695</p> <p>Corrective Action:</p> <ol style="list-style-type: none"> <li>1. Resident #14 has been discharged.</li> <li>2. Resident #17 and #38 have had their oxygen orders reviewed and are appropriate. Their oxygen tubing and equipment is marked and up to date.</li> </ol> <p>Identification:</p> <p>All residents with orders for oxygen have had their oxygen tubing checked to make sure tubing and equipment is up to date.</p> <p>Systemic Changes:</p> <p>Nursing staff educated regarding oxygen tubing and equipment needing to be marked and up to date per oxygen policies.</p> <p>Monitor:</p> <ol style="list-style-type: none"> <li>1. DNS or Designee to conduct audit of 5 random residents with oxygen orders to ensure tubing and equipment is marked and up to date.</li> <li>2. Audits to be conducted at the following frequencies:             <ol style="list-style-type: none"> <li>a. Weekly for four (4) weeks</li> <li>b. Monthly for three (3) months</li> </ol> </li> </ol>		

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F 695	<p>Continued From page 36</p> <p>Resident #14's quarterly MDS assessment, dated 9/28/18, documented the following:</p> <ul style="list-style-type: none"> <li>* She was cognitively intact.</li> <li>* Shortness of breath or trouble breathing with exertion and when lying flat.</li> <li>* Oxygen therapy while a resident.</li> </ul> <p>Resident #14's November 2018 physician orders documented the following:</p> <ul style="list-style-type: none"> <li>* Ordered on 8/28/17: Oxygen at 0-4 liters per minute to maintain oxygen saturation above 90%. Monitor oxygen saturation every shift.</li> <li>* Ordered on 2/26/18: Nebulizer-change tubing and mouth piece every week. Change nebulizer and tubing every week and when visibly soiled.</li> </ul> <p>Resident #14's current care plan documented the following:</p> <ul style="list-style-type: none"> <li>* She required use of oxygen due to a history of shortness of breath and hyperventilation secondary to asthma, heart failure, morbid obesity, and allergies.</li> <li>* Staff were directed to change oxygen tubing every month at night.</li> </ul> <p>Resident #14's November 2018 TAR documented the oxygen tubing was changed on 11/7/18.</p> <p>Resident #14's Nebulizer Administration Record documented the nebulizer tubing and mouth piece were changed on 11/7/18.</p> <p>On 11/5/18 at 2:44 PM, Resident #14's oxygen was connected to the concentrator and was</p>	F 695	<p>3. Findings to be reviewed by Administrator and reported to QA Committee.</p> <p>Completion Date: 12/24/2018</p>		

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F 695	<p>Continued From page 37</p> <p>flowing at 4.5 liters per minute. There was no date on the oxygen tubing or humidifier to show when the tubing was changed.</p> <p>On 11/8/18 at 1:04 PM, Resident #14's nebulizer tubing and administration set were inside a bag labeled "bipap 9/5" in her room. The UMD said the nebulizer tubing should be changed once a month. The UMD reviewed Resident #14's MAR with the surveyor and said the nebulizer tubing change was signed as completed on 11/7/18. The UMD said the staff needed to start labeling oxygen and nebulizer tubing.</p> <p>2. Resident #17 was re-admitted to the facility on 10/27/18 with multiple diagnoses including personal history of other diseases of the respiratory system.</p> <p>Resident #17's annual MDS assessment, dated 10/12/18, documented the following:</p> <ul style="list-style-type: none"> <li>* Severe cognitive impairment.</li> <li>* Oxygen therapy while a resident.</li> </ul> <p>Resident #17's October 2018 physician's orders documented the following:</p> <ul style="list-style-type: none"> <li>* Ordered on 10/27/18: Oxygen at 2 liters per minute by nasal cannula continuously.</li> <li>* Ordered on 10/27/18: Oxygen: change tubing and cannula weekly and when visibly soiled.</li> </ul> <p>Resident #17's current care plan directed staff to provide medication and oxygen as ordered.</p> <p>Resident #17's November 2018 TAR documented the oxygen tubing was changed on</p>	F 695			

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F 695	<p>Continued From page 38 11/7/18.</p> <p>On 11/5/18 at 9:23 AM and 1:40 PM, Resident #17 was in her room and had oxygen flowing from the portable oxygen machine at 3 liters per minute by nasal cannula. The oxygen tubing was undated. An oxygen concentrator was also present in Resident #17's room with oxygen tubing connected to the concentrator, and the oxygen tubing was undated.</p> <p>On 11/8/18 at 7:31 AM, Resident #17 was in her room and had oxygen flowing from the portable oxygen machine at 2 liters per minute by nasal cannula. There was no date on the oxygen tubing.</p> <p>On 11/8/18 at 7:37 AM, CNA #1 said oxygen tubing was changed on night shift every Tuesday by the CNA, and if the tubing was soiled it would be changed sooner.</p> <p>On 11/8/18 at 7:50 AM, the UMD said night shift staff changed oxygen tubing monthly and the nurse was in charge of making sure it was done. The UMD said if the oxygen tubing was soiled or contaminated it could be changed sooner, the tubing was supposed to be changed and labeled, and the facility needed to provide some education to the staff.</p> <p>3. Resident #38 was re-admitted to the facility on 10/2/17 with multiple diagnoses including gastrointestinal hemorrhage.</p> <p>Resident #38's November 2018 physician orders documented the following:</p>	F 695			

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F 695	Continued From page 39 * Ordered on 10/16/18: Oxygen 0-4 liters per minute by nasal cannula to maintain oxygen saturation above 90%. Monitor oxygen saturation every shift. * Ordered on 10/16/18: Oxygen: change tubing and cannula weekly and when visibly soiled.  Resident #38's current care plan documented oxygen 0-4 liters per minute by nasal cannula to maintain oxygen saturation above 90%.  Resident #38's November 2018 TAR documented the oxygen tubing was changed on 11/7/18.  On 11/5/18 at 3:37 PM, Resident #38 was sitting up in her mobility chair in her room and had oxygen flowing at 2 liters per minute from the portable oxygen machine. There was no date on the oxygen tubing.  On 11/8/18 at 8:23 AM and 10:30 AM, Resident #38 was lying in bed and had oxygen flowing at 3 liters per minute from the oxygen concentrator. There was no label on the oxygen tubing.  On 11/8/18 at 10:32 AM, the UMD said there was no date on Resident #38's oxygen tubing and the facility needed to provide some staff education so it would be clear when the tubing was changed.	F 695			
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	F 761		12/24/18	

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F 761	<p>Continued From page 40 instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's policy and staff interview, it was determined the facility failed to ensure expired medications were removed from medication storage room and medication carts and not available for administration to residents. This was true for 1 of 2 medication refrigerators and 1 of 3 medication carts checked for expired medications This failed practice created the potential for residents to receive expired medications with decreased efficacy. Findings include:  The facility's policy for Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, undated, documented:</p>	F 761	<p>F761</p> <p>Corrective Action: Medications identified as out of date were removed at the time they were identified.</p> <p>Identification: All med carts and medication rooms were checked for expired medications</p> <p>Systemic Changes: 1. Reeducated nursing staff to monitor for expired medications and discard them properly. 2. Nursing Unit managers will conduct a</p>		

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F 761	Continued From page 41 * Once any medication or biological package is opened, facility should follow manufacture/supplier guidelines with respect to expiration dates for opened medications.  On 11/6/18 at 12:55 PM, an open Tuberculin vial with an open date of 9/28/18 was found in the medication refrigerator located in the long-term care medication room. The medication box containing the Tuberculin vial documented, "discard after once entered in 30 days." The UMD stated the medication was out dated and should have been disposed of.  On 11/6/18 at 1:21 PM, a large jar of Dialysis Itch Cream was found on the D wing medication cart. An expiration date of 10/21/18 was hand written on the label. The UMD stated the medicated cream was outdated and should have been removed from the medication cart.	F 761	Bi-monthly audit of med rooms and Nurses carts.  Monitor:  1. DON or designee to audit all med rooms and med carts for expiration dates to ensure compliance. 2. Audits to be conducted at the following frequencies: a. Weekly for four (4) weeks b. Monthly for three (3) months to 3. Findings to be reviewed and reported to QA Committee  Completion Date: 12/24/2018		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing,	F 880		12/24/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 880	Continued From page 42 identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880			

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F 880	<p>Continued From page 43</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, policy review, medical record review and staff interview, it was determined the facility failed to ensure the glucometer used to test capillary blood glucose levels was properly cleansed between testing. This was true for 2 of 5 residents (#8 and #16) observed for the testing of capillary glucose levels. This deficient practice created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include:</p> <p>The facility policy for Cleaning and Disinfection of the Glucometer, dated 3/2010, documented the following procedure:</p> <p>* Pick up the glucometer from the first barrier and disinfect it with a Super Sani-Cloth wipe or an equivalent product that kills hepatitis B and Blood borne pathogens. Follow the manufacturer's guidelines for wet time when applying disinfectant. Pay close attention to the strip holder area and be sure to not over-saturate the area.</p>	F 880	<p>F880</p> <p>Corrective Action: Glucometers will not be used unless properly cleaned per our infection control policy.</p> <p>Identification: All residents with blood sugar checks can potentially be affected by this deficiency.</p> <p>Systemic Changes: Reeducated license nursing staff on facility procedures for proper cleaning of a glucometer machine.</p> <p>Monitor: 1. DON or designee to audit to observe 5 random blood sugar checks to observe proper cleaning of the glucometer. 2. Audits to be conducted at the following frequencies: a. Weekly for four (4) weeks</p>		

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F 880	<p>Continued From page 44</p> <p>* Place the glucometer down on the second barrier. Allow enough time to dry per the manufacturer instructions, approximately 2 minutes.</p> <p>1. On 11/07/18 at 4:55 PM, LPN#1 was observed to take the facility's glucometer out of the medication cart along with testing supplies in a plastic cup and walked into Resident #8's room. LPN#1 was observed to perform a capillary glucose test putting the test strip into the meter and using a lancet, prick Resident 8's finger to obtain a blood sample. After completion of the capillary glucose test, LPN #1 placed the glucometer on a paper towel on the resident's bedside table, removed her gloves and washed her hands. LPN #1 picked up the contaminated glucometer, walked out of the resident room and placed the contaminated glucometer on top of the medication cart. LPN #1 picked up the meter and placed the contaminated glucometer in the top drawer of the medication cart. LPN #1 failed to cleanse the contaminated glucometer prior to placing it in the medication cart.</p> <p>A prepackaged product of Super Sani-cloth was observed on the top of the cart and instructed the time of three minutes for the glucometer to be disinfected.</p> <p>On 11/7/18 at 5:05 PM, LPN #1 was observed to take the contaminated glucometer out of the medication cart, placed it into a plastic cup along with alcohol wipes and a lancet. LPN #1 placed her supplies on two paper towels on the Resident #16's bed side table. LPN#1 placed the test strip into the glucometer and pricked Resident #16's</p>	F 880	<p>b. Monthly for three (3) months to</p> <p>3. Findings to be reviewed and reported to QA Committee</p> <p>Completion Date: 12/24/2018</p>		

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F 880	<p>Continued From page 45</p> <p>finger with the lancet and obtained a blood sample. LPN #1 set the glucometer down on the paper towel, removed her gloves. washed her hands, picked up the contaminated glucometer and walked out of the resident's room. LPN #1 placed the glucometer back into the medication cart. LPN #1 did not cleanse the glucometer before placing it back into the medication cart.</p> <p>On 11/7/18 at 5:19 PM, LPN #1 stated she failed to cleanse the glucometer between residents and before placing the glucometer into the drawer of the medication cart as directed by the facility's policy.</p> <p>On 11/9/18 at 8:20 AM, the UMD stated there were no residents on the unit that received glucose monitoring that had blood borne disease processes such as Hepatitis C or HIV. The UMD identified five residents on the unit who received blood glucose testing.</p>	F 880			

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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiency was 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>Edith Cecil, RN, Team Coordinator Cecilia Stockdill, RN Kathi Davis, RN Susette Mace, RN</p>	C 000		
C 664	<p><b>02.150,02,a Required Members of Committee</b></p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) attendance records, it was determined the facility failed to ensure the Maintenance Director or a representative from the maintenance department participated in ICC meetings at least quarterly. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included:</p> <p>On 11/8/18 at 3:30 PM, the facility's Infection Control Program was reviewed with the Infection Control Nurse (ICN.) The ICN said the ICC met monthly. Review of the sign-in sheets from November 2017 to October 2018, covering the last 4 quarters, showed the Maintenance Director or a representative from the maintenance department did not attend the monthly meetings</p>	C 664	<p>C 664</p> <p>Corrective Action: Infection Control Meeting was held on 12-13-2018. The facility Maintenance Director was in attendance as required.</p> <p>Identification: All residents, staff, and visitors are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: Infection Control Committee educated on the members that are required to attend the Infection Control Committee Meetings.</p>	12/24/18

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

Electronically Signed

TITLE

(X6) DATE

12/17/18

Bureau of Facility Standards

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C 664	Continued From page 1  during the third quarter (July 2018 to September 2018). The ICN said she did not know why the Maintenance Director or a representative from the maintenance department did not attend the third quarter meetings.	C 664	Monitor: 1. Administrator to audit of attendance of Infection Control Meetings to ensure compliance. 2. Audits to be conducted at the following frequencies: Monthly for three (3) months 3. Findings to be reported to QA Committee.  Completion Date: 12/24/2018	
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