



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

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

December 21, 2018

Brian Davidson, Administrator  
Good Samaritan Society - Boise Village  
3115 Sycamore Drive  
Boise, ID 83703-4129

Provider #: 135085

Dear Mr. Davidson:

On **November 30, 2018**, a survey was conducted at Good Samaritan Society - Boise Village by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 31, 2018**.

Brian Davidson, Administrator  
December 21, 2018  
Page 2 of 4

Failure to submit an acceptable PoC by **December 31, 2018**, may result in the imposition of civil monetary penalties by **January 23, 2019**.

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

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

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

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

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

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

- **Civil Money Penalty**
- **Denial of payment for new admissions effective March 1, 2019**

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.**

Brian Davidson, Administrator  
December 21, 2018  
Page 3 of 4

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

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

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

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

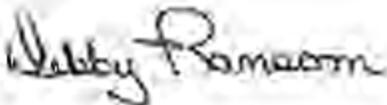
- BFS Letters (06/30/11)

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

This request must be received by **December 31, 2018**. If your request for informal dispute resolution is received after **December 31, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

dr/lj

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

PRINTED: 01/14/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/30/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from Novemeber 26, 2018 to November 30, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Presie Billington, RN Linda Close, RN Karen George, RN</p> <p>Survey Abbreviations:</p> <p>ADL = Activity of Daily Living BG = blood glucose cm = centimeter CNA = Certified Nursing Assistant DON = Director of Nursing LSW = Licensed Social Worker LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams RCM = Resident Care Manager RN = Registered Nurse RNA = Restorative Nursing Assistant u/ml = units per milliliter</p>	F 000			
F 580 SS=D	<p>Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p>	F 580		1/18/19	

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

TITLE

(X6) DATE

Electronically Signed

12/27/2018

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

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F 580	<p>Continued From page 1</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various</p>	F 580			

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F 580	<p>Continued From page 2</p> <p>locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure the physician was notified of residents' high blood glucose (BG) levels. This was true for 2 of 2 (#17 and #73) residents reviewed for diabetic management. Residents #17's and Resident #73's physician was not notified when their blood glucose results were greater than 400, as ordered by the physician. This failed practice had the potential for harm if Resident #17 and Resident #73 experienced signs and symptoms of hyperglycemia. Findings include:</p> <p>1. Resident #17 was admitted to the facility on 8/21/18, with multiple diagnoses including diabetes mellitus.</p> <p>Resident #17's admission MDS assessment, dated 8/28/18, documented she was cognitively intact and received insulin injections daily.</p> <p>Resident #17's November 2018 recapitulated Physician's Orders directed staff to notify the physician when Resident #17's BG was less than 70 or greater than 400, ordered on 8/21/18.</p> <p>Resident #17's 10/1/18 through 10/31/18 MAR, documented he had a BG result of greater than 400 on the following dates:</p> <p>* 10/16/18 - 405 at bedtime * 10/19/18 - 485 before dinner</p>	F 580	<p>General Disclaimer</p> <p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p> <p>F580 – Notify of Changes</p> <p>Resident Specific</p> <p>The physician has been notified of resident #17 and #73's high blood glucose (BG) levels and documented in the residents' record.</p> <p>Other Residents</p> <p>All residents with diabetes mellitus have the potential to be affected by this</p>		

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F 580	<p>Continued From page 3</p> <p>* 10/29/18 - 429 at bedtime * 10/31/18 - 448 before dinner</p> <p>There was no documentation in Resident #17's record the physician was notified when his BG results were greater than 400.</p> <p>On 11/29/18 at 8:23 AM, RN #1 said Resident #17's record did not include documentation his physician was notified when his BG levels were over 400. RN #1 said the nurse should have notified the physician and documented it in Resident #17's progress note.</p> <p>On 11/29/18 at 11:14 AM, the DON said her expectation was for staff to follow Resident #17's physician's orders and call the physician when his BG result was greater than 400.</p> <p>2. Resident #73 was admitted to the facility on 2/8/10, with multiple diagnoses which included diabetes mellitus.</p> <p>Resident #73's quarterly MDS assessment, dated 11/2/18, documented his cognition was moderately impaired and he received insulin injections daily.</p> <p>Resident #73's November 2018 recapitulated Physician's Orders directed staff to notify the physician when Resident #73's BG level was less than 70 or greater than 400, ordered on 4/2/15.</p> <p>Resident #73's MAR documented his BG level was 402 the evening of 10/4/18. There was no documentation in Resident #73's record his physician was notified of the BG level of 402.</p>	F 580	<p>practice. The nurse care managers completed an audit of all current residents with diabetes mellitus to ensure the doctor has been notified when BG levels are less than or greater than parameters ordered by the doctor. Such notifications will be documented in the resident record.</p> <p>Facility System</p> <p>In-servicing regarding BG levels, parameters, notifying the doctor, and documenting in the resident record has been provided for licensed nurses.</p> <p>Monitor</p> <p>Starting on 1/4/19, the nurse care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure resident abnormal BG levels are reported to the doctor and documented in the resident record. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p> <p>Date of Compliance</p> <p>January 18, 2019</p>		

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F 580	Continued From page 4 On 11/29/18 at 11:14 AM, the DON looked at Resident #73's record and said it was her expectation that staff follow Resident #73's physician's order and call the physician when his BG level was greater than 400.	F 580			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of resident records and facility policies, it was determined the facility failed to thoroughly investigate an injury of unknown origin as an allegation of potential abuse or neglect. This was true for 1 of 3 residents (Resident #12) reviewed for abuse or neglect. This deficient practice placed Resident #12 at risk of ongoing abuse/neglect and had the potential to affect the other residents residing in the facility. Findings include:	F 610	F610 – Investigate/Prevent/Correct Alleged Violation  Resident Specific  The facility has fully investigated the injury of unknown origin for resident #12. This included interviewing licensed nurses and observing the cares of other residents on the Eagle Unit. The	1/18/19	

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F 610	<p>Continued From page 5</p> <p>The facility's Abuse and Neglect Policy and Procedure, revised on October 2018, documented the following:</p> <ul style="list-style-type: none"> <li>* Ensure all identified incidents of alleged or suspected abuse/neglect were promptly investigated and reported.</li> <li>* Ensure that all identified incidents involving injuries of unknown origin were promptly investigated to determine probable cause of unknown origin injuries.</li> <li>* The facility would have evidence that all alleged or suspected violations are thoroughly investigated.</li> <li>* The investigation may include interviewing employees, residents or other witnesses to the incident.</li> </ul> <p>Resident #12 was admitted to the facility on 4/28/15, with multiple diagnoses which included anoxic (loss of oxygen supply) brain damage.</p> <p>Resident #12's quarterly MDS assessment, dated 8/29/18, documented she was cognitively impaired and required extensive assistance of 1-2 staff members for cares.</p> <p>Resident #12's Care Plan documented she used a Hoyer lift (mechanical) and required total assistance of two staff members for transfers.</p> <p>A Nurse's Progress Note, dated 12/13/18 at 5:53 PM, documented Resident #12 had pneumonia and was started on an antibiotic.</p>	F 610	<p>physician was notified. The facility did follow up with the hospital with no response.</p> <p>Other Residents</p> <p>All residents with injuries of unknown origin could be affected. The nurse care managers completed an audit of all current residents with injuries of unknown origin to ensure all such incidents had been fully investigated.</p> <p>Facility System</p> <p>The nurse care managers have been in-serviced regarding resident injuries of unknown origin to ensure each incident is fully investigated.</p> <p>Monitor</p> <p>Starting on 1/4/19, the nurse care managers will audit residents experiencing injuries of unknown origin weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure these incidents have been fully investigated. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p> <p>Date of Compliance</p> <p>January 18, 2019</p>		

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F 610	Continued From page 6  A Nurse's Progress Note, dated 12/26/18 at 11:55 AM, documented a repeat chest X-ray was done at the facility which showed Resident #12 had evidence of worsening pneumonia. The physician was notified and ordered Computerized Tomography (CT) scan to rule out pleural effusion (fluid in the lungs).  A CT Scan report, dated 12/26/18 at 2:02 PM, documented Resident #12 had right sided empyema (pus in the lungs), and a pulmonary consult was recommended.  A Nurse's Progress Note, dated 12/27/18 at 11:21 AM, documented Resident #12 was referred to a pulmonologist.  A Nurse's Progress Note, dated 1/2/18 at 1:28 PM, documented Resident #12 was scheduled for thoracentesis (a procedure to remove fluid from the lungs) on 1/5/18.  A Nurse's Progress Note, dated 1/5/18 at 3:24 PM, documented Resident #12 was admitted to the hospital for thoracentesis (insertion of a needle to remove excess fluid from the lungs and/or chest wall).  A Nurse's Progress Note, dated 1/12/18 at 6:13 PM, documented Resident #12 was discharged from the hospital and admitted back to the facility with a percutaneous indwelling central catheter (PICC) on her left upper arm.  A Nurse's Progress Note, dated 1/17/18 at 1:13 PM, documented Resident #12 went back to the hospital for an appointment with her	F 610		

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F 610	<p>Continued From page 7 pulmonologist.</p> <p>A Nurse's Progress Note, dated 2/14/18 at 12:05 PM, documented Resident #12 went back to the hospital for a repeat CT Scan.</p> <p>A Nurse's Progress Note, dated 2/14/18, at 12:50 PM, documented Resident #12's hospital physician called and informed the facility Resident #12 had a left anterior shoulder dislocation with fracture of the left humeral head (fracture at the top of the arm bone where it connects to the shoulder) based on the CT Scan result. The facility's physician was notified of the CT Scan result and said there was no way of knowing how it happened and it could have happened in the hospital during one of her visits.</p> <p>A CT Scan of Resident #12's chest, dated 2/14/18, documented "Anterior dislocation of the left humeral head with fracturing of the left humeral head. The left femoral head is perched on the anterior glenoid. Fracture of the inferior aspect of the glenoid (part of the shoulder)."</p> <p>An Incident and Accident report, dated 2/23/18, documented Resident #12 had not had a fall since 5/28/17, required total assistance for all cares, was on an air bed, and used a Hoyer lift for transfers. The report documented all of Resident #12's caregivers made statements as to how they provided care to her. The report contained written statements from two day shift CNAs and two evening shift CNAs who all said they used a Hoyer lift when transferring the resident and there were always two staff members present when she was being transferred. The report did not include statements</p>	F 610			

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F 610	Continued From page 8 or interviews of licensed nurses who provided care to Resident #12. The report also did not include interviews of other residents in the Eagle Hall where Resident #12 stayed, and whether the hospital was contacted regarding the incident. The Incident and Accident report documented Resident #12 received routine pain medications via her percutaneous endoscopic gastrostomy (PEG) tube and there was no increase in her pain level noted. The report concluded that abuse and neglect were ruled out and the facility could not find conclusive evidence Resident #12's injury occurred in the facility.  On 11/30/18 at 11:30 AM, the DON, with LSW #1 present, said Resident #12's left arm was contracted, and her injury could have happened during her PICC line insertion at the hospital. The DON said the facility called the hospital but the hospital did not cooperate with the investigation and she believed hospital staff hung up on them. The DON said she was not sure why the licensed nurses were not interviewed. The DON said Resident #12 was in Eagle Hall which was the Brain Injury unit and there was only one resident who was interviewable during the time the incident was being investigated and they did not interview that resident. When asked if residents were observed for their reactions or facial expressions while the staff were providing cares or while they were being transferred using a Hoyer lift as part of the investigation, the DON said they did not.	F 610			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		1/18/19	

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

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F 623	<p>Continued From page 9</p> <p>resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p>	F 623			

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F 623	<p>Continued From page 10</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <ul style="list-style-type: none"> <li>(i) The reason for transfer or discharge;</li> <li>(ii) The effective date of transfer or discharge;</li> <li>(iii) The location to which the resident is transferred or discharged;</li> <li>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</li> <li>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</li> <li>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</li> <li>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</li> </ul> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon</p>	F 623			

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F 623	<p>Continued From page 11 as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review, and record review, it was determined the facility failed to ensure transfer notices were provided in writing to residents and the local Ombudsman. This was true for 4 of 4 residents (#3, #41, #57, and #77) reviewed for transfers and had the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:  The facility's policy and procedure for Transfers and Discharges, last revised 9/2017, documented the following:  Before a resident transfers or discharges, the facility must:  * Notify the resident and the resident's representative of the transfer or discharge and the reason for the move in writing and in a language and manner they understand.  * When a resident is temporarily transferred on</p>	F 623	<p>F623 – Notice Requirements Before Transfer/Discharge</p> <p>Resident Specific</p> <p>A written transfer/discharge notice has been given to residents #41, #57, and #77 and/or to the resident's representative as well as to the Ombudsman for the specific dates noted in the 2567. Resident #3 deceased on 12/10/18.</p> <p>Other Residents</p> <p>Failure to ensure transfer notices were provided in writing to residents, resident representatives, and to the local Ombudsman had the potential to affect all residents if residents were not made aware of or able to exercise their rights related to transfers or discharges. Social services have audited all resident</p>		

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F 623	<p>Continued From page 12</p> <p>an emergency basis to an acute care center, the facility must send a copy of the transfer to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>1. a. Resident #41 was admitted to the facility on 12/7/12, with multiple diagnoses including cerebral palsy.</p> <p>Nurses' Progress Notes documented the facility transferred Resident #41 to the hospital on 2/8/18, 4/2/18, and 9/10/18. Resident #41's medical record did not document the facility provided written notice of the three transfers to Resident #41 and/or Resident #41's representative, or the Ombudsman.</p> <p>b. Resident #77 was admitted to the facility on 12/30/14, with multiple diagnoses cerebral vascular accident (stroke).</p> <p>Nurses' Progress Notes documented the facility transferred Resident #77 to the hospital on 3/26/18, 8/13/18, and 9/1/18. Resident #77's medical record did not document the facility provided written notice of the three transfers to Resident #41 and/or Resident #77's representative, or the Ombudsman.</p> <p>On 11/29/18 at 9:54 AM and at 10:35 AM, LSW #2 stated the facility had not contacted or notified the Ombudsman of a resident's transfer to the hospital, until the transfer became a discharge situation. LSW #2 stated she was not aware of the need to contact the Ombudsman when the resident was expected to return to the facility. LSW #2 stated the facility had not implemented written notices of transfers for Resident #41 and</p>	F 623	<p>transfers/discharges of current residents to ensure proper notices have been served.</p> <p>Facility System</p> <p>In-servicing has been completed for social services and nurse care mangers to ensure transfer notices are provided in writing to residents and/or resident representatives, and to the local Ombudsman. The notice must include the reason for the move, the effective date of transfer or discharge, the location where resident is transferred or discharged, and a statement of the resident's appeal rights.</p> <p>Monitor</p> <p>Starting on 1/4/19, social services will audit transfer/discharge notices weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure they have been served to the appropriate individuals and agencies. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p> <p>Date of Compliance</p> <p>January 18, 2019</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	<p>Continued From page 13</p> <p>Resident #77 when they were admitted to the hospital, as the expectation was for them to return to the facility. LSW #2 stated the Ombudsman was not notified of the residents' hospitalizations.</p> <p>2. Resident #3 was admitted to the facility on 12/8/17, with diagnoses that included Rheumatoid arthritis, diabetes mellitus, and chronic pain. The medical record indicated Resident #3 was transferred to the hospital on 7/29/18 and was readmitted to the facility on 7/31/18 with a diagnosis of atrial fibrillation (irregular heart rate.)</p> <p>Resident #3's quarterly MDS assessment, dated 6/20/18, documented he was cognitively intact.</p> <p>Nurses' Progress Notes documented Resident #3 was transferred to the hospital on 7/29/18 and was readmitted to the facility on 7/31/18, with a diagnosis of atrial fibrillation (irregular heart rate.) Resident #3's medical record did not document the facility provided written notice of the transfer to Resident #3 and/or Resident #3's representative, or the Ombudsman</p> <p>On 11/29/18 at 5:30 PM, LSW #3 stated she did not notify Resident #3 and Resident #3's representative in writing of the reason for transfer to hospital and she did not notify the Ombudsman.</p> <p>3. Resident #57 was admitted to the facility on 11/1/10 with multiple diagnoses, including hemiplegia (paralysis.)</p> <p>Resident #57's annual MDS assessment, dated</p>	F 623			

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F 623	Continued From page 14 10/20/18, documented he had severe cognitive impairment.  Resident #57's Nurses' Progress Notes documented he was transferred to the hospital on 11/12/18 and was readmitted to the facility on 11/21/18, with multiple diagnoses, including urosepsis (severe urinary tract infection.) Resident #57's medical record did not document the facility provided written notice of the transfer to Resident #57 and/or Resident #57's representative, or the Ombudsman  On 11/29/18 at 5:30 PM, LSW #3 provided a copy of a signed bed-hold for Resident #57's transfer. LSW #3 stated she did not notify the resident and resident's representative in writing of the reason for transfer to hospital and she did not notify the Ombudsman.	F 623			
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 nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with	F 625		1/18/19	

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F 625	<p>Continued From page 15 paragraph (e)(1) of this section, permitting a resident to return; and (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: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure bed-hold agreements were provided to a resident. This was true for 1 of 4 residents (#57) reviewed for transfers. The deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include:</p> <p>The facility policy for Bed-Hold Notice, last revised 11/2016, directed staff that at the time of admission, transfer or therapeutic leave, the facility will provide written information to the resident or resident representative that specifies:</p> <ul style="list-style-type: none"> <li>* The duration of the State bed-hold policy, if any, during which a resident is permitted to return and resume residence.</li> <li>* The reserve bed payment policy in the State plan.</li> <li>* The location's policies regarding bed-hold</li> </ul>	F 625	<p>F625 – Notice of Bed Hold Policy Before/Upon Transfer</p> <p>Resident Specific</p> <p>The facility has issued a bed hold notice to resident #57 and to the resident representative outlining the duration and payment policy.</p> <p>Other Residents</p> <p>All residents who transfer out of the facility are at risk if bed hold agreements are not issued specifying the duration of the bed-hold and the resident's right to return to their former bed/room at the facility within a specified time frame.</p> <p>Facility System</p> <p>In-servicing was completed for social services and nurse care managers to ensure bed-hold notices are being served</p>		

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F 625	Continued From page 16 periods permitting a resident to return.  Resident #77 was admitted to the facility on 12/30/14, with multiple diagnoses including cerebral vascular accident (stroke.)  Nurses' Progress notes from 1/1/18 through 11/30/18, documented the facility transferred Resident #77 to the hospital on 3/26/18, 8/13/18, and 9/1/18, .  Resident #77's medical record did not document the facility provided the resident with a bed-hold notification when the resident was transferred to the hospital on 3/26/18, 8/13/18, and 9/1/18.  On 11/29/18 at 11:40 AM, LSW #1 stated they looked for the bed-hold notifications for Resident #77's three stays at the hospital over the last year and the notifications could not be found.  On 11/29/18 at 11:45 AM, LSW #2 stated they were not able to find the bed-hold notifications for Resident #77 and the notifications had not been completed.	F 625	to residents and/or resident representatives when residents transfer to the hospital or go on therapeutic leave.  Monitor  Starting on 1/4/19, social services will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure residents who transfer to the hospital or go out on therapeutic leave receive bed-hold notices. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.  Date of Compliance  January 18, 2019		
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	F 656		1/18/19	

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F 656	Continued From page 17 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document 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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, policy review, review of Incident and Accident Reports, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans. This was true for 3 of 18 residents (#32, #35, and #65) reviewed for	F 656	F656 – Develop/Implement Comprehensive Care Plan  Resident Specific  Resident #35's care plan was updated to		

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F 656	<p>Continued From page 18</p> <p>care plans. Resident #2's care plan did not address her risk for skin injury, and Resident #32 and #65's care plans did not address their use of antipsychotic medications including the specific behavior and side effects of the medication the staff were to monitor. These failures created the potential for residents to receive inappropriate or inadequate care with a subsequent decline in health. Findings include:</p> <p>The facility's Care Plan Policy revised on November 2016, documented each resident would have an individualized, person centered, comprehensive plan of care that would include measurable goals and timetables directed toward, achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. The policy also documented the residents' care plan would emphasize the care and development of the whole person ensuring that the resident would receive appropriate care and services.</p> <p>1. Resident #32 was admitted to the facility on 6/10/14 with multiple diagnoses, which included traumatic brain injury.</p> <p>Resident #32's quarterly MDS assessment, dated 9/19/18, documented he was cognitively impaired, had physical and verbal behaviors directed toward others occurring several days of the week and received antipsychotic and antidepressant medications daily.</p> <p>Resident #32's Care Plan revised on 3/1/17, documented he had mood and behavioral symptoms related to his history of traumatic brain</p>	F 656	<p>address her risk for skin tear injuries. Resident #32 and #65's care plans were updated to address their use of antipsychotic medications to include the specific behavior and side effects of the medication that the staff is to monitor.</p> <p>Other Residents</p> <p>All residents with fragile skin are prone to develop skin tears. The care managers completed an audit of all residents with fragile skin to ensure the care plan addresses the risk for skin tear injuries. All residents using antipsychotic medications are at risk for specific behaviors and side effects. Social services completed an audit of all residents on antipsychotic medications to ensure the care plan addresses specific behaviors and side effects that the staff is to monitor.</p> <p>Facility System</p> <p>In-servicing has been completed for nursing to care plan residents at risk for skin tears and social services to care plan specific behaviors and side effects from residents taking psychoactive medications.</p> <p>Monitor</p> <p>Starting on 1/4/19, the care managers and social services will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure residents at risk for skin tears and</p>		

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

PRINTED: 01/14/2019  
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OMB NO. 0938-0391

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F 656	<p>Continued From page 19</p> <p>injury, dementia and depressive disorder as evidenced by loud vocalizations and anger outbursts, grabbing staff by the arm, and biting of staff. The care plan directed staff were to keep all body parts away from Resident #32's mouth to make sure he did not bite, observe him for non-verbal signs of pain or discomfort, to not place him within arm's reach of others, approach him in calm manner, and remove him from the situation and take him to an alternate location, as needed, until he calmed down. The care plan did not document Resident #32 was on antidepressant and antipsychotic medications, and the side effects of the medications staff were to monitor.</p> <p>On 11/30/18 at 2:21 PM, RCM #4 said Resident #32's care plan did not address his psychotropic medications and the side effects staff were to monitor.</p> <p>2. Resident #65 was admitted to the facility on 5/10/18 with multiple diagnoses, which included dementia without behavioral symptoms.</p> <p>Resident #65's quarterly MDS assessment, dated 10/31/18, documented he was cognitively impaired, had no behaviors, and he received antidepressant and antipsychotic medications daily.</p> <p>Resident #65's Care Plan, revised on 5/27/18, documented he had depression as evidenced by tearfulness and isolation. Interventions in the care plan included staff were to provide a 1 to 1 visits to the resident, offer activities of choice and discuss his feelings related to unhappiness, anger, and isolation. The care plan did not</p>	F 656	<p>residents with specific behaviors and side effects from taking psychoactive medications are care planned. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p> <p>Date of Compliance January 18, 2019</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	<p>Continued From page 20</p> <p>address his antipsychotic medication, his specific target behaviors staff were to monitor and the side effects of his medication the staff were to monitor.</p> <p>On 11/28/18 at 3:38 PM, LSW #2 said Resident #65's care plan did not address his antipsychotic medication and the specific target behavior and side effects the staff were to monitor.</p> <p>3. Resident #35 was admitted to the facility on 1/18/17, with multiple diagnoses which included dementia.</p> <p>Resident #35 quarterly MDS assessment, dated 9/25/18, documented she was cognitively impaired, required extensive assistance of 1-2 staff members for ADLs, and had skin tears.</p> <p>On 11/27/18 at 8:45 AM, Resident #35 was observed in her wheelchair wearing Geri sleeves (designed to protect sensitive skin from tears and abrasions) on both forearms that partially covered the top of of her hands and elbows. Resident #35's was observed to have a skin tear on her left elbow which was about 2-3 inches in length and covered with loose steri strips. The Geri sleeve on Resident #35's left arm was bloody at the top near her left elbow.</p> <p>Review of Incident and Accident reports documented Resident #35's experienced five skin tears during direct care by staff as follows:</p> <p>* An Incident and Accident report, dated 1/22/18, at 2:38 AM, documented Resident #35 became combative during a shower and as a result had a circular skin tear about 2 centimeters (cm) in</p>	F 656			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	<p>Continued From page 21 diameter on the back of her left hand.</p> <p>*An Incident and Accident report, dated 3/27/18 at 9:30 PM, documented a CNA found a new skin tear on the back of Resident #35's left hand.</p> <p>* An Incident and Accident report, dated 9/18/18 at 6:40 PM, documented Resident #35 developed a skin tear while her shirt was being changed. The report documented the CNA noted Resident #35's shirt was tight around her elbow while removing the resident's shirt causing a skin tear to the Resident #35's elbow. The skin tear measured 3 x 3 cm and steri strips were applied. The Incident and Accident report documented education was provided to staff regarding shirt removal and Geri sleeves were provided to Resident #35 to protect her skin.</p> <p>* An Incident and Accident report, dated 9/28/18 at 7:23 AM, documented Resident #35 developed a skin tear on her left hand while her shirt was being changed.</p> <p>* An Incident and Accident report, dated 11/21/18, at 6:05 PM, documented Resident #35 tried to pinch a staff while she was being dressed causing a self-inflicted 1 cm tear on her left hand. Steri strips were applied.</p> <p>A care plan, dated 7/21/18, did not address Resident #35's potential risk factors for the development of skin tear injuries. The care plan did not address the resident's advanced age, poor skin turgor, hydration, or history of skin tear injuries. The care plan did not address interventions for prevention of skin tear injuries such as protective sleeves, increased hydration,</p>	F 656			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 656	Continued From page 22 transfer methods, or mobility limitations.  On 11/27/18 at 1:30 PM, LPN #1 stated Resident #35 had paper thin skin, grabbed the staff during cares, and was prone to developing skin tears.  On 11/29/18 at 2:00 PM, RN #3 who was the MDS Coordinator, said she was not aware Resident #35 had skin tears. RN #3 said Resident #35's care plan addressed her potential for skin injury related to pressure ulcers but did not address her potential risk for skin tear injuries.	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	F 657		1/18/19	

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F 657	<p>Continued From page 23 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents' care plans were regularly reviewed and revised as needed. This was true for 1 of 18 residents (#3) reviewed for care plan revisions and created the potential for harm if care was not provided or decisions were made based on inaccurate or outdated information. Findings include:</p> <p>Resident #3 was admitted to the facility on 12/8/17, with diagnoses that included Rheumatoid arthritis and chronic pain and readmitted on 7/31/18, with a diagnosis of atrial fibrillation (irregular heartbeat).</p> <p>Resident #3's significant change of condition MDS assessment, dated 8/21/18, documented he was cognitively intact, required extensive assistance from two plus staff for bed mobility, transfers, dressing, and personal hygiene, The MDS assessment documented Resident #3 was at risk for developing pressure ulcers and had no pressure ulcers. The MDS documented Resident #3 had not had falls since his readmission on 7/31/18.</p> <p>a. Resident #3's care plan area addressing his Potential for Impairment to Skin Integrity, dated 12/8/17 and revised on 5/30/18, directed staff to:</p>	F 657	<p>F657 – Care Plan Timing and Revision Resident Specific Resident #3 deceased on 12/10/18. Other Residents All residents with fragile skin and who are at risk for falls have the potential to be affected when care plans are not kept current and revised as necessary. The nurse care managers have reviewed the care plans of residents at risk for skin breakdown and falls to ensure the care plans have been revised and/or updated as necessary. Facility System In-servicing has been completed for nursing to update and revise care plans for residents at risk for skin breakdown and falls. Monitor Starting on 1/4/19, the nurse care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 care plans for residents at risk for skin breakdown and</p>		

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F 657	<p>Continued From page 24</p> <ul style="list-style-type: none"> <li>* Keep skin clean and dry, use lotion on dry skin</li> <li>* CNA's to check skin during cares and report changes to LN</li> <li>* Complete weekly skin observation by LN</li> <li>* Pressure reducing mattress to bed and Roho (pressure reducing) cushion to wheelchair and recliner.</li> </ul> <p>Resident #3's Skin Observation assessment, dated 11/10/18, documented he had an abraded area to the gluteal cleft (groove between the buttocks that runs just below the tailbone) which measured 0.5 X 0.8 cm, with a dressing placed for treatment. Resident #3's Skin Observation assessment, dated 11/17/18, documented he had a stage 3 pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) on his sacrum (area just above the tailbone). Resident #3's wound assessment, dated 11/26/18, documented Resident #3 had a stage 4 pressure ulcer on his sacrum.</p> <p>The care plan did not include direction to staff on when to reposition Resident #3. The care plan did not reflect interventions to prevent and treat pressure ulcers.</p> <p>On 11/29/18 at 4:05 PM, RCM #3 stated the care plan did not provide enough direction for the wound.</p> <p>On 11/30/18 at 2:18 PM, the DON stated the care plan did not provide appropriate interventions.</p> <p>b. Resident #3's area addressing Fall Risk, dated 12/8/17 and revised on 1/31/18, directed staff to ensure Resident #3 wore appropriate footwear of</p>	F 657	<p>falls. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p> <p>Date of Compliance January 18, 2019</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 25 fully enclosed slip resistant shoes when ambulating or mobilizing in his wheelchair.  The facility's fall risk assessments, dated 12/8/17, 7/31/18, and 8/29/18, documented Resident #3 was a low risk for falls.  The facility's fall risk assessment, dated 9/28/18, documented Resident #3 was a medium risk for falls. Resident #3's medical record documented a fall occurred on 8/29/18.  The facility's fall risk assessment, dated 11/5/18, documented Resident #3 was a low risk for falls. Resident #3's medical record documented falls occurred on 8/29/18, 9/28/18, 11/3/18, 11/5/18,  The facility's fall risk assessments, dated 11/11/18, 11/18/18, and 11/29/18, documented Resident #3 was a high risk for falls.  Resident #3's medical record documented falls occurred on 8/29/18, 9/28/18, 11/3/18, 11/5/18, 11/11/18 , 11/18/18 and 11/29/18.  The care plan was not revised to implement preventative interventions following each fall. On 11/29/18 at 4:05 PM, RCM #3 stated the care plan was not updated each time the resident fell.  On 11/30/18 at 2:00 PM, the DON stated she expected staff to update the care plan with each fall occurrence.	F 657			
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care	F 684		1/18/19	

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F 684	<p>Continued From page 26</p> <p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, record review, review of Incident and Accident reports, and policy review, it was determined the facility failed to ensure professional standard of practice were followed for 4 of 18 residents (#17, #35 #65, and #73) reviewed for standards of practice. Resident #35 was at risk of medical complications when she experienced multiple skin tear injuries. Resident #17 and #73 were placed at risk of uncontrolled hyperglycemia when they experienced elevated blood glucose (BG) levels and were not administered their insulin as ordered. Resident #65 was at risk of constipation and impaction when his bowel protocol was not implemented as ordered. Resident #73 was also at risk of developing a urinary tract infection when his indwelling catheter was not changed monthly as ordered. Findings include:</p> <p>1. The facility's Skin Tear Treatment and Prevention Policy and Procedure revised January 2017, documented:</p> <p>* Skin tears occur most commonly on the arms and hands. A resident who needed assistance in Activities of Daily Living (ADLs) was at greatest risk for developing a skin tear. Risk factors included, but not limited to, advancing age,</p>	F 684	<p>F684 – Quality of Care</p> <p>Resident Specific</p> <p>Resident #35 is receiving appropriate care and interventions to reduce or eliminate skin tears. Resident #73 and #17's BG's are being monitored per Physician Orders with outside parameters being reported to the physician, extra insulin administered as prescribed, and everything documented. Resident #73's catheter was changed and a family member has agreed to give consent for future catheter changes. Resident #65 has been receiving appropriate bowel medications as ordered by the physician and that is being documented.</p> <p>Other Residents</p> <p>All residents with fragile skin, diabetes mellitus, catheters, and bowel complications have the potential to be affected if not provided the appropriate care.</p> <p>Facility System</p>		

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F 684	<p>Continued From page 27</p> <p>chronic diseases, decrease in pain perception, mechanical trauma such as repositioning and removal of clothes, and skin issues such as fragile skin.</p> <p>* Preventive interventions included, but not limited to, moisturize skin routinely, especially on arms and legs, protect skin on arms and legs by having residents wear long sleeves or pants, heavy stocking/tube socks or products such as Geri Sleeves, have two employees if appropriate to provide cares. If the resident was resistive to cares, stop the cares and return at a later time when the resident was calmer.</p> <p>Resident #35 was admitted to the facility on 1/18/17, with multiple diagnoses which included dementia.</p> <p>Resident #35's quarterly MDS assessment, dated 9/25/18, documented she was cognitively impaired, required extensive assistance of 1-2 staff members for ADLs, had no physical behaviors directed toward others such as hitting, scratching or grabbing, and had skin tears.</p> <p>On 11/27/18 at 8:45 AM, Resident #35 was observed in her wheelchair wearing Geri sleeves (designed to protect sensitive skin from tears and abrasions) on both forearms that partially covered the top of of her hands and elbows. Resident #35's was observed to have a skin tear on her left elbow which was about 2-3 inches in length, bleeding, and covered with a loose steri strips. The Geri sleeve on Resident #35's left arm was bloodstained at the top near her left elbow. CNA #1, present at the time, said Resident #35 had the skin tear a few days ago and said the</p>	F 684	<p>In-servicing has been completed for nursing regarding appropriate care for residents with fragile skin, diabetes mellitus, catheters, and bowel complications.</p> <p>Monitor</p> <p>Starting on 1/4/19, the care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure residents with fragile skin, diabetes mellitus, catheters, and bowel complications are provided quality care. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p> <p>Date of Compliance</p> <p>January 18, 2019</p>		

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F 684	<p>Continued From page 28</p> <p>night shift was to take the Geri sleeves off. CNA #1 said they would put Resident #35 to bed to check her incontinence brief and would inform the nurse the bandage came off. CNA #1 said they had to talk and take their time when providing cares to Resident #35 because she grabbed their hands during cares. CNA #1 then removed Resident #35's Geri sleeves from her arms and a skin tear was observed on the top of her left hand.</p> <p>On 11/27/18 at 2:00 PM, CNA #3 assisted Resident #35 to bed using a gait belt and positioned her on her right side and checked her incontinence brief. Resident #35 was observed lying with her right arm underneath her body. The surveyor informed CNA #3 Resident #35 was lying on top of her arm. CNA #3 then went to the other side of the bed and repositioned Resident #35 off her right arm.</p> <p>Incident and Accident reports documented Resident #35's had experienced five skin tears during direct care by staff as follows:</p> <p>* An Incident and Accident report, dated 1/22/18, at 2:38 AM, documented Resident #35 became combative during a shower and as a result had a circular skin tear about 2 centimeters (cm) in diameter on the back of her left hand.</p> <p>*An Incident and Accident report, dated 3/27/18 at 9:30 PM, documented a CNA found a new skin tear on the back of Resident #35's left hand.</p> <p>* An Incident and Accident report, dated 9/18/18 at 6:40 PM, documented Resident #35 developed a skin tear while her shirt was being</p>	F 684			

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

PRINTED: 01/14/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/30/2018</b>
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F 684	<p>Continued From page 29</p> <p>changed. The report documented the CNA noted Resident #35's shirt was tight around her elbow while removing the resident's shirt causing a skin tear to the Resident #35's elbow. The skin tear measured 3 x 3 cm and steri strips were applied. The Incident and Accident report documented education was provided to staff regarding shirt removal and Geri sleeves were provided to Resident #35 to protect her skin.</p> <p>* An Incident and Accident report, dated 9/28/18 at 7:23 AM, documented Resident #35 developed a skin tear on her left hand while her shirt was being changed.</p> <p>* An Incident and Accident report, dated 11/21/18, at 6:05 PM, documented Resident #35 tried to pinch a staff while she was being dressed causing a self-inflicted 1 cm tear on her left hand. Steri strips were applied.</p> <p>A care plan dated 07/21/18, did not address Resident #35's potential risk factors for the development of skin tear injuries. The care plan did not address Resident #35's advanced age, poor skin turgor, hydration, or history of skin tear injuries. The care plan did not include interventions for prevention of skin tear injuries such as protective sleeves, increased hydration, transfer methods, or mobility limitations.</p> <p>On 11/30/18 at 9:30 AM, LPN #1 said he educated the CNA when Resident #35 had a skin tear during cares on 9/18/18, but he did not document it. LPN #1 said he did not remember if Resident #35 was wearing Geri sleeves on 9/18/18 when she sustained a skin tear. LPN #1 also said Resident #35 had a paper thin skin and</p>	F 684			

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

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FORM APPROVED  
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F 684	<p>Continued From page 30 staff had to be careful when dressing or undressing her.</p> <p>On 11/30/18 at 10:00 AM, the Staff Development Coordinator (SDC) said she was not aware of the skin tear injuries to Resident #35. The SDC stated she would like to be informed of any training needs of the staff. The SDC said she provided one on one training, group training, and used the skills checklist for dressing and undressing a resident. The SDC also said she gave copies of policies and procedures to each CNA, such as the skin tear treatment and prevention policy. The SDC said the staff had good training on caring for residents with dementia and the training was titled "Dementia, agitation, and resistance to personal care."</p> <p>On 11/30/18 at 10:55 AM, LPN #3 said he was the nurse on duty on 11/21/18 at 6:05 AM. Regarding Resident #35 LPN #3 stated "The resident can get very feisty and grabs at your hands. She tries to dig her nails in your hand and she pinches. She was wearing short sleeves that night because we were told to take the geri-sleeves off at night. We were taking her shirt off and noticed blood. She had a crescent shaped skin tear on her left hand."</p> <p>On 11/30/18 at 11:15 AM, CNA #5 said she provided care to Resident #35 on 9/29/18 at 7:23 AM, when the skin tear injury occurred. CNA #5 stated they changed Resident #35's incontinence brief and she was hitting them while they were putting her shirt on. CNA #5 said they told Resident #35 to hold on to their hands and they were able to put her shirt on, then they noticed the blood. CNA #5 said she did not know how</p>	F 684		

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F 684	<p>Continued From page 31 Resident #35 got the skin tear.</p> <p>On 11/30/18 at 11:40 AM, the DON stated she looked at Resident #35's skin and made changes on her care plan. She was to be assisted by two persons for transfer, dressing, and undressing. The DON said staff were directed to use a mechanical lift when transferring Resident #35 and the sling was to be left under her to due to her fragile skin. The DON also said she changed Resident #35's Geri sleeves because they were too small and too tight, you could not slide a finger under it. The DON said they did not have a policy for using Geri sleeves and the sleeves should be removed during bathing. The DON said she did not know why the staff were taking the Geri sleeves off at night. The DON said she would call Resident #35's representative to ask the representative to bring long sleeve shirts for Resident #35 to further protect her skin. The DON said Resident #35's skin tears occurred during cares and she would ask the SDC to educate the staff. The DON also said she would update Resident #35's care plan to make sure she was not positioned on her arms.</p> <p>2. Resident #73 was admitted to the facility on 2/8/10, with multiple diagnoses which included diabetes mellitus and Cauda Equina Syndrome. Cauda Equina Syndrome is a rare, but serious condition causing nerve root damage due to pressure exerted on a collection of nerves located at the bottom of the spinal cord known as the cauda equina. It can also result in incontinence.</p> <p>Resident #73's quarterly MDS assessment dated 11/2/18, documented his cognition was</p>	F 684			

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F 684	<p>Continued From page 32</p> <p>moderately impaired, he was dependent on staff for ADLs, he received insulin injections daily, and had an indwelling catheter.</p> <p>a. Resident #73's November 2018 recapitulated Physician's Orders included the following:</p> <ul style="list-style-type: none"> <li>* Monitor BG as needed ordered on 4/2/15</li> <li>* Notify physician if BG was less than 70 or greater than 400 ordered on 4/2/15</li> <li>* Humalog (Insulin Lispro) 5 units subcutaneously as needed for BG greater than 350, ordered on 2/29/16.</li> <li>* Lantus Solution 10 units subcutaneously one time a day.</li> <li>* Lantus Solution 40 units subcutaneously one time a day in the morning.</li> </ul> <p>Resident #73's October and November 2018 MAR, documented staff were to monitor his BG level two times a day, notify the physician when his BG level was less than 60 or greater than 350, administer Humalog insulin 5 units as needed for BG greater than 350. Resident #73 had BG results of greater than 350 in the evening of the following dates:</p> <ul style="list-style-type: none"> <li>* 10/4/18 - 402</li> <li>* 10/12/18 - 390</li> <li>* 10/16/18 - 388</li> <li>* 10/20/18 - 376</li> <li>* 10/21/18 - 352</li> <li>* 11/1/18 - 367</li> <li>* 11/4/18 - 365</li> <li>* 11/10/18 - 396</li> <li>* 11/16/18 - 400</li> <li>* 11/17/18 - 360</li> </ul>	F 684			

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

PRINTED: 01/14/2019  
FORM APPROVED  
OMB NO. 0938-0391

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F 684	<p>Continued From page 33</p> <ul style="list-style-type: none"> <li>* 11/18/18 - 461</li> <li>* 11/20/18 - 406</li> </ul> <p>Resident #73's 10/1/18 through 11/28/18 MAR, did not include documentation 5 units of Humalog insulin was administered on 10/12/18, 10/20/18, 10/21/18, 11/1/18, 11/4/18 11/10/18, and 11/17/18, when his BG levels exceeded 350.</p> <p>b. Resident #73's care plan documented he had an indwelling catheter related to Chronic Cauda Equina Syndrome. Interventions in the care plan directed staff were to flush his catheter daily with 30 cc of normal saline, change his catheter per his physician order, catheter care every shift and he would be sent to a urologist monthly to change his catheter.</p> <p>Resident #73's November 2018 Physician Order summary report included the following:</p> <ul style="list-style-type: none"> <li>* Change drainage bag monthly and as needed if plugged and unable to clear with irrigation.</li> <li>* Catheter care every shift.</li> <li>* Change Foley catheter monthly and as needed if dislodged or plugged and unable to clear with irrigation.</li> <li>* Flush Foley catheter with 30 cc of normal saline at bedtime.</li> </ul> <p>On 11/27/18 at 11:33 AM, CNA #6 was observed providing peri care to Resident #73. CNA #6 wiped the resident's Foley catheter with a disposable cleansing wipe going downward starting from the end of his penis. The middle</p>	F 684			

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F 684	<p>Continued From page 34</p> <p>third of Resident #73's Foley catheter was observed to be dark brown in color. The Foley catheter discoloration remained after it was cleaned by CNA #6.</p> <p>On 11/28/18 at 3:28 PM, RN #2 said a urologist had to change Resident #73's Foley catheter due to severe pain he experienced when it was being changed. RN #2 said the last time Resident #73's Foley catheter was changed by a urologist was in September 2018. Resident #73 had an appointment in October 2018, but it was canceled by the urologist clinic due to facility's inability to get a consent from Resident #73's representative to change his Foley catheter. RN #2 said the facility been trying to get a legal guardian for Resident #73.</p> <p>On 11/28/18 at 4:25 PM, LSW #1 said Resident #73's representative lived out of state and was not returning their calls. LSW #1 said the facility was working on getting a legal guardian for Resident #73 and they had contacted the local county volunteer office, and were told none were available. LSW #1 said they were waiting for the availability of a local volunteer to act as a legal guardian of Resident #73.</p> <p>On 11/28/18 at 4:41 PM, RCM #4 said he was aware of the condition of Resident #73's Foley catheter and the physician's order for it to be changed monthly. RCM #4 said the urologist clinic would not change Resident #73's Foley catheter and canceled his appointment in October due to lack of consent from the resident's representative. RCM #4 said he contacted Resident #73's representative several times but the representative did not return his call</p>	F 684			

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

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F 684	<p>Continued From page 35</p> <p>and said the facility was now looking to get a legal guardian for Resident #73. RCM #4 said he called the urologist clinic in early November and explained Resident #73's situation. RCM #4 said the urologist clinic agreed to change Resident #73 Foley catheter using the resident's previous consent, but the earliest they could accommodate him was 11/30/18. RCM #4 said he did not inform the Medical Director regarding the concern he had regarding the lack of catheter change for Resident #73.</p> <p>3. Resident #17 was admitted to the facility on 8/21/18, with multiple diagnoses including diabetes mellitus.</p> <p>Resident #17's admission MDS assessment, dated 8/28/18, documented she was cognitively intact and received insulin injections daily.</p> <p>Resident #17's care plan area addressing diabetes, revised 9/7/18, documented goals that he would be free of signs and symptoms of hyperglycemia and hypoglycemia, and he would not have complications related to diabetes. The care plan directed the staff to ensure Resident #17 was wearing non-slip footwear when he was out of bed and to provide nail care.</p> <p>Resident #17's November 2018 recapitulated Physician's Orders directed staff to:</p> <ul style="list-style-type: none"> <li>* Monitor Resident #17's blood glucose level before meals and at bedtime, ordered on 8/21/18.</li> <li>* Notify the physician when Resident #17's BG was less than 70 or greater than 400, ordered on 8/21/18</li> </ul>	F 684			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 36</p> <ul style="list-style-type: none"> <li>* Give 5 units of Humalog Insulin when Resident #17's BG was over 350 before meals and at bedtime, and every four hours as needed, ordered on 10/14/18.</li> <li>* Administer Glimipiride (diabetes medicine) 4 mg two times a day.</li> </ul> <p>Resident #17's October 2018 MAR, documented he had BG results over 350 on the following dates:</p> <ul style="list-style-type: none"> <li>* 10/14/18 - 375 at bedtime</li> <li>* 10/15/18 - 399 before lunch</li> <li>* 10/15/18 - 369 before dinner</li> <li>* 10//16/18 - 405 at bedtime</li> <li>* 10/18/18 - 388 before dinner</li> <li>* 10/19/18 - 485 before dinner</li> <li>* 10/24/18 - 429 at bedtime</li> <li>* 10/29/18 - 449 at bedtime</li> <li>* 10/31/18 - 448 before dinner</li> </ul> <p>Resident #17's record did not include documentation Humalog insulin 5 units was administered when his BG levels were over 350 on the following dates: 10/15/18, 10/18/18, 10/29/18, and on 10/31/18.</p> <p>Resident #17's November 2018 MAR, documented he had BG results over 350 on the following dates:</p> <ul style="list-style-type: none"> <li>* 11/11/18 - 398 at bedtime</li> <li>* 11/15/18 - 398 at bedtime</li> <li>* 11/17/18 - 359 before dinner</li> <li>* 11/17/18 - 397 at bedtime</li> <li>* 11/20/18 - 367 at bedtime</li> <li>* 11/24/18 - 384 before dinner</li> </ul>	F 684			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 37</p> <p>Resident #17's November 2018 MAR, did not include documentation Humalog insulin 5 units was administered on the November dates above, when his BG level was over 350, or that his BG levels were rechecked after four hours.</p> <p>On 11/28/18 at 1:39 PM, RCM #2 said the nurse should administered insulin as ordered.</p> <p>On 11/28/18 at 1:48 PM, RCM #3 provided a copy of the verbal order from Resident #17's physician, dated 10/14/18 at 6:00 PM, which documented "Humalog insulin give 5 units for BG over 350 every 4 hours as needed for Type II related to Type 2 Diabetes Mellitus with diabetic neuropathy." The same order was discontinued on 10/14/18 at 6:06 PM. RCM #3 said he was unable to find Resident #17's current insulin order.</p> <p>4. Resident #65 was admitted to the facility on 5/10/18, with multiple diagnoses which included dementia.</p> <p>Resident #65's quarterly MDS assessment dated 10/31/18, documented he was on hospice service, was cognitively impaired, was dependent on staff for all ADLs, and was incontinent of bowel and bladder.</p> <p>Resident #65's November 2018 Physician Order summary included the following:</p> <p>* Biscolax Suppository 10 mg insert 1 suppository rectally every 24 hours as needed for bowel care related to constipation. * Sorbitol Solution (laxative) 70%, 30 cc by mouth as needed for constipation not managed with</p>	F 684			

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F 684	Continued From page 38 suppositories or prune juice, on 4th day no bowel movement.  Resident #65's November 2018 Bowel Movement Record, documented he did not have a bowel movement as follows:  * 11/12/18 through 11/15/18 (4 days) * 11/17/18 through 11/21/18 (5 days)  Resident #65's November 2018 MAR, did not include documentation that he was administered his bowel medications.  On 11/28/18 at 1:35 PM, RCM #2 reviewed Resident #65 MAR and said his bowel medications were not administered as ordered by the physician.  On 11/28/18 at 2:18 PM, Hospice Nurse #1 said she did not have access to the facility's electronic medical record system. Hospice Nurse #1 said when she came to the facility she asked staff if there were any concerns with Resident #65. She said she was not aware Resident #65 did not have a bowel movement for more than three days. Hospice Nurse #1 said staff should have given Resident #65 his bowel medications when he did not have a bowel movement for more than 3 days.	F 684			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		1/18/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/30/2018</b>
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F 686	<p>Continued From page 39</p> <p>professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, policy review, and record review, it was determined the facility failed to prevent the development and worsening of pressure ulcers, and failed to provide services to promote healing, and prevent new ulcers from developing for 1 of 1 resident (#3) reviewed for pressure ulcers. This failure resulted in harm to Resident #3 when he developed a pressure ulcer which progressed to a stage 4 (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer). Findings include:</p> <p>A facility policy, titled Wound and Pressure Ulcer Management, revised 1/2017, documented the promotion of healing, pain management, and prevention of complication is extremely important, as well as accurate assessment and documentation.</p> <p>Resident #3 was admitted to the facility on 12/8/17, with diagnoses that included Rheumatoid arthritis, diabetes mellitus, and chronic pain. The medical record indicated Resident #3 transferred to the hospital on 7/29/18 and readmitted to the facility on 7/31/18</p>	F 686	<p>F686 – Treatment/Services to Prevent/Heal Pressure Ulcers</p> <p>Resident Specific</p> <p>Resident #3 deceased on 12/10/18.</p> <p>Other Residents</p> <p>All residents with fragile skin have the potential to be affected if not provided the appropriate care.</p> <p>Facility System</p> <p>In-servicing has been completed for nursing regarding appropriate care for residents with fragile skin to include skin assessments, Braden Scale assessments, care planning, and steps to prevent/heal pressure sores.</p> <p>Monitor</p> <p>Starting on 1/4/19, the nurse care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure</p>		

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F 686	<p>Continued From page 40 with a diagnosis of atrial fibrillation (irregular heartbeat).</p> <p>A significant change of condition MDS assessment, dated 8/21/18, documented Resident #3 was cognitively intact, did not reject care, and required extensive assist of two plus staff for bed mobility, transfers, and personal hygiene. The MDS assessment documented he was frequently incontinent of bowel and bladder. Resident #3's skin was intact but was at risk of developing a pressure ulcer. The MDS documented Resident #3 utilized a pressure reducing device for the bed and chair.</p> <p>The Braden Scale assessment (a tool for predicting pressure ulcer risk,) completed on 8/21/18, indicated Resident #3 was at mild risk of developing pressure ulcers.</p> <p>The Braden Scale assessment, completed on 9/25/18, indicated Resident #3 was not at risk for the development of pressure ulcers.</p> <p>The area of Resident #3's care plan addressing his potential for impairment to skin integrity, dated 12/8/17 and revised on 5/30/18, provided the following interventions:</p> <ul style="list-style-type: none"> <li>* Keep skin clean and dry, use lotion on dry skin</li> <li>* CNA's to check skin during cares and report changes to LN</li> <li>* Complete weekly skin observation by LN</li> <li>* Pressure reducing mattress to bed and Roho (pressure reduction) cushion to wheelchair and recliner.</li> </ul> <p>Resident #3's care plan was updated to include a</p>	F 686	<p>residents with fragile skin are provided accurate skin assessments, Braden Scale assessments, and care-planned interventions to prevent/heal pressure sores. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p> <p>Date of Compliance January 18, 2019</p>		

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

PRINTED: 01/14/2019  
FORM APPROVED  
OMB NO. 0938-0391

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F 686	<p>Continued From page 41</p> <p>stage 4 pressure ulcer to the sacrum (area just above the tailbone) area related to self-repositioning and scooting around in bed and recliner. This addition to the care plan was initiated on 11/19/18 and revised on 11/27/18. The care plan provided the following interventions:</p> <ul style="list-style-type: none"> <li>* To be followed by a wound clinic physician</li> <li>* Reposition Resident #3 side to side, check every 15 minutes.</li> <li>* Use of an air bed to protect the skin while in bed.</li> <li>* Get Resident #3 up last for meals and lay him down first after meals.</li> <li>* Monitor location, size, and treatment of pressure ulcer. Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc. to health care provider.</li> </ul> <p>Resident #3's Skin Observation assessments documented his skin as follows:</p> <ul style="list-style-type: none"> <li>*10/27/18 - Laniseptic (lanolin) cream was applied to Resident #3's coccyx (tailbone) to prevent breakdown and he did not have open areas to his skin.</li> <li>*11/3/18 - No skin conditions were observed.</li> <li>*11/10/18 - Resident #3 had an abraded area to the gluteal cleft (groove between the buttocks that runs from just below the tailbone), measured 0.5 X 0.8 cm with a dressing placed for treatment.</li> <li>*11/17/18 - A stage 3 pressure ulcer (full-thickness loss of skin, in which fat is visible</li> </ul>	F 686			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	<p>Continued From page 42</p> <p>in the ulcer) to Resident #3's sacrum. Treatment included a foam dressing, turn side to side, use of a Roho cushion, an air bed, last to get up for meals and first to lay down after meals.</p> <p>*11/23/18 - Resident #3 with an abrasion to his coccyx. Treatment to include dressing change daily and as needed to the coccyx, air bed, and turn side to side every 2 hours.</p> <p>A wound assessment, dated 11/19/18, documented Resident #3 had a pressure ulcer to the sacrum that measured 0.5 cm in length, 0.3 cm in width, and depth of 0.5 cm. The assessment documented the area was related to Resident #3 scooting around in his bed, wheelchair, and recliner.</p> <p>A wound assessment, dated 11/26/18, documented Resident #3 had a stage 4 pressure ulcer.</p> <p>A nursing note, dated 11/27/18 at 8:30 AM, documented Resident #3 was leaving the facility to go to a wound clinic appointment. An undated, unsigned Clinic Referral documented Resident #3 with a coccyx pressure injury, stage 4 with measurements of 0.6 cm in length x 0.3 cm width x 0.7 cm in depth with undermining at the largest measurement of 3.8 cm (undermining is caused by erosion under the wound edges, resulting in a large wound with a small opening. Much like an iceberg, what you see on the surface is not indicative of what lies below). On 11/29/18 at 4:05 PM, RCM #3 stated the documentation was completed by a physician at the wound clinic.</p> <p>A nursing note, dated 11/27/18 at 1:36 PM,</p>	F 686			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	<p>Continued From page 43</p> <p>documented the completion of an x-ray to the sacrum/coccyx area. The results documented Resident #3 did not have osteomyelitis (infection of the bone.)</p> <p>On 11/29/18 at 4:05 PM, RCM #3 stated the CNAs checked on Resident #3 every 15 minutes. RCM #3 stated the CNAs documented their checks on the CNA flowsheets. RCM #3 was unable to locate the flowsheet. The RCM was unable to verify whether Resident #3 was repositioned side to side every 15 minutes or what every 15-minute checks reflected on the care plan. The RCM stated, "I guess we need to be more specific, so the CNAs know what they should be doing." After review of the care plan, RCM #3 stated the skin and pressure ulcer areas of Resident #3's care plan did not provide enough direction to staff.</p> <p>On 11/30/18 at 8:46 AM, the pressure ulcer was observed as RCM #3 completed wound care. RCM #3 was using a Q-tip to place packing into the wound. The outer aspect of the wound appeared as a small hole, RCM #3 stated the wound went much deeper and the packing would allow the pressure ulcer to heal from the inside out.</p> <p>On 11/30/18 at 2:18 PM, the DON stated there should have been monitoring in place to check on Resident #3 every 15 minutes. The DON stated she was not aware the flowsheet had not been completed. The DON agreed the facility failed to prevent the onset of a pressure ulcer and agreed the skin assessments and the Braden Scale scores did not reflect the actual risk and the care plan did not provide appropriate</p>	F 686			

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F 686	Continued From page 44 interventions.	F 686			
F 688 SS=D	<p>Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)</p> <p>§483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interview, it was determined the facility failed to ensure residents received treatment and services to prevent further decrease in range of motion (ROM). This was true for 2 of 7 residents (#12 and #73) reviewed for treatment and services related to ROM. This deficient practice placed residents at risk of experiencing a decrease in mobility and function due to lack of active ROM (AROM) or passive ROM (PROM) services. Findings include:</p> <p>1. Resident #12 was admitted to the facility on</p>	F 688	<p>F688 – Increase/Prevent Decrease in ROM/Mobility</p> <p>Resident Specific</p> <p>Residents #12 and #73 are now on a restorative nursing program to help improve or maintain range of motion.</p> <p>Other Residents</p> <p>All residents have the potential to be affected if not provided appropriate care</p>	1/18/19	

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F 688	<p>Continued From page 45 4/28/15, with multiple diagnoses which included anoxic brain injury.</p> <p>Resident #12's quarterly MDS assessments, dated 3/21/18, 6/7/18 and 8/29/18, documented she was cognitively impaired, required extensive assistance of 1-2 staff member for ADLs, had impairment on both sides of her upper and lower extremities, and was not on a restorative nursing program.</p> <p>On 11/26/18 at 3:39 PM, Resident #12 was observed in bed, her hands were closed and her arms were flexed at the elbow and resting on her chest.</p> <p>On 11/28/18 at 3:16 PM, Resident #12 was observed in bed, her hands were closed and her arms were flexed at the elbow and resting on her upper abdomen. When asked to open her hands, Resident #12 looked at the surveyor and her fingers were observed to move. When asked to raise her arms, Resident #12 did not move her arms and just looked at the surveyor.</p> <p>On 11/28/18 at 3:31 PM, RN #2 said Resident #12's hands and fingers were not contracted. RN #2 said they could open and clean Resident #12's hands with no difficulty. The surveyor and RN #2 went to Resident #12's room and RN #2 asked permission from Resident #12 to check her palms. RN #2 opened Resident #12's hand, and flexed and extended her fingers. RN #2 said Resident #12 could not raise her arms or straighten them completely.</p> <p>On 11/30/18 at 9:40 AM, RN #3 who was the Restorative Nursing Supervisor, said she was not</p>	F 688	<p>to avoid a reduction or be able to maintain their current range of motion.</p> <p>Facility System</p> <p>In-servicing has been completed for nurse care managers, the restorative nurse, and restorative aides regarding Range of Motion to ensure residents do not experience a reduction in range of motion (unless clinically indicated) with the goal to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Monitor</p> <p>Starting on 1/4/19, the nurse care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure residents with mobility impairment are receiving restorative nursing to maintain or improve mobility, unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p> <p>Date of Compliance January 18, 2019</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 688	<p>Continued From page 46</p> <p>informed Resident #12 needed a restorative nursing program. RN #3 said she believed Resident #12 was not assessed and never had a restorative nursing program. When asked why Resident #12 was not assessed for a restorative nursing program, RN #3 said did not know. When asked if she thought Resident #12 could benefit from a restorative nursing program with passive range of motion (PROM) exercises, RN #3 said "Yes."</p> <p>2. Resident #73 was admitted to the facility on 2/8/10, with multiple diagnoses which included traumatic injury with hemiplegia (paralysis on one side of the body).</p> <p>Resident #73's quarterly MDS assessment dated 11/2/18, documented his cognition was moderately impaired and he required the assistance of 1-2 staff members for ADLs. The MDS also documented Resident #73 had functional limitation on one upper extremity and on both lower extremities, and a restorative nursing program was provided 15 minutes each day.</p> <p>Resident #73's care plan documented he needed a restorative intervention due to his history of traumatic brain injury with left hemiplegia and pain due to Cauda Equina Syndrome. Cauda Equina Syndrome is a very serious condition causing nerve root damage. It is a rare disorder where pressure is exerted on a collection of nerves located at the bottom of the spinal cord known as the cauda equina. Interventions included in the care plan were for staff to provide passive range of motion 3 times per week to Resident #73's bilateral lower extremities.</p>	F 688			

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F 688	Continued From page 47  On 11/27/18 at 11:22 AM, Resident #73 was observed awake and in bed. When asked if he could raise his arms Resident #73 raised his left arm and moved it up and down. Resident #73 was also observed to extend his left arm away from his body. Resident #73 then raised his right arm using his left hand, and said his right upper arm was weak.  On 11/27/18 at 1:43 PM, Resident #73 was observed in the Eagle Unit common room, seated at a table by himself. On the table were two unopened boxes of beads of different colors.  On 11/28/18 at 8:09 AM, RNA #1 was observed performing PROM exercises to Resident #73's lower extremities. RNA #1 said Resident #73 received PROM exercises on his lower extremities 2-3 times a week depending on his level of pain, and he did not have an RNA program for his upper extremities. When asked why Resident #73 did not have a RNA program for his upper extremities, RNA #1 said Resident #73 had full ROM on his upper extremities and he liked making necklaces with beads. RNA #1 then showed several necklaces hanging on the wall.  On 11/28/18 at 10:36 AM, Resident #73 was observed in the Eagle Unit common room, seated at a table by himself. On the table were two unopened boxes of beads of different colors and a tissue box. Resident #73's eyes were closed and he opened his eyes when the surveyor greeted him. The surveyor gave the tissue box to Resident #73 and asked him to hold it. Resident #73 held the tissue box lightly and	F 688			

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F 688	Continued From page 48 almost drop it on the floor. Resident #73 apologized to the surveyor and said he could not do it.  On 11/29/18 at 3:59 PM, CNA #8 said Resident #73 used to be busy making necklaces using the beads but lost his interest lately. CNA #8 said he noticed Resident #73 got easily frustrated making the necklaces and he thought it could be due to Resident #73's eyesight deteriorating.  On 11/29/18 at 4:18 PM, RN #2 said she did not know why Resident #73 did not have a restorative nursing program for his upper extremities.  On 11/30/18 at 9:45 AM, RN #3, who was the Restorative Nursing Supervisor, said she did not know why Resident #73 did not have a restorative nursing program for his upper extremities. RN #3 said she knew Resident #73 liked making necklaces using the beads, but she was not aware he recently lost interest in making the necklaces.	F 688			
F 689 SS=D	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, and	F 689	F689 – Free of Accident	1/18/19	

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F 689	<p>Continued From page 49</p> <p>record review, it was determined the facility failed to ensure adequate supervision of residents to prevent falls. This was true for 1 of 1 resident (#3) reviewed for accidents and who experienced multiple falls after admission to the facility. This failure placed the resident at risk for harm and injury from falling. Findings include:</p> <p>The facility's policy and procedure for Fall Prevention and Management, last revised 10/2017, documented its purpose was to identify risk factors and implement interventions before a fall occurred.</p> <p>The facility's falls algorithm directed staff to:</p> <ul style="list-style-type: none"> <li>* Consider fall risk factors specific to the resident and determine need for individualized care plan interventions.</li> <li>* Choose the most appropriate intervention and make it specific to the resident.</li> <li>* Communicate the care plan with the staff.</li> <li>* Review the care plan approaches at least quarterly and as needed for effectiveness and modify as appropriate.</li> </ul> <p>Resident #3 was admitted to the facility on 12/8/17 and readmitted on 7/31/18, with diagnoses that included rheumatoid arthritis, diabetes mellitus, chronic pain, and atrial fibrillation (irregular heartbeat).</p> <p>A significant change of condition MDS assessment, dated 8/21/18, documented Resident #3 was cognitively intact and required</p>	F 689	<p>Hazards/Supervision/Devices</p> <p>Resident Specific</p> <p>Resident #3 deceased on 12/10/18.</p> <p>Other Residents</p> <p>All residents have the potential to be affected if not provided appropriate care to avoid/prevent falls.</p> <p>Facility System</p> <p>In-servicing has been completed for nursing to ensure residents at risk for falls are provided adequate supervision to prevent future falls. This includes considering fall risk factors specific to the resident, developing individualized care plan interventions, communicating the plan with staff, and reviewing care plan approaches at least quarterly and as needed for effectiveness and modify as appropriate.</p> <p>Monitor</p> <p>Starting on 1/4/19, the nurse care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure residents at risk for falls have been identified, care planned, communicated with staff, and reviewed at least quarterly or as needed. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p>		

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F 689	<p>Continued From page 50</p> <p>extensive assistance of two plus staff for bed mobility, transfers, dressing, and personal hygiene. Resident #3 required extensive assistance of one staff for locomotion in his room. The MDS documented Resident #3 had not had falls since his readmission on 7/31/18.</p> <p>Resident #3's Fall Risk assessments documented the following:</p> <ul style="list-style-type: none"> <li>* Resident #3 was documented as a low risk for falls on 12/8/17, 7/31/18, 8/29/18 and 11/5/18.</li> <li>* Resident #3 was documented as a moderate risk for falls on 9/28/18.</li> <li>* Resident #3 was documented as a high risk for falls on 11/11/18, 11/18/18, and 11/29/18.</li> </ul> <p>Resident #3's Risk for Falls care plan, dated 12/8/17 and revised on 1/31/18, directed staff to ensure Resident #3 wore appropriate footwear-fully enclosed slip resistant shoes when ambulating or mobilizing in his wheelchair. On 11/19/18 an intervention was added to monitor Resident #3 every 15 minutes for self-transfers.</p> <p>Resident #3's medical record documented falls on 8/29/18, 9/28/18, 11/5/18, 11/11/18, 11/18/18, and 11/29/18.</p> <p>Resident #3's care plan, dated 11/12/18, documented an actual fall on 11/12/18 due to weakness and unsteady gait. The intervention directed staff to monitor daily and observe for latent injuries and report any concerns to the physician.</p>	F 689	<p>Date of Compliance</p> <p>January 18, 2019</p>		

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F 689	Continued From page 51 Resident #3's care plan, dated 11/19/18, documented an actual fall with no injury on 11/18/18 due to poor balance and unsteady gait. The interventions directed staff to monitor for latent injuries and complete every 15-minute checks. The care plan did not reflect interventions for the other falls documented.  On 11/29/18 at 4:05 PM, RCM #3 stated the 15-minute checks were completed by the CNAs. RCM #3 was not able to find documentation of the completion of the 15-minute checks in Resident #3's medical record. RCM #3 agreed the care plan was not updated each time the resident fell.  On 11/30/18 at 2:00 PM, the DON stated she expected staff to investigate the potential cause of falls, to update the care plan after each fall, to talk to staff for ideas, and to monitor the effectiveness of the interventions.	F 689			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)  §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		1/18/19	

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F 692	<p>Continued From page 52</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents were consistently provided with adequate hydration. This was true for 1 of 2 residents (Resident #73) reviewed for hydration. This failure created the potential for harm if Resident #73 became dehydrated. Findings include:</p> <p>Resident #73 was admitted to the facility on 2/8/10, with multiple diagnoses, which included traumatic brain injury.</p> <p>Resident #73 quarterly MDS assessment, dated 11/2/18, documented his cognition was moderately impaired and he was dependent on assistance of one staff member for eating and drinking.</p> <p>On 11/27/18 at 9:25 AM, Resident #73 was observed in his bed sleeping. A fall mat was observed to the right of Resident #73's bed and an over-the-bed tray table was not in his room. Resident #73's water mug with straw in it was observed on top of the table next to the television. The table was by the foot of the bed on the right side, which was approximately five feet away from Resident #73's reach.</p>	F 692	<p>F692 – Nutrition/Hydration Status Maintenance</p> <p>Resident Specific</p> <p>There is now a bedside table to place resident # 73's hydration mug on and the mug is within reach of the resident.</p> <p>Other Residents</p> <p>All residents have the potential to be affected if not provided adequate hydration.</p> <p>Facility System</p> <p>In-servicing has been completed for nursing to ensure residents are provided adequate hydration and that fluids are available at beside (as clinically appropriate) and within resident reach.</p> <p>Monitor</p> <p>Starting on 1/4/19, the nurse care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure residents have hydration available at</p>		

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F 692	Continued From page 53 On 11/27/18 at 11:22 AM, Resident #73 was observed in his bed awake. His water jug was observed on the table next to the television, by the foot of his bed on the right side.  On 11/28/18 at 8:09 AM, RNA #1 was observed performing passive range of motion (PROM) exercises to Resident #73's lower extremities. When Resident #73 finished with his PROM exercises, he asked RNA #1 for a drink. RNA #1 took the water jug on the top of the table next to the television, and said she would change the water and get a drink for him. RNA #1 came back with the water jug and handed it to Resident #73. After Resident #73 finished his drink he gave the water jug to RNA #1, and RNA #1 placed the water jug on top of the table next to the television.  On 11/29/18 at 1:50 PM, the DON and the surveyor were in Resident #73's room. The DON saw Resident #73's water jug on the table next to the television, and said he needed an over-the-bed tray table.	F 692	bedside and within resident reach. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.  Date of Compliance January 18, 2019		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and	F 761		1/18/19	

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F 761	<p>Continued From page 54</p> <p>Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, and staff interview, it was determined the facility failed to ensure insulin vials were dated when opened. This was true for 1 of 3 medication carts (Hoeger House unit cart) checked during medication cart inspection. This failed practice created the potential for residents to receive expired medications with decreased efficacy. Findings include:</p> <p>The facility policy for Acquisition, Receiving, Dispensing and Storage of Medications, last revised 9/2016, did not cover the subject of labeling medication vials and did not address how long a medication, such as insulin, could be kept after opened.</p> <p>On 11/30/18 at 8:35 AM, during inspection of the medication cart on the Hoeger House unit with LPN #1 present, the following were found:</p> <p>* Humalog 100 u/mL vial was in a box that was</p>	F 761	<p>F761 – Label/Store Drugs and Biologicals</p> <p>Resident Specific</p> <p>Residents receiving insulin on Hoeger House could have been affected by this practice. The insulin vials in the Hoeger House medication cart are being dated when opened.</p> <p>Other Residents</p> <p>All residents receiving insulin could be affected, so insulin vials in each medication cart are being dated when opened.</p> <p>Facility System</p> <p>In-servicing has been completed for nurses to ensure insulin vials are being</p>		

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F 761	<p>Continued From page 55</p> <p>dated as opened on 11/30/18. The vial was not dated.</p> <p>* Lantus 100 u/mL vial was in a box that was dated as opened on 11/26/18. The vial was not dated.</p> <p>* Levamir 100 u/mL vial was in a plastic bag that was dated as opened on 11/12/18. The vial was not dated.</p> <p>* Novolog 100 u/mL vial was in a box that was dated as opened on 11/14/18. The vial was not dated.</p> <p>*Novolin R 100 u/mL vial was in a box that was dated as opened on 11/19/18. The vial was not dated.</p> <p>*Novolin N 100 u/mL vial was in a box that was dated as opened on 11/19/18. The vial was not dated.</p> <p>On 11/30/18 at 8:35 AM, LPN #2 stated the policy was to mark the product box when opened and keep the product in the box.</p> <p>On 11/30/18 at 11:30 AM, RCM #1 stated, "As far as I know, you label the medication packaging when you open a new package." RCM #1 looked for a policy that provided direction for labeling medication when opened in the policy book found at the nurse's station. RCM #1 was unable to locate a policy that covered this topic. She said she would also look in the "portal" for a policy.</p> <p>On 11/30/18 at 11:40 AM, the DON stated she did not think there was a pharmacy policy that</p>	F 761	<p>dated when opened.</p> <p>Monitor</p> <p>Starting on 1/4/19, the nurse care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure insulin vials are being dated when opened. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p> <p>Date of Compliance</p> <p>January 18, 2019</p>		

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F 761	Continued From page 56 showed how staff should date a medication product once it had been opened. The DON said the staff should put the opened date on the medication vial or bottle, and not on the packaging.	F 761			
F 880 SS=D	<p>Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</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: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other</p>	F 880		1/18/19	

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F 880	<p>Continued From page 57</p> <p>persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <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 and staff interview, it was</p>	F 880	F880 – Infection Prevention & Control		

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F 880	Continued From page 58 determined the facility failed to ensure the glucometer used to check the blood glucose levels was cleansed after each use and staff followed hand hygiene practices consistent with accepted standards of practice. This was true for 1 of 1 resident (#73) observed for blood glucose level testing and 1 of 11 residents (#65) observed for personal care. The deficient practices created the potential for the spread of infectious organism from cross contamination which could harm all residents residing in the facility. Findings include:  1. On 11/27/18 at 1:29 PM, CNA #9 was observed as she provided personal care to Resident #65. Resident #65 was lying on his back and CNA #9 unfastened the resident's soiled incontinence brief, and wiped his private parts using a disposable cleansing wipe. CNA #9 then asked Resident #65 to turn to his right side. As Resident #65 was turning to his right side, CNA #9 grabbed his left hand with her contaminated gloves on and directed him to hold on to the mobility bar on the right side of his bed. CNA #9 wiped Resident #65's bottom with a disposable cleansing wipe and rolled the soiled incontinence brief and placed a new incontinence brief. CNA #9 asked Resident #65 to turn to his left side, and as the resident was turning to his left side, CNA #9 grabbed on to his right hand with her contaminated gloves on and directed the resident to hold on to the mobility bar on the left side of his bed. CNA #9 removed the soiled incontinence brief, asked Resident #65 to lie on his back, fastened the incontinence brief, took the call light with her contaminated gloves hand on and placed the call light on his chest. CNA #9 removed her gloves, washed her hands, picked up the trash bag, and walked out of Resident	F 880	Resident Specific  Caregivers providing incontinent care for resident #65 have been cleaning the resident's hands and his call light if they have been touched by contaminated gloves. The glucometer used for resident #73 was cleaned.  Other Residents  All residents receiving incontinent care could be affected by contaminated gloves and all residents receiving blood glucose tests with a facility glucometer could be affected if not cleaned after each use.  Facility System  In-servicing has been completed for nursing and CNA's (including CNA #9) to ensure resident hands and call lights are being cleaned if touched with contaminated gloves when providing incontinent care. In-servicing has been completed for nurse care managers and nurses (including LPN #5) to ensure glucometers are cleaned immediately after each use and not placed inside the medication cart without cleaning it first.  Monitor  Starting on 1/4/19, the nurse care managers will audit weekly x 4, bi-weekly x 4, and then monthly x 3 to ensure incontinent care is being done to avoid	

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F 880	<p>Continued From page 59 #65's room.</p> <p>On 11/27/18, at 1:37 PM, CNA #9 said she touched Resident's #65 hand and his call light with her dirty gloves on while she was providing peri care to the resident and failed to clean the resident's hands and his call light after she was done with his care.</p> <p>2. On 11/28/18 at 8:18 AM, LPN #5 was observed to perform a capillary blood glucose test to Resident #73 using a glucometer used for multiple residents. After completion of the capillary blood glucose test, LPN #5 placed the glucometer on top of a tissue paper on the resident's television table, removed her gloves and washed her hands. LPN #5 picked up the glucometer, returned to the medication cart and placed the glucometer on top of the medication cart using a tissue paper as a barrier. LPN #5 turned on the computer and started charting. LPN #5 then opened the medication cart and took out Bengay Ultra Strength patch (pain reliever) and Biofreeze ointment.</p> <p>On 11/28/18 at 8:29 AM, LPN #5 went back to Resident #73 with the medications in her hand. LPN #5 put on new gloves and applied the Biofreeze to Resident #73's lower back. LPN #5 then removed her gloves, put on new gloves, and applied the Bengay patch to Resident #73's lower back. LPN #3 removed her gloves and walked out of the resident's room.</p> <p>On 11/28/18 at 8:32 AM, LPN #5 returned to the medication cart and put the Biofreeze ointment on the top of the medication cart. The used glucometer was observed on top of a tissue</p>	F 880	<p>any contamination, and glucometers are being cleaned immediately after each use. Audit results will be reported to the monthly QAPI meeting for further monitoring and plan modification.</p> <p>Date of Compliance January 18, 2019</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135085</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/30/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - BOISE VILLAGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3115 SYCAMORE DRIVE BOISE, ID 83703</b>		
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F 880	<p>Continued From page 60</p> <p>paper on top of the medication cart. LPN #5 then went to the Eagle Dining Room, washed her hands and went back to the medication cart. LPN #5 opened the medication cart and placed the used glucometer in the top drawer of the medication cart. LPN #5 was not observed to sanitize the used glucometer before putting it inside the medication cart.</p> <p>On 11/28/18 at 8:32 AM, CNA #6 asked LPN #5 to help him transfer Resident #73 using the Hoyer lift.</p> <p>On 11/28/18 at 8:49 AM, LPN #5 said the glucometer should be cleaned prior to it being used on another resident and during the night when it was being calibrated. LPN #5 said she would clean the glucometer during her downtime later that day. LPN #5 then said she would like to finish her medication pass first before cleaning the glucometer.</p> <p>On 11/28/18 at 2:51 PM, the DON said the glucometer should be cleaned after each use right away and a used glucometer should not be placed inside the medication cart without cleaning it first.</p>	F 880			