



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
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DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
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December 26, 2018

Steve Lish, Administrator  
Discovery Rehabilitation And Living  
600 Shanafelt Street  
Salmon, ID 83467-4261

Provider #: 135129

Dear Mr. Lish:

On **November 30, 2018**, a survey was conducted at Discovery Rehabilitation And Living 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 a widespread deficiency 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 **January 5, 2019**. Failure to submit an acceptable PoC by **January 5, 2019**, may result in the imposition of penalties by **January 28, 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 **January 14, 2019 (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 **March 1, 2019**. A change in the seriousness of the deficiencies on **January 24, 2019**, may result in a

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change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 1, 2019** includes the following:

Denial of payment for new admissions effective **March 1, 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 30, 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 **March 1, 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:

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

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

- BFS Letters (06/30/11)

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

This request must be received by **January 5, 2019**. If your request for informal dispute resolution is received after **January 5, 2019**, 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/

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

PRINTED: 02/04/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135129</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/30/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>DISCOVERY REHABILITATION AND LIVING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SHANAFELT STREET SALMON, ID 83467</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted November 26, 2018 to November 30, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Coordinator Carmen Blake, RN</p> <p>Abbreviations:</p> <p>ADL = Activities of Daily Living CDC = Centers for Disease Control and Prevention CNA = Certified Nursing Assistant COPD = Chronic obstructive pulmonary disease DON = Director of Nursing FDA = Food and Drug IDT = Interdisciplinary Team LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = Milligram ml= milliliter PCV - Pneumococcal Conjugate Vaccine PPE - Personal Protective Equipment PPSV - Pneumococcal Polysaccharide Vaccine PRN = As Needed PT = Physical Therapy PTA - Physical Therapy Assistant RN = Registered Nurse RNA = Restorative Nursing Assistant RNP = Restorative Nursing Program ROM = Range of Motion SSD = Social Service Director UTI = Urinary tract infection</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

01/06/2019

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 554 SS=D	<p>Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)</p> <p>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure residents were assessed to determine if they were safe to self-administer nebulizer treatments. This was true for 3 of 3 residents (#4, #9, and #12) reviewed for respiratory care. The failure created the potential for adverse effects if the residents self-administered nebulizer treatments inappropriately. Findings include:</p> <p>1. The facility's Self Administration of Medications Policy and Procedure, dated 5/2007, documented the facility would allow residents to self-administer medications after the resident was assessed and reassessed for continued appropriateness.</p> <p>a. Resident #9 was admitted to the facility on 2/4/14, with diagnoses which included COPD.</p> <p>A quarterly MDS assessment, dated 11/9/18, documented Resident #9 was severely cognitively impaired and received oxygen therapy.</p> <p>The care plan area addressing Resident #9's COPD, undated, documented he had episodes of wheezing and was dependent on oxygen. The care plan documented he was to receive his</p>	F 554	<p>Corrective Actions: Corrective Actions for resident #4 was assessed and documented to be safe to self-administer medication on 11-27-18. Resident #9 was also assessed and documented but was found not to be safe to self-administer medication on 11/30/18 and directions placed in eTAR. Resident #12 was assessed and documented to be safe to self-administer medication on 11/27/18.</p> <p>identification of others affected and corrective action: Any resident that receives breathing treatments may have been affected. These residents will be assessed for self-administration, and care planned accordingly.</p> <p>Measures to ensure that deficient practice does not happen again: Nursing staff will be educated that residents receiving breathing treatments must be monitored, or assessed to self-administer the breathing treatment.</p> <p>Monitor corrective actions: DON or designee will monitor the breathing treatments for 1 time/week for 6</p>	1/11/19	

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F 554	<p>Continued From page 2</p> <p>nebulizer treatments per orders. The care plan did not document he was assessed to self-administer the medication.</p> <p>Resident #9's Physicians Orders included the following:</p> <ul style="list-style-type: none"> <li>- Ipratropium- Albuterol Solution (inhaler used to treat wheezing and shortness of breath) 0.5-2.5 mg/3 ml vial inhaled four times daily for COPD / asthma, ordered 3/18/16.</li> <li>- Ipratropium- Albuterol Solution 0.5-2.5 mg/3 ml vial inhaled every 3 hours PRN for COPD, ordered 3/18/16.</li> </ul> <p>Resident #9's 11/1/18 -11/27/18 MAR documented his scheduled Albuterol Solution treatment was provided per physician's orders.</p> <p>On 11/27/18 at 2:08 PM, Resident #9's Albuterol Solution hand held device was observed to be misting and the device was positioned on his chest and away from his mouth. Resident #9 appeared to be sleeping. At 2:13 PM, Resident #9's eyes opened, and he placed the hand held device to his mouth.</p> <p>On 11/27/18 at 2:19 PM, CNA #2 entered Resident #9's room and removed the hand held device from Resident #9's hand to clean it. Resident #9's eyes were closed, and CNA #2 said to Resident #9 he could go back to sleep.</p> <p>On 11/27/18 at 2:21 PM, CNA #2 stated Resident #9 would fall asleep and she would go in to periodically to check on him to ensure he was holding the hand held device to his mouth. CNA #2 stated most days she would have to remind</p>	F 554	<p>weeks to ensure the residents breathing treatment is administered as per care planned. The audit results will be brought to QA monthly. Audits will begin 01/14/19.</p> <p>Corrective Actions will be completed: 01/11/19</p>		

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F 554	<p>Continued From page 3</p> <p>him to place it near his mouth. CNA #2 stated she would check on him every 5-10 minutes and she knew the treatment was completed when the liquid was gone and not misting.</p> <p>A Self-Administration Assessment, dated 11/30/18, documented Resident #9 dozed off during administrations of his breathing treatments and the staff were to place the medication cart outside his room to visualize him while he administered the medication.</p> <p>b. Resident #4 was admitted to the facility on 5/30/18, with diagnoses which included COPD.</p> <p>A quarterly MDS assessment, dated 11/14/18, documented Resident #4 was cognitively intact and received oxygen therapy.</p> <p>The care plan area addressing Resident #4's COPD, undated, documented he received oxygen therapy related to his diagnoses of COPD. The care plan documented he was to receive his nebulizer treatments per orders. The care plan did not document he was assessed to self-administer the medication.</p> <p>Resident #4's Physicians Orders included DuoNeb Solution 0.5-2.5 mg/3 ml vial inhaled every 6 hours PRN for COPD, ordered 8/1/18.</p> <p>A Self-Administration Assessment, dated 11/27/18, documented Resident #4 was able to hold a hand held nebulizer without difficulty.</p> <p>c. Resident #12 was readmitted to the facility on 2/22/17, with diagnoses which included COPD.</p>	F 554			

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F 554	<p>Continued From page 4</p> <p>A quarterly MDS assessment, dated 9/21/18, documented Resident #12 was cognitively intact and received oxygen therapy.</p> <p>The care plan area addressing Resident #12's COPD, undated, documented she received oxygen therapy related to her diagnoses of COPD. The care plan documented she was to receive her nebulizer treatments per orders. The care plan did not document she was assessed to self-administer the medication.</p> <p>Resident #12's Physicians Orders included Albuterol Sulfate Solution (inhaler used to treat wheezing and shortness of breath) 0.5-2.5 mg/3 ml vial inhaled every 2 hours PRN for COPD, ordered 2/8/18.</p> <p>A Self-Administration Assessment, dated 11/27/18, documented Resident #12 was able to hold a hand held nebulizer without difficulty.</p> <p>On 11/27/18 at 2:54 PM, LPN #1 stated she had administered the breathing treatment for Resident #9 and left the room. LPN #1 stated it was not facility practice to stay with a resident while they completed their breathing treatment. LPN #1 stated a nebulizer treatment was considered a medication and she did observe residents while they received other medications. LPN #1 stated if the device was not in Resident #9's mouth he was not receiving the medication. LPN #1 stated staff would periodically check on Resident #9 and remind him to place the hand held device to his mouth. LPN #1 stated she was unsure if Resident #9 was assessed to self-administer medications. LPN #1 stated there were three residents who received breathing</p>	F 554			

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F 554	Continued From page 5 treatments and all three utilized hand held devices. LPN #1 stated she was unsure if Resident #4 or Resident #12 had assessments and care plans which documented they were appropriate to self-administer medications.  On 11/27/18 at 2:59 PM, the DON stated it was not facility practice to observe residents while nebulizer treatments were administered. The DON stated the residents did not have self-administration assessments completed, but it would be completed by the end of the week. The DON stated the nursing staff periodically checked on the residents to ensure they received their full doses and the nebulizer treatments were considered medications.	F 554			
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)  §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.  §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual	F 577		1/11/19	

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F 577	<p>Continued From page 6 to review upon request; and</p> <p>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</p> <p>(iv) The facility shall not make available identifying information about complainants or residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and resident and staff interview, it was determined the facility failed to ensure residents knew the last 3 years of survey results, including complaint investigations, were available for review and how to locate them. This was true for 9 of 9 residents in a group interview (#1, #3, #4, #5, #8, #13, #15, #18, and #23), and had the potential to impact other residents and visitors, who may want to review the survey results. Findings include:</p> <p>During a group interview on 11/28/18 at 10:15 AM, Residents #1, #3, #4, #5, #8, #13, #15, #18, and #239, stated they did not know where the survey results were located in the facility.</p> <p>On 11/26/18 at 2:00 PM, the survey results binder was observed by the main office near the front door. The binder contained the most recent recertification survey the facility had undergone on 8/11/17.</p> <p>On 11/28/18 at 11:32 AM, the SSD stated she was unaware the residents did not know where the survey results were. The SSD stated resident rights were reviewed in the resident council meetings and during care conferences. The SSD stated she would correct the issue.</p>	F 577	<p>Corrective Actions:</p> <p>Corrective Actions for resident #1, #3, #4, #5, #8, #13, #15, and #23 was to personally hand these residents a copy of the newsletter by 01-02-19. This newsletter will inform the resident of where to find the binder and that the previous survey results are in it for them to review.</p> <p>Identification of others affected and corrective action:</p> <p>Any resident may have been affected by this. As stated above, current resident will receive a copy of the newsletter; which will inform the resident where to find the binder and that the previous survey results are in it for them to review.</p> <p>Measures to ensure that deficient practice does not happen again:</p> <p>Social Services and the Executive Director will be educated that residents are to receive a monthly newsletter, after the resident council meeting has been held, to inform them of the resident council meeting as well as location of the survey binder for the residents to review.</p>		

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F 577	Continued From page 7	F 577	Monitor corrective actions: Executive Director or designee will monitor if the residents were provided the newsletter 1 time/month for 3 months. The audit results will be brought to QA monthly. Audits will begin 01/14/19.  Corrective Actions will be completed: 01/11/19		
F 578 SS=D	Request/Refuse/Dscntnue Trmmt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.	F 578		1/11/19	

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F 578	<p>Continued From page 8</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents' medical records included a copy of the residents' advance directives or documentation of their decision not to formulate advance directives. This was true for 2 of 5 residents (#9 and #16) reviewed for advance directives. This failure created the potential for harm if a resident's medical treatment wishes were not honored should the resident be unable to communicate them to a doctor. Findings include:</p> <p>The State Operations Manual defined an "Advance directive" is "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." "Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form" is a form designed to improve patient care by creating a portable medical order</p>	F 578	<p>Corrective Actions: Corrective Actions were representative(s) will be contacted regarding resident #9 and #16, to review their advanced directives. Additionally, the orders will be updated to reflect their wishes as well as the care plan.</p> <p>Identification of others affected and corrective action: Any resident may have been affected by this. Current residents will be reviewed and updated as needed.</p> <p>Measures to ensure that deficient practice does not happen again: Social Services, Medical Records and the licensed nurses will be educated regarding the advanced directives, how advanced directive orders will be in Point Click Care, and they will also be in the care plan. Additionally, during care plan reviews the POST and advanced</p>		

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F 578	<p>Continued From page 9</p> <p>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. The facility's Advanced Directive Policy and Procedure, dated 11/2016, documented after a resident's advance directives were determined, the clinical record would be updated with orders, care plan, and a copy of the advanced directive.</p> <p>a. Resident #9 was admitted to the facility on 2/4/14, with diagnoses which included COPD.</p> <p>A quarterly MDS assessment, dated 11/9/18, documented Resident #9 was severely cognitively impaired.</p> <p>Resident #9's Idaho Physician Orders for Scope of Treatment (POST), dated 2/4/14, documented he wished his code status to be Do Not Resuscitate (DNR) and comfort measures only. The POST documented Resident #9 did not want tube feeding, IV fluids, or blood products, but he would receive antibiotics. The POST documented he had a Durable Power of Attorney (DPA) in his record.</p> <p>Resident #9's medical record did not include documentation of the DPA/advance directives, or documentation advance directives were discussed with his family.</p> <p>b. Resident #16 was admitted to the facility on 9/26/18, with multiple diagnoses including repeat falls, and cognitive communication deficit.</p>	F 578	<p>directives will be reviewed with attendees.</p> <p>Monitor corrective actions: Medical Records or designee will monitor the advanced directives to ensure it is documented in Point Click Care, and that the POST is reviewed during the care plan meetings for 3 months. The audit results will be brought to QA monthly. Audits will begin 01/14/19.</p> <p>Corrective Actions will be completed: 01/11/19</p>		

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 578	Continued From page 10  An admission MDS assessment, dated 10/8/18, documented Resident #16 was severely cognitively impaired.  Resident #16's POST, dated 9/28/18, documented she wished to be DNR with limited additional interventions This included cardiac monitoring and oral or IV medications. It also included transfers to the hospital but not to the intensive care unit. The POST documented Resident #16 wished for tube feeding, IV fluids, and antibiotics and did not want blood products.  Resident #16's medical record did not include documentation of advance directives, or documentation advance directives were discussed with her.  On 11/27/18 at 10:14 AM, Business Office staff member #1 stated she believed Resident #9 and #16 had advanced directives but she could not locate them. The Business Office staff member stated she would ask social services about them.  On 11/27/18 at 3:48 PM, the SSD stated she was unable to locate advanced directives for Resident #9 and Resident #16. The SSD stated she had made phone calls to the families to get copies of the documents.	F 578			
F 625 SS=D	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	F 625		1/11/19	

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F 625	<p>Continued From page 11</p> <p>nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(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;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(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</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing 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 provided residents with information about how long their bed would be held. This was true for 2 of 2 residents (#14 and #76) reviewed for transfers. The deficient practice created the potential for harm if residents were not informed of how long the facility would hold their former bed or room. Findings include:</p> <p>1. The facility's policy for bed hold/reservation of</p>	F 625	<p>Corrective Actions: Corrective Actions were changes made to the bed hold form, to reflect that the bed will held for 3 days.</p> <p>Identification of others affected and corrective action: Any resident could have been affected. The changes made to the form will be in place for our current residents and all future residents.</p> <p>Measures to ensure that deficient practice</p>		

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F 625	<p>Continued From page 12</p> <p>room, revised on 11/2018, documented the facility provided written notification within 24 hours to the patient or patient representative regarding bed holds if the patient transfers to a hospital or the patient goes on therapeutic leave. The policy stated the facility would hold the bed for a duration of 3 days.</p> <p>a. Resident #14 was readmitted to the facility on 9/18/18, with multiple diagnoses including pneumonia, altered mental status, UTI, and heart failure. Resident #14 was discharged from the facility on 11/26/18.</p> <p>i. A Progress Note, dated 9/14/18, documented Resident #14 was sent to the emergency room (ER) for evaluation related to decreased oxygen saturation and increased agitation and confusion.</p> <p>A Notification of a bed-hold, dated 9/14/18, documented Resident #14 had a bed held without charges. The bed hold did not inform Resident #14 how long the facility would hold the bed.</p> <p>ii. A progress note, dated 11/26/18, documented Resident #14 was sent to the ER related to a fall and complaints of severe left hip pain.</p> <p>A Notification of a bed-hold, dated 11/26/18, documented Resident #14 had a bed held without charges. The bed hold did not inform Resident #14 how long the facility would hold the bed.</p> <p>b. Resident #76 was admitted to the facility on 1/30/18, with diagnoses including cardiac issues, depression, and weakness.</p>	F 625	<p>does not happen again: As stated above, the bed hold from was updated, as well as updates to the policy and procedure.</p> <p>Monitor corrective actions: Medical Records or designee will audit the bed hold from for 6 weeks, to ensure it is documented how long the facility would hold the bed. The audit results will be brought to QA monthly. Audits will begin 01/14/19.</p> <p>Corrective Actions will be completed: 01/11/19</p>		

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F 625	Continued From page 13  i. Resident #76 was transferred to the hospital on 2/8/18 for an acute medical condition.  A notification of a bed-hold, dated 2/8/18, documented Resident #76 had a bed held without charges. The bed hold did not inform the resident how long the facility would hold the bed. Resident #76 returned to the facility on 02/13/18.  ii. Resident #76 was transferred to the hospital for an acute medical condition on 5/17/18.  A notification of a bed-hold, dated 5/17/18, documented Resident #76 had a bed held without charges. The bed hold did not inform the resident how long the facility would hold the bed. Resident #76 returned to the facility on 5/22/18.  On 11/29/18 at 5:25 PM, the SSD and the Administrator stated the current bed-hold notice did not include a duration of time the facility would hold a bed. The Administrator stated the facility would correct the issue.	F 625			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' MDS assessments accurately reflected their ROM ability. This was true for 2 of 13 residents (#17 and #19) reviewed for MDS accuracy. This deficient practice created the	F 641	Corrective Actions: Corrective Actions for resident #17 and #19 was to correct and modify their last assessments completed in the last 6 months.	1/11/19	

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F 641	<p>Continued From page 14</p> <p>potential for harm if residents did not receive ROM therapy if needed. Findings include:</p> <p>1. On 11/29/18 at 2:46 PM, the DON stated she had a traveling RN completing the MDS assessments, and she would review the MDS assessments for accuracy.</p> <p>a. Resident #17 was admitted to the facility on 8/13/15, with diagnoses which included dementia and mild cognitive impairment.</p> <p>A quarterly MDS assessment, dated 10/25/18, documented Resident #17 had a severe cognitive impairment and he had a bilateral ROM impairment to his lower extremities.</p> <p>The care plan area addressing Resident #17's ADLs, undated, documented he had a dressing/grooming and walking ROM program.</p> <p>Resident #17's ROM and contracture screens, dated 7/11/18 and 11/29/18, documented he had no ROM impairments to his upper and lower extremities.</p> <p>b. Resident #19 was admitted to the facility on 1/18/16, with diagnoses which included Alzheimer's disease, dementia with behavioral disturbances, limitation of activities due to disability, and disorder of muscles.</p> <p>An annual MDS assessment, dated 10/26/18, documented Resident #19 had a severe cognitive impairment and a bilateral ROM impairment to his upper and lower extremities.</p> <p>The care plan area addressing Resident #19's</p>	F 641	<p>Identification of others affected and corrective action: Any resident that was assessed as having range of motion limitation may have been affected. These residents will be checked for accuracy and modified if necessary.</p> <p>Measures to ensure that deficient practice does not happen again: MDS Nurse and DON will be educated on section G0400 "Functional Limitation in Range of Motion."</p> <p>Monitor corrective actions: DON or designee will audit range of motion assessments, in section G of the MDS treatments for 12 weeks. The audit results will be brought to QA monthly. Audits will begin 01/14/19.</p> <p>Corrective Actions will be completed: 01/11/19</p>		

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F 641	Continued From page 15 ADL's, undated, documented the facility had discussed his decline in function with the family. and he required 1-2 staff assistance with cares.  Resident #19's ROM and contractures screens, dated 1/18/16, 8/25/16, 4/1/17, 7/12/18, and 11/29/18, documented he had no ROM impairments to his upper and lower extremities.  On 11/29/18 at 2:46 PM, the DON stated Resident #17 and Resident #19 did not have ROM impairments. The DON stated the MDS was coded wrong for Resident #17 and Resident #19.	F 641			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		1/11/19	

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F 656	<p>Continued From page 16</p> <p>rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, record review, and review of the facility's policy and procedure, the facility failed to ensure the staff developed person-centered care plans for 3 of 13 residents (#9, #13, and #16) whose care plans were reviewed. The care plans failed to include individualized behavior for staff to monitor and residents' medical treatment wishes if they were unable to communicate them to a doctor or if they had a DPA or living will. This deficiency had potential for harm if residents' behaviors were not monitored and effectively treated and if residents' medical treatment wishes were not honored.</p> <p>Findings include:</p> <p>1. Resident #13 was admitted to the facility on 1/13/18, with diagnoses including dementia, pain,</p>	F 656	<p>Corrective Actions: Corrective Actions for resident #13 was identifying her behaviors and placing them in the care plan. Corrective actions for residents #9 and #16 was to update their care plan as directed by their POST.</p> <p>Identification of others affected and corrective action: Any resident that takes medication for behaviors may have been affected. Any resident that has a POST may have been affected. These residents will be checked and the care plan updated if necessary.</p> <p>Measures to ensure that deficient practice does not happen again:</p>		

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F 656	<p>Continued From page 17 and heart failure.</p> <p>A physician order, dated 10/2/18, documented Resident #13 received Propranolol 10 mg twice daily for high blood pressure and aggression.</p> <p>The care plan area addressing Resident #13's behaviors, undated, did not identify the specific behaviors to monitor.</p> <p>The facility's pharmacy review book for psychiatric medications, documented Propranolol was used for Resident #13's side effect control.</p> <p>On 11/27/18 at 4:09 PM, the DON stated the facility's Behaviors Committee worked with the consulting Pharmacist and requested an order for Propranolol to treat Resident #13's behaviors. The DON also stated that the facility failed to identify the Propranolol was being used to manage Resident #13's behaviors. The DON acknowledged the facility failed to monitor Resident #13's behaviors to determine if the medication was effective in treating Resident #13's behaviors.</p> <p>2. Residents' care plans were not updated to include their medical treatment wishes if they were unable to communicate them to a doctor, as follows:</p> <p>a. Resident #9 was admitted to the facility on 2/4/14, with diagnoses which included COPD.</p> <p>A quarterly MDS assessment, dated 11/9/18, documented Resident #9 was severely cognitively impaired.</p>	F 656	<p>Social Services, ADON, and DON will be educated on the guidance of F656.</p> <p>Monitor corrective actions: DON or designee will audit care plans for behaviors(s) to monitor and advanced directive guidance for 6 weeks. The audit results will be brought to QA monthly. Audits will begin 01/14/19.</p> <p>Corrective Actions will be completed: 01/11/19</p>		

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F 656	<p>Continued From page 18</p> <p>Resident #9's Idaho Physician Orders for Scope of Treatment (POST), dated 2/4/14, documented he wished his code status to be Do Not Resuscitate (DNR) and comfort measures only. The POST documented Resident #9 did not want tube feeding, IV fluids, or blood products, but he would receive antibiotics. The POST documented he had a Durable Power of Attorney (DPA) in his record.</p> <p>The care plan area addressing Resident #9's family's plan for him to remain in the facility, undated, documented his advanced directive was a code status of DNR. The care plan did not include his wishes for comfort measures only or his wish to not receive tube feeding, IV fluids, or blood products, but he would receive antibiotics. The care plan did not document he had a DPA.</p> <p>b. Resident #16 was admitted to the facility on 9/26/18, with multiple diagnoses including repeat falls, and cognitive communication deficit.</p> <p>An admission MDS assessment, dated 10/8/18, documented Resident #16 was severely cognitively impaired.</p> <p>Resident #16's POST, dated 9/28/18, documented she wished her code status to be DNR with limited additional interventions. The interventions included cardiac monitoring and oral or IV medications. It also included transfers to the hospital but not to the intensive care unit. The POST documented Resident #16 wished for tube feedings, IV fluids, and antibiotics, and did not want blood products.</p> <p>The care plan area addressing Resident #16's</p>	F 656			

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F 656	Continued From page 19 family's plan to remain in the facility, undated, documented her code status was DNR. The care plan did not include her wishes for limited interventions, tube feeding, IV fluids, antibiotics, and no blood products. The care plan did not document if she had a living will or a DPA.	F 656			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary	F 657		1/11/19	

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F 657	<p>Continued From page 20</p> <p>team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised as care needs changed for 3 of 13 residents (#14, #15, and #19) whose care plans were reviewed. This failure had the potential for harm if care and services were not provided due to inaccurate information. Findings include:</p> <p>1. Resident #14 was readmitted to the facility on 9/18/18, with multiple diagnoses including pneumonia, altered mental status, UTI, and heart failure. Resident #14 was discharged from the facility on 11/26/18.</p> <p>An admission MDS assessment, dated 9/25/18, documented Resident #14 had moderate cognitive impairment and he rejected cares 4 to 6 days a week. The MDS documented he required extensive assistance with all cares but eating.</p> <p>The care plan area addressing Resident #14's ADLs, undated, documented he required PRN staff assistance with toilet use and transfers. The care plan documented staff were to utilize a gait belt when he was unsteady. The care plan did not document what PRN staff assistance Resident #14 needed or describe what his unsteadiness looked like.</p> <p>On 11/26/18 at 2:32 PM, Resident #14 was observed walking without staff assistance throughout the facility with his front wheeled</p>	F 657	<p>Corrective Actions:</p> <p>Corrective Actions for resident #14, #15, and #19 was reviewing and updating their care plans. Resident #14, we updated the care plan by removing PRN assistance, due to his current needs. Resident #15, we updated the care plan by removing the gait belt and stating she is stand by assist. Resident #19, we updated the care plan by adding that he will lower himself to the floor to pray and crawl around to look for things.</p> <p>Identification of others affected and corrective action:</p> <p>Any resident may have been affected. Care plans will be reviewed and updated if needed.</p> <p>Measures to ensure that deficient practice does not happen again:</p> <p>IDT team and nursing staff will be educated to update the care plan as needs change.</p> <p>Monitor corrective actions:</p> <p>DON or designee will randomly audit 2 care plans/week for 6 weeks to ensure they are being reviewed as care changes. The audit results will be brought to QA monthly. Audits will begin 01/14/19.</p> <p>Corrective Actions will be completed:</p>		

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F 657	<p>Continued From page 21 walker.</p> <p>On 11/26/18 at 2:37 PM, Resident #14 was observed taking himself to the restroom without staff assistance.</p> <p>On 11/26/18 at 2:41 PM, the DON was observed knocking on the bathroom door asking Resident #14 if he needed assistance and he stated he was fine.</p> <p>On 11/30/18 at 9:43 AM, the DON stated Resident #14 was independent with all cares including transfers, ambulation, and toilet use. The DON stated PRN staff assistance with toileting entailed staff offering their assistance with pericare when he was seen using the restroom. The DON stated Resident #14 would refuse to allow staff to provide pericare and he had a history of UTIs. The DON stated the care plan did not specify what PRN assistance Resident #14 needed.</p> <p>2. Resident #15 was readmitted to the facility on 3/2/17, with multiple diagnoses including dementia and altered mental status.</p> <p>A quarterly MDS assessment, dated 10/4/18, documented Resident #15 had a moderate cognitive impairment and she required extensive and limited assistance with cares except eating.</p> <p>The care plan area addressing Resident #15's ADLs, undated, documented she required the use of a gait belt and walker with ambulation.</p> <p>On 11/27/18 at 10:28 AM, Resident #15 was observed assisted into the dining room by the</p>	F 657	01/11/19		

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F 657	<p>Continued From page 22</p> <p>Activities Assistant, and no gait belt was used.</p> <p>On 11/27/18 at 9:45 AM, Resident #15 was observed assisted into the TV area by CNA #4 with the use of a gait belt.</p> <p>On 11/27/18 at 4:38 PM, the DON stated Resident #15 did not require a gait belt at this time and she was stand by assist only. The DON stated the care plan was incorrect and needed updated.</p> <p>3. Resident #19 was admitted to the facility on 1/18/16, with diagnoses which included Alzheimer's disease, dementia with behavioral disturbances, limitation of activities due to disability, and disorder of muscles.</p> <p>An annual MDS assessment, dated 10/26/18, documented Resident #19 had a severe cognitive impairment and he was totally dependent or required extensive assistance with all cares.</p> <p>The care plan area addressing Resident #19's risk for falls, undated, documented he may attempt to stand. The care plan documented he had a personal alarm while in his chair and a motion sensor while in bed.</p> <p>A Progress Note, dated 11/20/18, documented Resident #19 was found "crawling" on the floor after his motion sensor alarm sounded. The note documented Resident #19 stated he was looking for birds and staff assisted him back into bed.</p> <p>On 11/29/18 at 4:23 PM, CNA #8 stated Resident #19 was known to crawl on the floor because he</p>	F 657			

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F 657	Continued From page 23 was a miner in his earlier days. CNA #8 stated he also prays at his bedside on occasions. CNA #8 stated Resident #19 attempted to pray or crawl more often when he experienced moments of clarity.  On 11/29/18 at 4:28 PM, CNA #9 stated Resident #19 had times when he would crawl and pray at his bedside. CNA #9 stated he tended to move more when he experienced moments of clarity. CNA #9 stated she saw him standing by his bedside a few weeks ago and had to assist him back to bed.  On 11/29/18 at 4:40 PM, CNA #1 stated Resident #19 would crawl out of bed looking for items. CNA #1 stated Resident #19 would try and stand most frequently on the night shift.  On 11/29/18 at 4:44 PM, CNA #2 stated Resident #19 would crawl on the floor looking for items that were not there. CNA #2 stated Resident #19 was known to get on his knees and pray by his bedside.  On 11/30/18 at 9:43 AM, the DON stated she was unaware Resident #19 would attempt to pray at his bedside and this should be in the care plan. The DON stated Resident #19's crawling on the floor was on the care plan at one point and it was removed unintentionally.	F 657			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)  §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		1/11/19	

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F 688	<p>Continued From page 24</p> <p>range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and record review, it was determined the facility failed to ensure residents received treatment and services to prevent further decrease in ROM. This was true for 1 of 5 residents (Resident #9) reviewed for treatment and services related to ROM. The failed practice created the potential for harm when Resident #9 declined in function. Findings include:</p> <p>The facility's Restorative Care Policy and Procedure, dated 6/2018, documented restorative care was provided to each resident in accordance with their individualized care needs. The policy documented the restorative plan was outlined in residents' care plans.</p> <p>Resident #9 was admitted to the facility on 2/4/14, with diagnoses which included muscle weakness, lower back pain, and abnormal gait and mobility.</p>	F 688	<p>Corrective Actions: Corrective Action for resident #9 was to update the RNP that is inclusive of ambulation.</p> <p>Identification of others affected and corrective action: Any resident may have been affected. RNP will be reviewed and updated if needed.</p> <p>Measures to ensure that deficient practice does not happen again: Restorative nurse and therapy staff will be educated to effectively communicate between the departments, so that the continuity of care continues.</p> <p>Monitor corrective actions: DON or designee will audit therapy discharges (that remain within the</p>		

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F 688	Continued From page 25  A quarterly MDS assessment, dated 11/9/18, documented Resident #9 was severely cognitively impaired and required extensive assistance with all cares. The MDS documented he had no ROM impairments to his extremities and he was receiving restorative ROM dressing/grooming and transfers program.  The care plan area addressing Resident #9's ADLs, undated, documented he had a dressing/grooming program where staff were to cue and encourage him to perform as many ADLs by himself. The care plan documented staff were to cue Resident #9 with dressing as much as possible for 6-7 times a week and 15 minutes per session. The care plan documented Resident #9 had a transfer ROM program and he needed cueing to use both of his arms to push off his bed, chair, or toilet, pivot transfer, and a gait belt was to be used at all times.  A PT evaluation and plan of treatment, dated 10/29/18, documented Resident #9 complained of lower back pain with bed mobility and transfers. The evaluation documented he had global weakness, impaired cognition, and poor sitting and standing balance. The evaluation documented the weakness was consistent with his history of a compression fracture to his spine and spinal degeneration. The evaluation documented he was a good candidate for PT and for CNA staff to assist him with strengthening exercises.  A PT discharge summary, dated 11/9/18, documented Resident #9's PT therapy was discontinued because he reached his maximum	F 688	building) for 6 weeks to monitor for continuation of care (if recommended) to the RNP. The auditing results will be brought to QA monthly. Audits will begin 01/14/19.  Corrective Actions will be completed: 01/11/19		

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F 688	<p>Continued From page 26</p> <p>potential and he was referred to a RNP. The summary documented Resident #9 was to walk with the assistance of two staff members utilizing a front wheeled walker and a wheelchair following behind him. The summary documented nursing staff were to walk with him PRN because of a decreased tolerance to activity and global weakness. The summary documented Resident #9's discharge recommendations were for a RNP with bed mobility, transfers, and ambulation. The summary outlined Resident #9's restorative ambulation program was he needed PRN walking with nursing staff when he was mentally alert and showed capable signs of walking. The summary did not document a functional maintenance program.</p> <p>A nursing summary, dated 11/18/18, documented Resident #9 ambulated with a wheelchair and he required the assistance of 1 staff member with ambulation. The assessment documented he required 1 to 2 staff assistance with transfers because he did not ambulate.</p> <p>Resident #9's restorative documentation, dated 11/1/18 through 11/28/18, documented staff provided 2 restorative programs, one for dressing/grooming and one for transfers. The restorative documentation did not include the recommended restorative ambulation program outlined in the PT discharge summary.</p> <p>On 11/27/18 at 8:31 AM, Resident #9 was observed awake and talking with CNA #6 as she pushed his wheelchair out of the dining room and into the hall. CNA #6 did not attempt to walk with Resident #9.</p>	F 688			

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F 688	<p>Continued From page 27</p> <p>On 11/27/18 at 9:09 AM, CNA #3 was observed assisting Resident #9 to his bed. After Resident #9 was laying down, CNA #3 removed his pants and placed a blanket over his legs. CNA #3 did not encourage or cue Resident #9 to remove his pants.</p> <p>On 11/28/18 at 7:22 AM, Resident #9 was sleeping and was awakened by CNA #3. CNA #3 removed Resident #9's blankets and physically assisted him with rolling onto his back. CNA #3 removed Resident #9's incontinence briefs and provided pericare. CNA #3 placed a clean incontinence brief onto Resident #9 and removed her gloves and placed his legs into pants, one leg at a time. CNA #3 placed Resident #9's arms into his sleeves one arm at a time and assisted him up enough to get his head through the shirt hole. Resident #9 was assisted with rolling from side to side as CNA #3 pulled his pants up and his shirt down in the back. CNA #3 did not cue or encourage Resident #9 to dress himself.</p> <p>CNA #3 then assisted Resident #9 to a sitting position on the edge of his bed, adjusted Resident #9's wheelchair into the transferring position, and locked the breaks. CNA #3 then used a gait belt to transfer him into the wheelchair. CNA #3 moved Resident #9's wheelchair over to the sink and asked Resident #9 to open his mouth and she swabbed his mouth, then cleaned his face with a hand towel. The grooming assistance was completed at 7:33 AM. CNA #3 provided Resident #9 with a total of 11 minutes of passive ROM assistance with combined dressing/grooming and transfers.</p> <p>Resident #9's restorative documentation, dated</p>	F 688			

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F 688	<p>Continued From page 28</p> <p>11/28/18, documented staff provided 15 minutes of dressing and grooming ROM and 15 minutes of transfer ROM during the morning observation.</p> <p>On 11/28/18 at 2:06 PM, RN #1, who was the restorative RN, stated she worked doing restorative care 2 days a month and would assess residents when she was able. RN #1 said Resident #9's restorative program should include staff picking out clothing items for him and allowing him to get dressed under his own power as much as possible. RN #1 also said staff were to allow him to brush his own teeth as much as possible. RN #1 stated the CNAs knew to allow Resident #9 as much autonomy as possible. RN #1 stated if Resident #9 was unable to perform these tasks by himself then the CNAs should notify her so his RNP could be adjusted.</p> <p>On 11/29/18 at 11:50 AM, RN #1 stated she had updated Resident #9's care plan to reflect his change of condition and his inability to participate in his dressing/grooming ROM program. RN #1 stated she had not provided passive ROM because it was not recommended by PT.</p> <p>The care plan area addressing Resident #9's ADLs, updated 11/28/18, documented he had a general decline in physical function with his dressing/grooming program. The care plan documented staff were to cue and encourage him to perform as many ADLs by himself. The care plan documented staff were to cue Resident #9 with dressing as much as possible for 6 to 7 times a week and 15 minutes per session. The care plan documented Resident #9 had increased weakness and may need more assistance with ADLs. The care plan documented</p>	F 688			

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F 688	Continued From page 29 Resident #9 had a transfer ROM program and he needed cueing to use both of his arms to push off his bed, chair, or toilet, pivot transfer, and a gait belt was to be used at all times.	F 688			
F 689 SS=D	The facility failed to update Resident #9's RNP as his function declined and the facility failed to provide a recommended ambulation program from PT.  Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, review of Incident and Accident (I&A) Reports, review of facility in-service training, and record review, it was determined the facility failed to ensure gait belts were utilized appropriately to reduce potential injuries. This was true for 2 of 8 residents (#9 and #17) reviewed for supervision and accidents. These failed practices placed residents at risk of bone fractures and other injuries related to inappropriate use of a gait belt. Findings include:  1. The facility's Falls Policy and Procedure, dated 5/2018, documented staff were to evaluate residents for injury after a fall and prevent complications.	F 689	Corrective Actions: Corrective Actions for resident #9 and #17, was to re-educate all current nursing staff on proper grip of a gait belt and when it is to be used.  Identification of others affected and corrective action: Any resident may have been affected. Re-educating all current nursing staff on proper grip of a gait belt and when it is to be used would be the corrective action.  Measures to ensure that deficient practice does not happen again: Re-educating all current nursing staff on	1/11/19	

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F 689	Continued From page 30  The facility's Gait Belt Policy and Procedure, dated 6/2007, documented gait belts were utilized to ensure the safety of residents who required assistance with transfers and ambulation. The policy documented employees who were transferring, or ambulating residents used a gait belt to ensure the safety of the resident and staff.  A facility in-service training on transfers, dated 3/14/18, documented gait belt use was discussed.  a. Resident #9 was admitted to the facility on 2/4/14, with diagnoses which included muscle weakness, lower back pain, and abnormal gait and mobility.  A quarterly MDS assessment, dated 11/9/18, documented Resident #9 was severely cognitively impaired and required extensive assistance with all cares. The MDS documented he experienced one fall with minor injury.  The care plan area addressing Resident #9's risk for falls, undated, documented he was at risk for falls related to dementia, a gait/balance problem, incontinence, and poor safety awareness. The care documented staff were to utilize a gait belt with transfers to his wheelchair.  The care plan area addressing Resident #9's ADLs, undated, documented Resident #9 had a transfer ROM program and he needed cueing to use both of his arms to push off his bed, chair, or toilet, pivot transfer, and a gait belt was to be used at all times.	F 689	proper grip of a gait belt and when it is to be used would be the corrective action.  Monitor corrective actions: DON or designee will audit gait belt usage 2 times/week for 6 weeks. The audit results will be brought to QA monthly. Audits will begin 01/14/19.  Corrective Actions will be completed: 01/11/19		

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F 689	<p>Continued From page 31</p> <p>The Fall Risk Evaluations, dated 9/21/18 and 10/13/18, documented Resident #9 was a medium fall risk, and required the use of assistive devices with gait/balance/ambulation.</p> <p>On 11/27/18 at 9:09 AM, Resident #9 was observed as CNA #3 pushed his wheelchair down the hall and into his room. CNA #3 asked Resident #9 to stand up from his wheelchair while she placed one hand under his arm and her other hand on the seat of Resident #9's pants after he stood. CNA #3 removed her hand from Resident #9's arm and grasped the top of his pants on his left side. CNA #3 assisted Resident #9 to turn his body towards his bed and to sit on the edge of his bed, while her hands were on the seat of his pants and his side. CNA #3 did not utilize a gait belt while transferring him to bed.</p> <p>On 11/27/18 at 9:12 AM, CNA #3 stated she had not been instructed to utilize a gait belt with transfers for Resident #9. CNA #3 stated staff utilized a gait belt with him "only" when he was walking.</p> <p>On 11/28/18 at 2:06 PM, RN #1, who was the restorative RN, stated staff members should be utilizing a gait belt with all transfers as documented in the care plan and she would ensure staff were reeducated.</p> <p>b. Resident #17 was admitted to the facility on 8/13/15, with diagnoses which included dementia, obesity, and a mild cognitive impairment.</p> <p>A quarterly MDS assessment, dated 10/25/18,</p>	F 689			

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F 689	<p>Continued From page 32</p> <p>documented Resident #17 had a severe cognitive impairment and required extensive assistance with all cares but eating. The MDS documented he experienced one fall with no injury.</p> <p>The care plan area addressing Resident #17's risk for falls, undated, documented staff were to follow the fall protocol and use a gait belt with transfers and ambulation PRN, and staff were to follow with a wheelchair while ambulating PRN.</p> <p>The Fall Risk Evaluations, dated 9/9/18, documented Resident #17 was a high fall risk, and required the use of assistive devices with gait/balance/ambulation.</p> <p>An I&amp;A Report, dated 9/9/18, documented Resident #17 was ambulating with his front wheeled walker and his knees buckled and he went down on the floor. The I&amp;A documented the facility staff was reminded to utilize a gait belt and follow behind with his wheelchair. The I&amp;A documented he was a 1 person assist with ambulation and a walker.</p> <p>On 11/26/18 at 5:07 PM, Resident #17 was observed assisted to the dining room by CNA #5. CNA #5 had a gait belt around his mid-section and she was holding onto the gait belt from the top with two fingers and her thumb. CNA #5 walked Resident #17 from his room and into the dining room with her fingers on the top of the gait belt. CNA #5 readjusted her hand to under the gait belt as she approached a chair and assisted him into the chair.</p> <p>On 11/27/18 at 4:39 PM, the DON stated aides</p>	F 689			

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F 689	Continued From page 33 should be holding the gait belt with their hands under the belt and not over the belt. The DON stated all CNAs were trained with proper use of gait belts. The DON stated the PT department trained all CNAs on the proper use of the gait belt. The DON also said she would reeducate staff of the proper use of a gait belt.	F 689			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents received respiratory care as ordered by a physician. This was true for 1 of 1 resident (Resident #9) reviewed for respiratory care. The deficient practice had the potential for harm if residents did not receive nebulizer treatments as ordered to maintain adequate oxygen levels. Findings include:  The facility's Nebulizer Policy and Procedure, dated 5/2007, documented nursing staff would	F 695	Corrective Actions: Corrective Action for resident #9, was to change resident to a mask for his duoneb, continue to visualize him while the medication is administered, and update the care plan.  Identification of others affected and corrective action: No other residents were identified to be affected by this due to they were assessed to be able to self administer the breathing treatments.	1/11/19	

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F 695	<p>Continued From page 34</p> <p>administer nebulizer treatments per orders. The policy documented the nurse would provide the treatment at a residents' bedside and add the medication into the device. The policy documented staff would encourage residents to breathe through the mouth piece. The policy did not document if the staff had to stay with the resident.</p> <p>Resident #9 was admitted to the facility on 2/4/14, with diagnoses which included COPD.</p> <p>A quarterly MDS assessment, dated 11/9/18, documented Resident #9 was severely cognitively impaired and received oxygen therapy.</p> <p>The undated care plan addressed Resident #9's COPD. It included documentation of Patient #9's wheezing and dependence on oxygen, and a plan for him to receive nebulizer treatment per orders. The care plan did not document he was assessed to self-administer the medication.</p> <p>Resident #9's Physicians Orders included the following:</p> <ul style="list-style-type: none"> <li>- Ipratropium- Albuterol Solution (inhaler used to treat wheezing and shortness of breath) 0.5-2.5 mg/3 ml vial inhaled four times daily for COPD / asthma, ordered 3/18/16.</li> <li>- Ipratropium- Albuterol Solution 0.5-2.5 mg/3 ml vial inhaled every 3 hours PRN for COPD, ordered 3/18/16.</li> </ul> <p>Resident #9's 11/1/18 -11/27/18 MAR documented his scheduled Albuterol Solution treatment was provided per physician's orders.</p>	F 695	<p>Measures to ensure that deficient practice does not happen again: Educate all current licensed nurses on breathing treatments and self-administration requirements.</p> <p>Monitor corrective actions: DON or designee will monitor use of breathing treatments usage 2 times/week for 6 weeks. The audit results will be brought to QA monthly. Audits will begin 01/14/19.</p> <p>Corrective actions will be completed 01/11/19.</p>		

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F 695	Continued From page 35  On 11/27/18 at 2:08 PM, Resident #9's Albuterol Solution hand held device was observed to be misting and the device was positioned on his chest and away from his mouth. Resident #9 appeared to be sleeping. At 2:13 PM, Resident #9's eyes opened, and he placed the hand held device to his mouth.  On 11/27/18 at 2:19 PM, CNA #2 entered Resident #9's room and removed the hand held device from Resident #9's hand to clean it. Resident #9's eyes were closed and CNA #2 said to him he could go back to sleep.  On 11/27/18 at 2:21 PM, CNA #2 stated Resident #9 would fall asleep and she would go in to periodically check on him to ensure he was holding the hand held device to his mouth. CNA #2 stated most days she would have to remind him to place the hand held device near his mouth. CNA #2 stated she would check on him every 5-10 minutes and she knew the treatment was completed when the liquid was gone and not misting.  A Self-Administration Assessment, dated 11/30/18, documented Resident #9 dozed off during administrations of his breathing treatments and the staff were to place the medication cart outside his room to visualize him while he administered the medication.  On 11/27/18 at 2:54 PM, LPN #1 stated she had administered the breathing treatment for Resident #9 and left the room. LPN #1 stated it was not facility practice to stay with the resident while the resident completed the breathing	F 695			

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F 695	Continued From page 36 treatment. LPN #1 stated a breathing treatment was considered a medication and she did observe residents while they received other medications. LPN #1 stated if the device was not in Resident #9's mouth he was not receiving the medication. LPN #1 stated staff would periodically check on Resident #9 and remind him to place the hand held device in his mouth.  On 11/27/18 at 2:59 PM, the DON stated it was not facility practice to observe residents while nebulizer treatments were administered. The DON stated the nursing staff periodically checked on the residents to ensure they received their full doses and the nebulizer treatments were considered medications.	F 695			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(2) For excessive duration; or  §483.45(d)(3) Without adequate monitoring; or  §483.45(d)(4) Without adequate indications for its use; or  §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		1/11/19	

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F 757	<p>Continued From page 37</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents receiving a psychoactive medication had an appropriate indication for use of the medication. This was true for 1 of 5 residents (Resident #13) reviewed who received a medication for aggression. This deficient practice created the potential for harm if residents received medications that may result in negative outcomes without clear indication of need. Findings include:</p> <p>Resident #13 was admitted to the facility on 1/13/18, with diagnoses including dementia, weakness, and heart issues.</p> <p>A physician order, dated 10/2/18, documented Resident #13 received Propranolol 10 mg twice daily for high blood pressure and aggression.</p> <p>The facility's pharmacy review book for psychiatric medications, documented Propranolol was used for control of Resident #13's side effects.</p> <p>The care plan area addressing Resident #13's behaviors, undated, did not identify specific behaviors to monitor.</p> <p>On 11/27/18 at 4:09 PM, the DON stated the facility's Behaviors Committee worked with the consulting pharmacist and requested an order for the Propranolol to treat Resident #13's behaviors.</p>	F 757	<p>Corrective Actions:</p> <p>Corrective Action for resident #13, was to implement behavior monitoring that will be reviewed during pharmacy review as well as the doctor lowered her parameters for administration of her Propranolol.</p> <p>Identification of others affected and corrective action:</p> <p>Any resident may have been affected. We will review current residents for behavior monitoring and if implemented.</p> <p>Measures to ensure that deficient practice does not happen again:</p> <p>Pharmacy IDT will be educated on ensuring that resident behaviors are monitored.</p> <p>Monitor corrective actions:</p> <p>Executive Director or designee will monitor for behavior monitoring 2 times/month for 3 months. The audit results will be brought to QA monthly. Audits will begin 01/14/19.</p> <p>Corrective actions will be completed 01/11/19.</p>		

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F 757	Continued From page 38 The DON said the facility failed to identify the Propranolol was being used to manage Resident #13's behaviors. The DON also acknowledged the facility failed to monitor Resident #13's behaviors to determine if the medication was effective in treating her behaviors.  On 11/28/18 at 11:45 AM, the SSD stated the facility did not implement behavior monitoring for the blood pressure medication used for aggression because it was not a psychoactive medication.  On 11/29/18 at 11:50 AM, the consulting pharmacist stated Propranolol was used for the treatment of residents with aggression.	F 757			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  §483.60(i) Food safety requirements. The facility must -  §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		1/11/19	

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F 812	<p>Continued From page 39</p> <p>standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, review of facility policy and the 2017 FDA Food Code, and staff interview, it was determined the facility failed to ensure food was handled properly and maintained according to safe practices. This was true when Potentially Hazardous Food (PHF) cold food temperatures were not assessed prior to service. The facility failed to ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen. These failed practices placed 26 of 26 residents (#1 - 25 and #28) who dined in the facility, at risk of adverse health outcomes. Findings include:</p> <p>1. The facility's Dietary Handwashing Policy and Procedure, undated, documented staff should wash their hands after handling soiled equipment or utensils. The policy documented staff should wet their hands, apply soap, rub their hands together for 20 seconds and, rinse well and dry their hands.</p> <p>On 11/29/18 at 8:53 AM, Dishwasher #1 was observed during the dishwashing process. Dishwasher #1 was observed touching and rinsing off dirty dishes and began putting clean dishes away without performing hand hygiene. The Certified Dietary Manager (CDM) in training was present during the observation. She stated this was not the correct procedure for handling clean dishware. The CDM in training approached Dishwasher #1 and reminded him to wash his hands. Dishwasher #1 then began washing soiled dishes again and when he was completed</p>	F 812	<p>Corrective Actions:</p> <p>Corrective Actions for resident #1, through #25, and #28 was to educate all dietary staff on hand washing, pots and ware washing, procedures, cleaning and sanitizing, infection control and temperature control.</p> <p>Identification of others affected and corrective action: Any resident may have been affected. The education provided to all dietary staff on hand washing, pots and ware washing procedures, cleaning and sanitizing, infection control and temperature control would be the corrective measure.</p> <p>Measures to ensure that deficient practice does not happen again: The education provided to all dietary staff on hand washing, pots and ware washing procedures, cleaning and sanitizing, infection control and temperature control would be the corrective measure.</p> <p>Monitor corrective actions: Executive Director or designee will monitor for hand washing, pots and ware washing procedures, and temps of salads 3 times/week for 6 weeks. The audit results will be brought to QA monthly. Audits will begin 01/14/19.</p> <p>Corrective actions will be completed 01/11/19.</p>		

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F 812	<p>Continued From page 40</p> <p>with the task, approached the three compartment sink and dipped his arms into the sanitizer for one second, then proceeded to dip his arms into the water compartment for one second, wrung his arms in the air and wiped his hands on his soiled apron, and began putting clean dishes away. The CDM in training was present during the observation. She stated this was not the correct procedure for washing hands or handling clean dishware. The CDM in training approached Dishwasher #1 and reminded him to wash his hands at the sink with soap and water. The CDM in training stated Dishwasher #1 should have washed his hands before touching the clean dishes.</p> <p>The facility failed to ensure measures were in place to prevent possible cross-contamination of dirty to clean areas in the kitchen for Residents #1 - 25 and #28.</p> <p>2. The 2017 FDA Food Code, Chapter 3, Part 3-5, Limitation of Growth of Organisms of Public Health Concern, subpart 3-501.12 Time/Temperature Control for Safety Food, Slacking, documented, "(A) Under refrigeration that maintains the food temperature at 5 C (41 F [Fahrenheit]) or less..."</p> <p>On 11/29/18 at 12:07 PM, Cook #1 was observed assessing the temperatures of hot food items. There was a cart of cold food items set out with chopped salad, milk, juice, condiment packets and lemon bars. Cook #1 stated he was finished with assessing temperatures of the food items at 12:39 PM. When asked who assessed the cold food items, Cook #1 responded Cook #2 would usually complete this task. Cook #1 asked Cook</p>	F 812			

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F 812	Continued From page 41 #2 if he had assessed the temperatures of the cold items and Cook #2 stated, "No." Cook #1 proceeded to obtain a temperature for the chopped salad. The chopped salad was assessed to be 46 degrees F. The lemon bars, milk, and juice were not assessed.  Cook #1 asked Cook #2 how long the salads were left out and Cook #2 stated approximately 15 minutes.  On 11/29/18 at 12:43 PM, Cook #1 asked the CDM in training what to do with the salad because its temperature was above 41 degrees F, and the CDM in training instructed Cook #1 to continue with tray-line and did not remove the chopped salads from service.  On 11/29/18 at 12:48 PM, the first chopped salad left the kitchen on a residents' tray.  On 11/29/18 at 1:19 PM, the CDM and CDM in training stated the milk and juice should be assessed for temperature. The CDM in training stated the chopped salad was a PHF food and the kitchen staff should have removed the salads and chilled it until it reached less than 41 degrees F. The CDM stated the salads should have been placed somewhere to chill until they reached the appropriate temperature.  The facility failed to ensure food was handled properly and maintained according to safe practices for Residents #1 - 25 and #28.	F 812			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control	F 880		1/11/19	

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F 880	<p>Continued From page 42</p> <p>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.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> <li>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</li> <li>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</li> <li>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</li> <li>(iv) When and how isolation should be used for a resident; including but not limited to:</li> </ul>	F 880			

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F 880	<p>Continued From page 43</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <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, staff interview, record review, and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented as they related to laundry service practices and hand hygiene practices. Failure to prevent cross-contamination during laundry services had the potential to impact 26 of 26 residents (#1 - 25 and #28) residing at the facility. Lapses in hand hygiene directly impacted 2 of 22 residents (#19 and #21)</p>	F 880	<p>Corrective Actions: Corrective Actions for resident #1, through #25, and #28 was to educate all laundry/housekeeping staff on sanitizing the washing rim before removing the clean items. Additionally, on resident #21 and #19; all current staff attended a hand washing clinic for hand washing, hand sanitizer, and if appropriate on pericare and dressing changes with regards to</p>		

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F 880	<p>Continued From page 44</p> <p>whose care was observed. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include:</p> <p>1. The facility's Infection Prevention and Control Program, revised 8/2016, documented measures to prevent infections, such as educating staff on proper techniques and procedures. The policy documented the facility provided personal protective equipment (PPE) and monitored employees for the proper use of PPE.</p> <p>On 11/29/18 at 2:25 PM, the Laundry Supervisor described the linen cleaning process. She stated the linens came in through a small sorting room where linens were sorted. This room was located in front of the main laundry room. She stated her staff wore aprons, gloves, and masks while in the small sorting room when they sorted laundry. She stated it was not facility practice to leave the sorting room with these items on. In addition, the Laundry Supervisor stated the washers were part of the soiled area and the dryers were part of the clean area. The Laundry Supervisor stated soiled items were placed into the washing machine and depending on the load, the detergent and sanitizer was added with an automated system. The Laundry Supervisor stated after the cycle was completed, the staff removed the clean items and placed them into the dryer. The Laundry Supervisor stated the staff did not sanitize the rim of the washing machine to prevent re-contamination of the clean items. The Laundry Supervisor stated she had not thought about the need to sanitize the washing rim before removing the clean items. The Laundry Supervisor stated the soiled items did touch the rim of the washing</p>	F 880	<p>hand hygiene.</p> <p>Identification of others affected and corrective action: Any resident may have been affected. The education provided to all laundry staff on cleaning the washing rim and staff on hand washing, hand sanitizer, and if applicable on pericare and dressing changes would be the corrective measure.</p> <p>Measures to ensure that deficient practice does not happen again: The education provided to all laundry staff on cleaning the washing rim and staff on hand washing, hand sanitizing, and if applicable pericare and dressing changes would be the corrective measure.</p> <p>Monitor corrective actions: The Infection Preventionist or designee will monitor for hand hygiene with pericare and dressing changes, along with laundry and washing the rim for 3 times/week for 6 weeks. The audit results will be brought to QA monthly. Audits will begin 01/14/19.</p> <p>Corrective actions will be completed 01/11/19.</p>		

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F 880	<p>Continued From page 45 machine and she saw the need to complete this step.</p> <p>The facility failed to ensure laundry items were not re-contaminated after the washing cycle was completed for Residents #1 - 25 and #28.</p> <p>2. According to the CDC website, accessed on 12/6/18, hand hygiene should be performed after removing gloves, after contact with blood, body fluids or excretions, mucous membranes, after contact with inanimate objects in the immediate vicinity of the patient, and if hands will be moving from a contaminated body site to a clean body site during patient care.</p> <p>a. Resident #21 was admitted to the facility on 11/23/16, with diagnoses including diabetes, skin ulcers and heart issues. Resident #21 was diagnosed with a leg wound infected with MRSA on 11/26/18.</p> <p>The care plan area addressing Resident #21's pressure ulcer documented she was at high risk for skin breakdown related to a history of a stage III pressure ulcer to her coccyx. The care plan documented Resident #21 had actual skin impairment to the right heel and right lower extremity. The care plan documented staff were to provide treatment as ordered to her right heel and right lower extremity. The care plan documented PT was to provide light therapy to her right lower extremity as ordered.</p> <p>On 11/28/18 at 9:00 AM, Resident #21's right lower extremity wound was observed with three open areas, one large and 2 smaller ones. LPN #2 stated the open area on her right lower</p>	F 880			

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F 880	<p>Continued From page 46</p> <p>extremity was new and had occurred since last week. LPN #2 stated Resident #21's right heel wound was draining and had not been open since last week.</p> <p>On 11/28/18 at 9:00 AM, Resident #21 was observed receiving her light therapy leg wound treatment by the Physical Therapy Assistant (PTA).</p> <p>The PTA was observed applying PPE, performing hand hygiene, and applying gloves. The PTA removed the soiled dressing and then removed her gloves, reapplied gloves and did not perform hand hygiene. The PTA cleansed the wound and removed her gloves, performed hand hygiene, and applied clean gloves. The PTA applied Resident #21's light therapy pads directly to the wound bed and timed the treatment. When the treatment was completed, the PTA removed the light pads, changed the plastic bag coverings to the light pads, and reapplied the light pads to her right heel wound for treatment. The PTA timed the treatment, removed the light pads and plastic bag covering, removed her gloves, applied new gloves without hand hygiene, and examined the wounds. The PTA removed all PPE, performed hand hygiene, and left the room.</p> <p>On 11/28/18 at 9:45 AM, the PTA stated she should have performed hand hygiene between glove changes.</p> <p>On 11/28/18 at 2:51 PM, RN #1 stated staff were to perform hand hygiene after removing gloves.</p> <p>b. Resident #19 was admitted to the facility on 1/18/16, with diagnoses which included</p>	F 880			

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F 880	<p>Continued From page 47</p> <p>Alzheimer's disease, dementia with behavioral disturbances, limitation of activities due to disability, and disorder of muscles.</p> <p>i. On 11/26/18 at 2:42 PM, Resident #19 was observed being assisted by CNA #1 and CNA #6 with pericare.</p> <p>CNA #1 was observed removing Resident #19's clothes and his soiled incontinence brief. CNA #1 with the assistance of CNA #6, provided Resident #19 with pericare. The CNAs applied a clean incontinence brief and adjusted his blankets without first performing hand hygiene or removing gloves. CNA #1 placed Resident #19's call light within reach and picked up his water cup by the rim and placed it next to him without first performing hand hygiene or removing gloves. At 2:52 PM, CNA #1 and CNA #6 removed their gloves and performed hand hygiene.</p> <p>On 11/26/18 at 2:53 PM, CNA #1 stated she forgot to remove her gloves and perform hand hygiene after pericare. CNA #1 stated she would provide Resident #19 with a new water cup and she would sanitize his call light.</p> <p>ii. On 11/27/18 at 8:38 AM, Resident #19 was observed being assisted by CNA #3 and CNA #6 with pericare after breakfast.</p> <p>CNA #3 was observed removing Resident #19's clothes and his soiled incontinence brief. CNA #3 with the assistance of CNA #6, provided Resident #19 with pericare. The CNAs applied a clean incontinence brief and adjusted his blankets without first performing hand hygiene or removing gloves. At 8:41 AM, CNA #3 and CNA</p>	F 880			

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F 880	Continued From page 48 #6 removed their soiled gloves and washed their hands.  iii. On 11/28/18 at 7:22 AM, CNA #3 was observed assisting Resident #19 with pericare. CNA #3 removed Resident #19's incontinence brief and provided pericare. CNA #3 placed a clean incontinence brief onto Resident #19 and removed her gloves, re-gloved, and assisted him with dressing. CNA #3 then performed hand hygiene.  On 11/28/18 at 1:38 PM, RN #1, who was the infection control RN, stated the correct protocol to complete hand hygiene for pericare consisted of staff washing their hands before starting cares, applying gloves, then providing pericare, then removing their gloves, sanitizing and re-gloving, applying a clean incontinence brief and clothing, and then assist the resident with washing their hands. RN #1 stated the hand hygiene issues described above were incorrect and she was told about some of them from the nursing staff. RN #1 stated she would complete an in-service on hand hygiene during pericare and wound care.	F 880			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)  §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31	F 883		1/11/19	

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F 883	<p>Continued From page 49</p> <p>annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p>	F 883			

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F 883	<p>Continued From page 50</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, CDC website review, and staff interview, it was determined the facility failed to ensure the development and implementation of processes to provide pneumococcal (bacterial pneumonia) immunizations consistent with current CDC guidelines. The facility's pneumococcal immunization process and pneumococcal immunization consent form did not reflect current CDC recommendations for 3 of 5 residents (#11, #19, and #22) reviewed for pneumococcal vaccination. This deficient practice placed residents at risk of developing pneumococcal pneumonia and developing subsequent serious, potentially life threatening, complications. Findings include:</p> <p>1. The CDC website, updated 9/6/17, documented recommendations for pneumococcal vaccination (PCV13 or Prevnar13, and PPSV23 or Pneumovax23) for all adults 65 years of older:</p> <p>* Adult 65 years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23.</p> <p>* If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most recent dose of PPSV23.</p>	F 883	<p>Corrective Actions: Corrective Actions for resident #11, was to educate and immunize with Prevnar13 as of 12/04/18. For resident #22 and #19, their consents were updated as per their family's request.</p> <p>Identification of others affected and corrective action: Any resident may have been affected. We will review current residents with their pneumovax history and if previous consent was refused we will update it accordingly, with our new consent form.</p> <p>Measures to ensure that deficient practice does not happen again: Education will be provided to all licensed nursing staff, regarding new consent form and that resident(s) will be educated on vaccination.</p> <p>Monitor corrective actions: The Infection Preventionist or designee will monitor for consents and ensure that education was provided to the resident for 3 times/week for 6 weeks. The audit results will be brought to QA monthly. Audits will begin 01/14/19.</p> <p>Corrective actions will be completed 01/11/19.</p>		

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F 883	<p>Continued From page 51</p> <p>The facility's Pneumococcal Vaccine Policy and Procedure, dated August 2016, documented the facility would offer the influenza and pneumococcal immunizations to residents in accordance with CDC guidelines.</p> <p>a. Resident #11 was readmitted to the facility on 11/24/18, with diagnoses which included heart failure, renal calculous obstructions, and hypertension.</p> <p>A consent for the administration of the pneumococcal vaccine, signed by Resident #11's family on 11/24/18, documented he consented to receive a pneumococcal vaccine every 5 years. The 11/24/18 consent did not include the type of pneumococcal vaccine Resident #11 would receive every 5 years (PCV13 or Pneumovax23). Resident #11's record did not include documentation he was provided with the current CDC pneumococcal vaccine recommendations, nor the risks and benefits of receiving the vaccine.</p> <p>b. Resident #22 was admitted to the facility on 11/2/17, with diagnoses which included chronic kidney disease and hypertension.</p> <p>A consent for the administration of the pneumococcal vaccine, signed by Resident #22's family on 11/2/17, documented she declined the pneumococcal vaccine. The consent form did not specify the type of pneumococcal vaccine Resident #22 was declining (PCV13 or Pneumovax23). Resident #22's medical record did not include documentation she was provided with the current CDC pneumococcal vaccine recommendations and the risks and benefits of</p>	F 883			

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F 883	<p>Continued From page 52 receiving the vaccine.</p> <p>c. Resident #19 was admitted to the facility on 1/18/16, with diagnoses which included Alzheimer's disease, dementia with behavioral disturbances, limitation of activities due to disability, and disorder of muscles.</p> <p>Resident #19's Immunization Record documented his family refused the Pneumovax23 on 1/18/16 and the PCV13 on 4/10/17. The immunization record documented education was provided to the family. However, Resident #19's record did not contain evidence of a signed or verbal consent for the refusal of the vaccine. Resident #19's medical record did not include documentation he was provided with the current CDC pneumococcal vaccine recommendations and the risks and benefits of refusing the vaccine.</p> <p>On 11/28/18 at 1:38 PM, RN #1, who was the infection control RN, stated the consents for the pneumococcal vaccine were not updated with the current CDC guidelines. RN #1 stated Resident #19's family was of a certain religion and they refused most things. RN #1 stated Resident #11 had previously refused the pneumococcal vaccine and she would administer the vaccine when it was available.</p>	F 883			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001170</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/30/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DISCOVERY REHABILITATION AND LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SHANAFELT STREET SALMON, ID 83467</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the State licensure survey conducted at the facility from November 26, 2018 to November 30, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN, LD, Team Coordinator Carmen Blake, RN</p>	C 000		
C 422	<p>02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas</p> <p>vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure a minimum number of bathing facilities were maintained for 26 of 26 residents (#1 - 25 and #28) residing at the facility. This resulted in the potential for residents to experience a lack of bathing opportunities. Findings include:</p> <p>The facility was licensed for 45 certified beds. At the beginning of the survey process, 26 residents resided in the facility.</p> <p>On 11/25/18 at 2:25 PM, the Bathing Room was observed with 1 bathtub filled with equipment and</p>	C 422	A request for another waiver is being made.	1/11/19

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

TITLE

(X6) DATE  
01/06/19

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001170</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/30/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DISCOVERY REHABILITATION AND LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 SHANAFELT STREET SALMON, ID 83467</b>
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C 422	<p>Continued From page 1</p> <p>one shower stall in usable condition for residents.</p> <p>The Administrator stated he was aware the facility did not have the required number of bathing facilities for the number of licensed beds. The Administrator stated the facility had historically been granted a waiver for this requirement, as the number of bathing facilities was sufficient to meet resident bathing needs and preferences, and the facility planned to request a waiver again.</p> <p>Individual and group resident interviews and resident family interviews conducted throughout the survey revealed no difficulties with residents receiving baths or showers. No concerns with resident bathing were identified through resident reviews.</p>	C 422		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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June 19, 2019

Steve Lish, Administrator  
Discovery Rehabilitation and Living  
600 Shanafelt Street,  
Salmon, ID 83467-4261

Provider #: 135129

Dear Mr. Lish:

On **November 26, 2018 through November 30, 2018**, an unannounced on-site complaint survey was conducted at Discovery Rehabilitation and Living. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007899**

**ALLEGATION #1:**

Facility failed to ensure residents were protected from situations wherein there was a high likelihood of accidents and injury, resulting in a resident sustaining a hip fracture.

**FINDINGS #1:**

Two surveyors conducted an onsite complaint investigation at the facility. Observations were conducted throughout the facility and interviews were conducted with residents, residents' family, and staff.

One resident's record reviewed documented she was at high risk for falls, and had fall risk factors including behaviors, unawareness of safety, and impaired gait (walking). A physical therapy evaluation documented goals for the resident were turning and sitting into a chair using a rolling walker and correct hand placement. The physical therapy evaluation also documented the resident required skilled therapy and interventions for safe mobility. The resident's quarterly fall risk assessment documented

Steve Lish, Administrator  
June 19, 2019  
Page 2

she had balance problems with standing/walking. The resident fell when she attempted to sit on a rolling stool used by staff in the dining room without supervision and sustained a hip fracture.

Another resident's care plan documented he was a medium fall risk and staff were to utilize a gait belt with transfers to his wheelchair. A staff member was observed assisting the resident from his wheelchair to his bed and did not utilize a gait belt with the transfer. In an interview with the restorative nurse, she stated staff members should be utilizing a gait belt with all transfers as documented in the care plan.

A third resident's fall risk evaluation documented he was a high fall risk and required the use of assistive devices with gait/balance/ambulation. The resident's care plan documented staff were to follow the fall protocol and use a gait belt with transfers and ambulation as needed, and staff were to follow with a wheelchair when the resident was ambulating. Review of an injury and accident report for the resident documented he was ambulating with his front wheeled walker and his knees buckled, and he went down to the floor. The report documented the facility staff was reminded to utilize a gait belt and follow behind his wheelchair.

#### CONCLUSIONS:

Based on the investigative findings, the allegation was substantiated. A deficiency was cited at F689 as it relates to the failure of the facility to ensure residents were provided with the services and supervision necessary to prevent falls.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



BELINDA DAY, RN, Supervisor  
Long Term Care Program