



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 14, 2018

Steve Gannon, Administrator  
Quinn Meadows Rehabilitation and Care Center  
1033 West Quinn Road  
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Gannon:

On **November 30, 2018**, a survey was conducted at Quinn Meadows Rehabilitation And Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **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.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 24, 2018**. Failure to submit an acceptable PoC by **December 24, 2018**, may result in the imposition of additional civil monetary penalties by **January 16, 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.
- Include dates when corrective action will be completed in column (X5).

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

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

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

This agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

- 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.**

Your facility's noncompliance with the following:

- **F0883 -- S/S: F -- 483.80(d)(1)(2) -- Influenza And Pneumococcal Immunizations**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **#11, #29, and #30** as identified on the Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

If you believe the 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

- BFS Letters (06/30/11)

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

This request must be received by **December 24, 2018** . If your request for informal dispute resolution is received after **December 24, 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

cc: Chairman, Board of Examiners - Nursing Home Administrators

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/30/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>QUINN MEADOWS REHABILITATION AND CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted November 26, 2018 to November 30, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN, Team Coordinator Susette Mace, RN</p> <p>Acronyms used in the report include:</p> <p>ADL = Activity of Daily Living COPD = Chronic Obstructive Pulmonary Disease DNR = Do Not Resuscitate DNS = Director of Nursing LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record mg = Milligram ml = Milliliter MDS = Minimum Data Set POA = Power of Attorney RN = Registered Nurse TAR = Treatment Administration Record</p>	F 000			
F 552 SS=D	<p>Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5)</p> <p>§483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:</p> <p>§483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to,</p>	F 552		1/15/19	

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

TITLE

(X6) DATE

Electronically Signed

12/24/2018

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 552	<p>Continued From page 1 his or her medical condition.</p> <p>§483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.</p> <p>§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents receiving psychoactive medication had consents in place prior to initiation of the medications. This was true for 1 of 6 residents (Resident #30) who were reviewed for unnecessary medications. This deficient practice placed residents at risk of receiving psychotropic medications without knowledge of the risks and benefits associated with each medication, alternative treatment options, and the right to refuse the medications. Findings include:</p> <p>Resident #30 was readmitted to the facility on 11/8/18, with multiple diagnoses including respiratory failure and weakness.</p> <p>An admission MDS assessment, dated 11/15/18, documented Resident #30 was cognitively intact and had minimal depression.</p> <p>A November 2018 MAR, dated 11/22/18, documented Resident #30 was receiving Zolof 25 mg daily for depression.</p>	F 552	<p>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</p> <p>F- 552 SS=D Right to be Informed/Make Treatment Decisions</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p>		

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F 552	Continued From page 2  Resident #30's record did not include a consent for the use of the antidepressant.  On 11/28/18 at 5:17 PM, the Unit Manager stated Resident #30 did not have a consent for the use of Zoloft and stated the facility should not have administered the antidepressant until they had a signed consent.	F 552	On 11/28/2018 Consent for Resident #30 anti-depression medication was completed.  On 12/20/2018 nurse responsible for obtaining consent for anti-depression medication was given a written disciplinary action related to consent form not being obtained.  Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:  This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all residents who are currently have physician orders for psychotropic medications have the potential to be affect by this deficient practice, therefore by 1/4/2019 a review will be performed of all residents records that currently have physician orders for psychotropic medications to ensure they have a current consent form signed for each psychotropic medication.  Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:  By 1/1/2019 the Director of Nursing or designee will perform an in-service education with all licensed nursing staff to		

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F 552	Continued From page 3	F 552	<p>ensure: All residents that receive orders for psychotropic medications have a consent form signed for each psychotropic medication before administration of the medication begins.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through The Director of Nursing or designee who will do visual observation of at least three (3) residents records that have orders for psychotropic medications to ensure they have a consent form signed for each psychotropic medication before administration of the medication begins.</p> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Director of Nursing or designee will present to the quarterly QA&amp;A Committee meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		
F 578 SS=E	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p>	F 578		1/14/19	

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F 578	Continued From page 4  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it	F 578	F- 578 SS=E		

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F 578	<p>Continued From page 5</p> <p>was determined the facility failed to ensure a) residents were provided information regarding advance directives upon admission and if necessary, assisted to formulate advance directives, and b) the residents' medical records included documentation of this process, a copy of the residents' advance directive, or documentation of their decision not to formulate an advance directive. This was true for 7 of 9 residents (#11, #17, #18, #20, #25, #29, and #134) whose records were reviewed for advance directives. These failures increased the risk of residents not having their decisions documented, honored, and respected when they were unable to make or communicate health care preferences. Findings include:</p> <p>The State Operations Manual (SOM) defined an Advance Directive as "...a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." The SOM also stated "'Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form' is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advance directive."</p> <p>1. Residents were interviewed regarding whether they had an Advance Directive or not, and if they had a discussion with staff and were provided</p>	F 578	<p>Request/Refuse/Discontinue Treatment; Formulate Adv Dir</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Res # 11, #18 and #20 – By 12/21/2018 Social Services Director will review &amp; discuss advance directive options with each of these residents;</p> <p>Res #25 – No longer a resident in the facility;</p> <p>Res #29 – No longer a resident in the facility;</p> <p>Res #17 – On 12/17/2018 Advance Directive was obtained from Family and placed in resident's record;</p> <p>Res #134 – No longer a resident in the facility</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>All residents in the facility have the potential to be affected by this deficient practice, therefore by 1/4/2019 a review of all residents will be performed to ensure Advance Directives or documentation of are part of each resident's medical record.</p>		

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F 578	<p>Continued From page 6</p> <p>information regarding an Advance Directive if they did not already have one. Examples include:</p> <ul style="list-style-type: none"> <li>- On 11/28/18 at 9:43 AM, Resident #11 stated she did not have a living will or other Advance Directive and the staff had not discussed it with her or offered information about an Advance Directive.</li> <li>- On 11/27/18 at 9:18 AM, Resident #25 stated "I don't have an Advance Directive, but I did sign a form to be a Full Code when I got here."</li> <li>- On 11/26/18 at 4:52 PM, Resident #29 stated "I don't have an Advance Directive, but I did sign a form to be a no code."</li> </ul> <p>On 11/28/18 at 11:15 AM, the MDS Coordinator reviewed the records and verified Residents #11, #25, and #29 did not have an Advance Directive in their records and there was no documentation an Advance Directive was addressed with the residents as required on admission.</p> <p>2. The records of Residents #17, #18, #20, and #134 did not include an Advance Directive or documentation they were provided information regarding an Advance Directive or a discussion about an Advance Directive by staff occurred.</p> <p>On 11/28/18 at 10:49 AM, the MDS Coordinator stated there was no documentation in the records of Residents #17, #18, #20, and #134 the facility reviewed and discussed an Advance Directive with the residents or their representatives on admission. The MDS Coordinator stated the facility recognized the POST as the Advance</p>	F 578	<p>By 1/4/2019 Social Services Director will visit and discuss Advance Directive options with any current residents that do not have Advance Directives.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 12/3/2018 an in-service education was given to the Social Services director regarding the responsibility &amp; Timeliness of obtaining advance directives or discussing advance directive options with residents and documenting in residents record upon admission to the facility, with quarterly assessments, annual assessments and/or upon a significant change in condition;</p> <p>An updated Social Services assessment tool has been Implemented which includes advance directive options.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>The Administrator or designee will perform a visual observation of at least</p>		

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F 578	Continued From page 7 Directive.  The facility did not include documentation an Advance Directive was discussed or provided to the residents upon admission.	F 578	three (3) current resident records to ensure advance directive documentation is included.  Monitoring will start on 1/11/2019 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.  The Administrator or designee will present to the quarterly QA&A Committee meeting the findings and/or corrective actions taken.  Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)  §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.  §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.  §483.10(j)(3) The facility must make information on how to file a grievance or complaint available	F 585		1/15/19	

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F 585	Continued From page 8 to the resident.  §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 585			

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F 585	Continued From page 9 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, it was determined the facility failed ensure grievances were responded to,	F 585	F- 585 SS=D Grievances		

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F 585	<p>Continued From page 10</p> <p>investigated, and prompt corrective action taken to resolve the grievances. This failed practice affected 2 of 14 residents (#11 and #83) who were reviewed for grievances. The deficient practice had the potential for harm if residents' grievances were not acted upon and residents did not receive appropriate care or were at risk for abuse/neglect. Findings include:</p> <p>1. Resident #11 was admitted to the facility on 9/20/18, with diagnoses of injuries from a motor vehicle accident which included multiple facial fractures, laceration of the head and right ear, and a tibia (lower leg) fracture.</p> <p>An MDS assessment, dated 10/3/18, documented Resident #11 was cognitively intact and capable of decision making about her care.</p> <p>On 11/27/18 at 9:41 AM, Resident #11 stated "I have to wait for my pain medicine up to an hour when [RN #1] works. When I ask again, the aide will say I told her and she gets angry when I tell her again. If I don't take my pain medicine every 4 hours, it gets so bad and then the medicine doesn't help. I set my phone alarm when I'm awake, so I don't ask too early to have my pain medicine. I can't sleep when she works because I worry if she will give me my medicine when I need it." Resident #11 also stated, "I wrote a letter to the Administrator and put it under his door Sunday [11/25/18]. I checked with him on Monday [11/26/18] and he said he got my letter. I told him about not getting my pain medication when I ask for it and how rude she [RN #1] is to me and my family. He didn't come and talk to me on Monday, [11/26/18], but he did say he got my letter."</p>	F 585	<p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #11's grievance was in the process of being investigated immediately upon receiving it on 11/26/18;</p> <p>(There was no actual delay in the investigation of this grievance. The grievance letter that was submitted had been misplaced but the information in the letter was at the level of a grievance and was in the process of being investigated;</p> <p>Upon interview with the surveyor, Res #11 revealed more details of the situation than originally submitted in the grievance letter; When this additional Information was presented to the Administrator by the surveyor it was immediately reported through the Abuse Reporting Portal)</p> <p>Resident #11's grievance investigation was completed, resolved and feedback given to resident #11;</p> <p>Resident #83 is no longer a resident in the facility</p> <p>Identification of other residents having the</p>		

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F 585	<p>Continued From page 11</p> <p>Resident #11's record included a physician order for Oxycodone (a narcotic pain medication) 5-325 mg 1-2 tablets every 4 hours as needed for pain.</p> <p>On 11/28/18 at 9:43 AM, during a second interview Resident #11 stated "Doing better, the Administrator came in today and had me sign a paper on the note I wrote to him. The note read going to do a disciplinary action on the nurse [RN #1]. Last night [11/27/18] I had to wait 45 minutes after requesting pain medicine from [RN #1] and I did not get my medicine. I saw [LPN #1] and told her I had not had my medicine I had asked for 45 minutes ago for pain. [LPN #1] went to [RN #1] and I got my medicine." LPN #1 was interviewed on 11/30/18 at 3:00 PM, and she confirmed the event as described by the resident.</p> <p>On 11/28/18 at 10:30 AM, a request was made to the Administrator for the investigation related to the letter submitted by Resident #11. The Administrator stated "I did read the letter but have misplaced it, and I have not completed the investigation into the grievance." The Administrator verified he received the letter from the resident on Monday 11/26/18, and stated he did not consider it abuse.</p> <p>On 11/28/18 at 4:00 PM, the surveyor requested the investigation and copy of the grievance letter from Resident #11. The Administrator stated "I have not completed the investigation and cannot find the letter." The Administrator stated he sent a screen shot to the State Survey Agency of the initial report because he was unable to complete an electronic report to the state. The Administrator stated he removed RN #1 from the</p>	F 585	<p>same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>All residents in the facility that would like to file a grievance have the potential to be affected by this deficient practice, therefore by 1/4/2019 a review of all grievances will be performed to ensure resolution.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 12/21/2018 the facility Administrator will receive an in-service education &amp; written disciplinary action related to:</p> <ul style="list-style-type: none"> <li>- the importance of promptly investigating all grievances submitted;</li> <li>- identifying allegations of abuse/neglect/mistreatment and immediate reporting of such;</li> <li>- abuse policy review;</li> </ul> <p>By 1/1/2019 a systematic change will be implemented Which includes the following:</p> <ul style="list-style-type: none"> <li>- a centrally located lock box for submission of Grievances to prevent misplacement;</li> <li>- a second staff member DNS or Asst Administrator will be Involved in the process of receiving,</li> </ul>		

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F 585	<p>Continued From page 12 schedule and placed her on Administrative Leave.</p> <p>On 11/29/18 at 10:00 AM, Resident #11 stated "I slept so good last night. I got my medication within 10 minutes when I requested. [RN #1] did not work last night. She's not coming back is she?"</p> <p>On 11/30/18 at 2:00 PM, the Administrator provided a copy of a screen shot from a computer of the report he sent to the State Survey Agency. The document stated the Incident Type was Mistreatment. The Incident Detail on the form documented the date and time of the incident was 11/28/18 at 3:00 PM. The document described the incident stating on 11/26/18, the facility received a grievance from Resident #11 regarding a nurse that was rude to her and did not pass her medications on time. The document stated on 11/28/18, Resident #11 related more details than originally were given in the grievance which changed the status of the investigation to an allegation of abuse.</p> <p>There was no investigation initiated by the Administrator until three days after receipt of the letter of grievance from Resident #11. The Administrator did not recognize the letter as an allegation of abuse/neglect and did not start an investigation into an allegation of abuse/neglect in a timely manner. The untimely investigation resulted in additional opportunities for RN #1 to care for Resident #11 despite her documented concerns.</p> <p>2. Resident #83 was admitted to the facility on 12/26/17, with multiple diagnoses including</p>	F 585	<p>reviewing and Investigating grievances in a timely manner;</p> <p>- An in-service education to all staff regarding their Role in reporting residents' grievances in a timely manner, the process of how to file a resident grievance, and notification to Administration of grievance filed.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through the Director of Nursing and/or the Assistant Administrator who will perform a random audit of at least three (3) grievances to ensure they are investigated in a timely manner and the proper protocol has been followed per facility policy.</p> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The DNS or Assistant Administrator will present to the Governing Board the findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		

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F 585	<p>Continued From page 13</p> <p>cancer and diabetes. He was discharged from the facility on 1/23/18.</p> <p>A care plan conference, dated 1/3/18, documented Resident #83 and his family had concerns with the nursing staff regarding his "...tube feeding not connected for 3 hours, CNAs not providing two person assistance, having to ask for Zofran [anti-nausea medication], no free water (on schedule now), went without beta protein for several days, nursing has to be reminded to use PICC line, feeding tube has been clogged, catheter not completely emptied and causing leaking." The summary of the care plan conference documented Resident #83's daughter completed a formal grievance and requested someone help resolve their concerns.</p> <p>On 11/30/18 at 10:30 AM, the LSW stated when concerns were voiced during a care conference, she documented on the care plan conference summary report and if there was a concern in nursing, they wrote it down and addressed the concerns, but did not make it a formal grievance. The LSW thought the concerns for Resident #83 were resolved. The LSW was unable to provide documentation the concerns in Resident #83's care conference were investigated or resolved with Resident #83 or his family.</p> <p>On 11/30/18 at 10:48 AM, the Administrator stated there were no grievances filed for Resident #83 during his stay. The Administrator was not aware Resident #83 and his family had concerns that were documented on the care plan conference summary. The Administrator stated the LSW should have given him a copy of the care plan conference summary report to</p>	F 585			

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F 585	Continued From page 14 investigate the grievance.	F 585			
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and facility policy review, it was determined the facility failed to protect residents from neglect when residents experienced pain after requests were made for their ordered pain medication, and one resident who was not provided enteral feeding as ordered for three hours. This affected 3 of 14 residents (#11, #19, and #83) who were reviewed for abuse. This deficient practice had the potential for harm if residents experienced uncontrolled pain and/or weight loss. Findings include:  The facility's policy for abuse and neglect, revised 2/2018, stated each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation of any type	F 600	F- 600 SS=D Free from Abuse and Neglect  Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:  Resident #11's grievance was in the process of being investigated immediately upon receiving it on 11/26/18;  (There was no actual delay in the investigation of this grievance. The grievance letter that was submitted had been	1/15/19	

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F 600	<p>Continued From page 15</p> <p>by anyone which included staff. The policy also stated if there was suspected abuse and/or neglect the administrator or designee will investigate the occurrence and protection will be provided (e.g. staff changes, room changes, etc.). The policy stated if the accused individual was an employee they will be removed from the resident care areas immediately and placed on suspension pending results of the investigation. The administrator or designee will also complete an incident report to document the investigation.</p> <p>1. Residents did not receive their pain medications as ordered, or when they requested them for pain. Examples include:</p> <p>a. Resident #11 was admitted to the facility on 9/20/18, with diagnoses of injuries from a motor vehicle accident which included multiple facial fractures, laceration of the head and right ear, and a tibia (lower leg) fracture.</p> <p>An MDS assessment, dated 10/3/18, documented Resident #11 was cognitively intact and capable of decision making about her care.</p> <p>On 11/27/18 at 9:41 AM, Resident #11 stated "I have to wait for my pain medicine up to an hour when [RN #1] works. When I ask again, the aide will say I told her and she gets angry when I tell her again. If I don't take my pain medicine every 4 hours, it gets so bad and then the medicine doesn't help. I set my phone alarm when I'm awake, so I don't ask too early to have my pain medicine. I can't sleep when she works because I worry if she will give me my medicine when I need it." Resident #11 also stated, "I wrote a letter to the Administrator and put it under his</p>	F 600	<p>misplaced but the information in the letter was at the level of a grievance and was in the process of being investigated;</p> <p>Upon interview with the surveyor, Res #11 revealed more details of the situation than originally submitted in the grievance letter; When this additional Information was presented to the Administrator by the surveyor it was Immediately reported through the Abuse Reporting Portal)</p> <p>RN #1 is no longer employed at the facility;</p> <p>Resident #83 is no longer a resident in the facility; Access to previous EMAR system has been obtained and resident #83's MAR is available for review – the facility was not using paper MARs at the time this resident was in the facility.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>No other residents were directly affected by this deficient practice, however all residents in the facility have the potential to be affected, therefore by 1/4/2019 a review of all residents pain management will be conducted.</p>		

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F 600	<p>Continued From page 16</p> <p>door Sunday [11/25/18]. I checked with him on Monday [11/26/18] and he said he got my letter. I told him about not getting my pain medication when I ask for it and how rude she [RN #1] is to me and my family. He didn't come and talk to me on Monday, [11/26/18], but he did say he got my letter."</p> <p>Resident #11's record included a physician order for Oxycodone (a narcotic pain medication) 5-325 mg 1-2 tablets every 4 hours as needed for pain.</p> <p>On 11/28/18 at 9:43 AM, during a second interview Resident #11 stated "Doing better, the Administrator came in today and had me sign a paper on the note I wrote to him. The note read going to do a disciplinary action on the nurse [RN #1]. Last night [11/27/18] I had to wait 45 minutes after requesting pain medicine from [RN #1] and I did not get my medicine. I saw [LPN #1] and told her I had not had my medicine I had asked for 45 minutes ago for pain. [LPN #1] went to [RN #1] and I got my medicine." LPN #1 was interviewed on 11/30/18 at 3:00 PM, and she confirmed the event as described by the resident.</p> <p>On 11/28/18 at 10:30 AM, a request was made to the Administrator for the investigation related to the letter submitted by Resident #11. The Administrator stated "I did read the letter but have misplaced it, and I have not completed the investigation into the grievance." The Administrator verified he received the letter from the resident on Monday 11/26/18, and stated he did not consider it abuse.</p> <p>On 11/28/18 at 4:00 PM, the surveyor requested the investigation and copy of the grievance letter</p>	F 600	<p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 12/21/2018 the facility Administrator will receive an in-service education &amp; written disciplinary action related to:</p> <ul style="list-style-type: none"> <li>- the importance of promptly investigating all grievances submitted;</li> <li>- identifying allegations of abuse/neglect/mistreatment;</li> <li>- review of abuse policy;</li> </ul> <p>By 1/1/2019 an in-service education will be provided to all staff regarding appropriate and professional interactions with resident;</p> <p>By 1/1/2019 an in-service education will be provided to all licensed nurses to ensure:</p> <ul style="list-style-type: none"> <li>- timely administration of PRN pain medications especially when requested by residents;</li> <li>- timely and complete documentation of medication and treatment administrations in the residents' records;</li> </ul> <p>By 1/1/2019 an in-service education will be provided to all staff involved with resident admissions to ensure necessary equipment and supplies are ordered and ready to be used in the facility upon arrival of a new resident admission;</p> <p>By 1/1/2019 an in-service education will be given to the Medical Records Director related to making sure closed resident records are complete and accurate.</p>		

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F 600	<p>Continued From page 17 from Resident #11. The Administrator stated "I have not completed the investigation and cannot find the letter." The Administrator stated he sent a screen shot to the State Survey Agency of the initial report because he was unable to complete an electronic report to the state. The Administrator stated he removed RN #1 from the schedule and placed her on Administrative Leave.</p> <p>On 11/29/18 at 10:00 AM, Resident #11 stated "I slept so good last night. I got my medication within 10 minutes when I requested. [RN #1] did not work last night. She's not coming back is she?"</p> <p>On 11/30/18 at 2:00 PM, the Administrator provided a copy of a screen shot from a computer of the report he sent to the State Survey Agency. The document stated the Incident Type was Mistreatment. The Incident Detail on the form documented the date and time of the incident was 11/28/18 at 3:00 PM. The document described the incident stating on 11/26/18, the facility received a grievance from Resident #11 regarding a nurse that was rude to her and did not pass her medications on time. The document stated on 11/28/18, Resident #11 related more details than originally were given in the grievance which changed the status of the investigation to an allegation of abuse.</p> <p>There was no investigation initiated by the Administrator until three days after receipt of the letter of grievance from Resident #11. The Administrator did not recognize the letter as an allegation of abuse/neglect and did not start an investigation into an allegation of abuse/neglect</p>	F 600	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through the following-</p> <p>The Director of Nursing or designee will perform an interview of at least (3) residents that are on PRN pain medications: - to ensure timeliness of PRN pain medications when requested;</p> <p>The Director of Nursing or designee will perform a visual observation of at least (3) residents' records: - to ensure timely and complete documentation of medication and treatment administrations in the residents' records; -to ensure necessary equipment and supplies were ordered and ready to be used upon arrival of a new resident admission;</p> <p>The Administrator and/or designee will: - perform a visual observation of at least three (3) closed resident records to ensure all documentation is in the resident record or available thru current EMAR system upon closing the resident record after discharge from the facility;</p> <p>The Director of Nursing or the Assistant Administrator who will perform a random audit of at least three (3) grievances to</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>QUINN MEADOWS REHABILITATION AND CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>		
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F 600	<p>Continued From page 18</p> <p>in a timely manner. The untimely investigation resulted in additional opportunities for RN #1 to care for Resident #11 despite her documented concerns.</p> <p>b. Resident #19 was admitted to the facility on 10/1/18, with multiple diagnoses including a fracture of the left tibia (lower leg) and neuropathy (damage to the peripheral nerves).</p> <p>Resident #19's physician's order, dated 10/1/18, documented she received Dilaudid 2 mg one tablet every 4 hours as needed for moderate pain and two tablets for severe pain.</p> <p>An admission MDS assessment, dated 10/15/18, documented Resident #19 was cognitively intact and capable of decision making about her care. The pain section portion of the assessment documented Resident #19 received pain medication as needed and was able to vocalize the expression of pain.</p> <p>Resident #19's care plan, dated 10/25/18, documented she was at risk for pain related to a left tibia fracture. The goal was for Resident #19 to be as comfortable as possible regarding any pain issues. The interventions on the care plan included medications and treatment as ordered by the physician and to reassess after pain medication was provided for effectiveness.</p> <p>Resident #19's narcotic record documented the following administration of Dilaudid by RN #1:</p> <p>*11/23/18 at 8:45 PM *11/26/18 at 9:45 PM *11/27/18 at 9:02 PM</p>	F 600	<p>ensure they are investigated in a timely manner and the proper protocol has been followed per facility policy.</p> <p>Monitoring will start on 1/11/2019 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee and DNS or designee will present their findings and/or corrective actions taken to the QA&amp;A Committee, during their quarterly QA&amp;A meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		

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F 600	<p>Continued From page 19</p> <p>On 11/29/18 at 8:52 AM, Resident #19 said "I like to go to bed at 7:00 PM. I asked for my pain medication at 7:00 to 7:30 PM. [RN #1] comes in my room flips on the bright overhead light between 9:00 and 9:30 PM and brings my pain medication 2 hours after I ask for the medicine. This has happened multiple times, I cannot remember the exact dates. She [RN #1] was put out because I requested to move to a quiet room and it is at the end of the hallway and she [RN #1] must walk further. The other night she [RN #1] was complaining about stuff and I just did not respond to her."</p> <p>RN #1's Time Card Report documented she continued to work on 11/26/18, after the Administrator received the grievance letter from Resident #11 which documented RN #1 was rude and failed to provide pain medications in a timely manner after they were requested. The time card for RN #1 documented she worked in the facility on 11/26/18 from 5:45 PM to 11:31 PM and on 11/27/18 from 1:51 PM to 11:35 PM. The residents were not protected after an allegation of abuse/neglect was reported.</p> <p>On 11/28/18 at 10:45 AM, the Administrator said RN #1 was placed on administrative leave due to an allegation of abuse/neglect.</p> <p>2. Resident #83 was admitted to the facility on 12/26/17, with multiple diagnoses including cancer and diabetes.</p> <p>A care plan conference summary, dated 1/3/18, documented Resident #83's tube feeding was not connected and running for 3 hours.</p>	F 600			

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F 600	Continued From page 20  The December 2017 MARs documented Resident #83 had an order for Jevity 1.5 at 65 ml/hr, dated 12/26/17. On 12/26/17 and 12/27/17, there was no documentation or signature his Jevity was administered as ordered.  On 11/30/18 at 12:30 PM, the Unit Manager and LPN #1 stated the facility had a different electronic system. They stated they documented on the MARs and TARs in writing and also on the electronic system. They stated if the MARs and TARs were left blank, there should have been handwritten signatures on Resident #83's December MARs.  The facility was unable to provide additional documentation Resident #83 received his Jevity as ordered.  On 11/30/18 at 12:45 PM, the MDS Coordinator stated if Resident #83's MARs were left blank for his tube feeding then he did not receive nutrition for 2 days because there was no documentation to support he did.	F 600			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		1/15/19	

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F 609	<p>Continued From page 21</p> <p>that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§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:</p> <p>Based on record review, resident interview, and staff interview, it was determined the facility failed to report an allegation of abuse/neglect to the State Survey Agency within 2-24 hours when a resident filed a complaint related to not receiving pain medication timely upon request and was talked to rudely by staff. This affected 1 of 14 residents (Resident #11) who were reviewed for abuse/neglect. This deficient practice created the potential for harm if allegations were not acted upon in a timely manner and the abuse/neglect continued. Findings include:</p> <p>Resident #11 was admitted to the facility on 9/20/18, with diagnoses of injuries from a motor vehicle accident which included multiple facial fractures, laceration of the head and right ear, and a tibia (lower leg) fracture.</p>	F 609	<p>F- 609 SS=D Reporting of Alleged Violations</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #11's grievance was in the process of being investigated immediately upon receiving it on 11/26/18;</p> <p>(There was no actual delay in the investigation of this grievance. The grievance letter that was submitted had been misplaced but the information in the letter</p>		

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F 609	<p>Continued From page 22</p> <p>An MDS assessment, dated 10/3/18, documented Resident #11 was cognitively intact and capable of decision making about her care.</p> <p>On 11/27/18 at 9:41 AM, Resident #11 stated "I have to wait for my pain medicine up to an hour when [RN #1] works. When I ask again, the aide will say I told her and she gets angry when I tell her again. If I don't take my pain medicine every 4 hours, it gets so bad and then the medicine doesn't help. I set my phone alarm when I'm awake, so I don't ask too early to have my pain medicine. I can't sleep when she works because I worry if she will give me my medicine when I need it." Resident #11 also stated, "I wrote a letter to the Administrator and put it under his door Sunday [11/25/18]. I checked with him on Monday [11/26/18] and he said he got my letter. I told him about not getting my pain medication when I ask for it and how rude she [RN #1] is to me and my family. He didn't come and talk to me on Monday, [11/26/18], but he did say he got my letter."</p> <p>Resident #11's record included a physician order for Oxycodone (a narcotic pain medication) 5-325 mg 1-2 tablets every 4 hours as needed for pain.</p> <p>On 11/28/18 at 9:43 AM, during a second interview Resident #11 stated "Doing better, the Administrator came in today and had me sign a paper on the note I wrote to him. The note read going to do a disciplinary action on the nurse [RN #1]. Last night [11/27/18] I had to wait 45 minutes after requesting pain medicine from [RN #1] and I did not get my medicine. I saw [LPN #1] and told her I had not had my medicine I had asked for 45</p>	F 609	<p>was at the level of a grievance and was in the process of being investigated; Upon interview with the surveyor, Res #11 revealed more details of the situation than originally submitted in the grievance letter; When this additional Information was presented to the Administrator by the surveyor it was Immediately reported through the Abuse Reporting Portal)</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. No other residents were directly affected by this deficient practice, however all residents in the facility have the potential to be affected, therefore by 1/4/2019 a review of all residents pain management will be conducted.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 12/21/2018 the facility Administrator will receive an in-service education &amp; written disciplinary action related to:</p>		

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F 609	<p>Continued From page 23</p> <p>minutes ago for pain. [LPN #1] went to [RN #1] and I got my medicine." LPN #1 was interviewed on 11/30/18 at 3:00 PM, and she confirmed the event as described by the resident.</p> <p>On 11/28/18 at 10:30 AM, a request was made to the Administrator for the investigation related to the letter submitted by Resident #11. The Administrator stated "I did read the letter but have misplaced it, and I have not completed the investigation into the grievance." The Administrator verified he received the letter from the resident on Monday 11/26/18, and stated he did not consider it abuse.</p> <p>On 11/28/18 at 4:00 PM, the surveyor requested the investigation and copy of the grievance letter from Resident #11. The Administrator stated "I have not completed the investigation and cannot find the letter." The Administrator stated he sent a screen shot to the State Survey Agency of the initial report because he was unable to complete an electronic report to the state. The Administrator stated he removed RN #1 from the schedule and placed her on Administrative Leave.</p> <p>On 11/29/18 at 10:00 AM, Resident #11 stated "I slept so good last night. I got my medication within 10 minutes when I requested. [RN #1] did not work last night. She's not coming back is she?"</p> <p>On 11/30/18 at 2:00 PM, the Administrator provided a copy of a screen shot from a computer of the report he sent to the State Survey Agency. The document stated the Incident Type was Mistreatment. The Incident</p>	F 609	<ul style="list-style-type: none"> <li>- the importance of promptly investigating all grievances submitted;</li> <li>- identifying allegations of abuse/neglect/mistreatment and immediate reporting of such;</li> <li>- review of abuse policy;</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through The Director of Nursing Services or designee who will conduct an interview of at least three (3) residents that will be assessed and interviewed to ensure that any concerns or injuries are identified, properly investigated and, if needed, reported to the state reporting portal immediately.</p> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee will present to the Governing Board the findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		

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F 609	Continued From page 24 Detail on the form documented the date and time of the incident was 11/28/18 at 3:00 PM. The document described the incident stating on 11/26/18, the facility received a grievance from Resident #11 regarding a nurse that was rude to her and did not pass her medications on time. The document stated on 11/28/18, Resident #11 related more details than originally were given in the grievance which changed the status of the investigation to an allegation of abuse.  The Administrator did not recognize the letter as an allegation of abuse/neglect and did not report the allegation to the State Survey Agency within 2-24 hours.	F 609			
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:	F 610		1/15/19	

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F 610	<p>Continued From page 25</p> <p>Based on resident interview, staff interview, record review, and facility policy review, it was determined the facility failed to ensure an investigation was conducted in a timely manner for an allegation of abuse/neglect for 2 of 14 residents (#11 and #83) who were reviewed for abuse/neglect. This deficient practice created the potential for harm if allegations were not acted upon in a timely manner and the abuse/neglect continued. Findings include:</p> <p>The facility's policy for abuse and neglect, revised 2/2018, stated each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation of any type by anyone which included staff. The policy also stated if there was suspected abuse and/or neglect the administrator or designee will investigate the occurrence and protection will be provided (e.g. staff changes, room changes, etc.). The policy stated if the accused individual was an employee they will be removed from the resident care areas immediately and placed on suspension pending results of the investigation. The administrator or designee will also complete an incident report to document the investigation.</p> <p>1. Resident #11 was admitted to the facility on 9/20/18, with diagnoses of injuries from a motor vehicle accident which included multiple facial fractures, laceration of the head and right ear, and a tibia (lower leg) fracture.</p> <p>An MDS assessment, dated 10/3/18, documented Resident #11 was cognitively intact and capable of decision making about her care.</p> <p>On 11/27/18 at 9:41 AM, Resident #11 stated "I</p>	F 610	<p>F- 610 SS=D Investigate/Prevent/Correct Alleged Violation</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #11's grievance was in the process of being investigated immediately upon receiving it on 11/26/18;</p> <p>(There was no actual delay in the investigation of this grievance. The grievance letter that was submitted had been misplaced but the information in the letter was at the level of a grievance and was in the process of being investigated; Upon interview with the surveyor, Res #11 revealed more details of the situation than originally submitted in the grievance letter; When this additional Information was presented to the Administrator by the surveyor it was Immediately reported through the Abuse Reporting Portal)</p> <p>Resident #11's grievance investigation was completed, resolved and feedback given to resident #11;</p>		

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F 610	<p>Continued From page 26</p> <p>have to wait for my pain medicine up to an hour when [RN #1] works. When I ask again, the aide will say I told her and she gets angry when I tell her again. If I don't take my pain medicine every 4 hours, it gets so bad and then the medicine doesn't help. I set my phone alarm when I'm awake, so I don't ask too early to have my pain medicine. I can't sleep when she works because I worry if she will give me my medicine when I need it." Resident #11 also stated, "I wrote a letter to the Administrator and put it under his door Sunday [11/25/18]. I checked with him on Monday [11/26/18] and he said he got my letter. I told him about not getting my pain medication when I ask for it and how rude she [RN #1] is to me and my family. He didn't come and talk to me on Monday, [11/26/18], but he did say he got my letter."</p> <p>Resident #11's record included a physician order for Oxycodone (a narcotic pain medication) 5-325 mg 1-2 tablets every 4 hours as needed for pain.</p> <p>On 11/28/18 at 9:43 AM, during a second interview Resident #11 stated "Doing better, the Administrator came in today and had me sign a paper on the note I wrote to him. The note read going to do a disciplinary action on the nurse [RN #1]. Last night [11/27/18] I had to wait 45 minutes after requesting pain medicine from [RN #1] and I did not get my medicine. I saw [LPN #1] and told her I had not had my medicine I had asked for 45 minutes ago for pain. [LPN #1] went to [RN #1] and I got my medicine." LPN #1 was interviewed on 11/30/18 at 3:00 PM, and she confirmed the event as described by the resident.</p> <p>On 11/28/18 at 10:30 AM, a request was made to</p>	F 610	<p>Resident #83 is no longer a resident in the facility</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>No other residents were directly affected by this deficient practice, however all residents in the facility have the potential to be affected.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 12/21/2018 the facility Administrator will receive an in-service education &amp; written disciplinary action related to:</p> <ul style="list-style-type: none"> <li>- the importance of promptly investigating all grievances submitted;</li> <li>- identifying allegations of abuse/neglect/mistreatment and immediate reporting of such;</li> <li>- review of abuse policy;</li> </ul> <p>By 1/1/2019 a systematic change will be implemented Which includes the following:</p> <ul style="list-style-type: none"> <li>- a centrally located lock box for submission of Grievances to prevent misplacement;</li> <li>- a second staff member (DNS or Asst Administrator) will be</li> </ul>		

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NAME OF PROVIDER OR SUPPLIER  <b>QUINN MEADOWS REHABILITATION AND CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>		
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F 610	<p>Continued From page 27</p> <p>the Administrator for the investigation related to the letter submitted by Resident #11. The Administrator stated "I did read the letter but have misplaced it, and I have not completed the investigation into the grievance." The Administrator verified he received the letter from the resident on Monday 11/26/18, and stated he did not consider it abuse.</p> <p>On 11/28/18 12:30 PM, the Administrator was asked if the initial report of the allegation with concerns of medication for pain not provided promptly was filed or the investigation completed. The Administrator responded "No still unable to find the letter and have not completed the investigation."</p> <p>On 11/28/18 at 4:00 PM, the surveyor requested the investigation and copy of the grievance letter from Resident #11. The Administrator stated "I have not completed the investigation and cannot find the letter." The Administrator stated he sent a screen shot to the State Survey Agency of the initial report because he was unable to complete an electronic report to the state. The Administrator stated he removed RN #1 from the schedule and placed her on Administrative Leave.</p> <p>On 11/29/18 at 10:00 AM, Resident #11 stated "I slept so good last night. I got my medication within 10 minutes when I requested. [RN #1] did not work last night. She's not coming back is she?"</p> <p>On 11/30/18 at 2:00 PM, the Administrator provided a copy of a screen shot from a computer of the report he sent to the State</p>	F 610	<p>Involved in the process of receiving, reviewing and Investigating grievances in a timely manner;</p> <p>- An in-service education to all staff regarding their Role in reporting residents' grievances in a timely manner the process of how to file a resident grievance, and notification to Administration of grievance filed.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through the Director of Nursing and/or the Assistant Administrator who will perform a random audit of at least three (3) grievances to ensure they are investigated in a timely manner and the proper protocol has been followed per facility policy.</p> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Director of Nursing and/or Assistant Administrator will present to the Governing Board the findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the</p>		

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F 610	<p>Continued From page 28</p> <p>Agency. The document stated the Incident Type was Mistreatment. The Incident Detail on the form documented the date and time of the incident was 11/28/18 at 3:00 PM. The document described the incident stating on 11/26/18, the facility received a grievance from Resident #11 regarding a nurse that was rude to her and did not pass her medications on time. The document stated on 11/28/18, Resident #11 related more details than originally were given in the grievance which changed the status of the investigation to an allegation of abuse.</p> <p>Resident #11 was not protected from from potential abuse/neglect for three days after the allegation was made to the Administrator. The Administrator did not recognize the letter as an allegation of abuse/neglect and did not start an investigation into an allegation of abuse/neglect in a timely manner. The untimely investigation resulted in additional opportunities for RN #1 to care for Resident #11 despite her documented concerns.</p> <p>2. Resident #83 was admitted to the facility on 12/26/17, with multiple diagnoses including cancer and diabetes. He was discharged from the facility on 1/23/18.</p> <p>A care plan conference, dated 1/3/18, documented Resident #83 and his family had concerns with the nursing staff regarding his "...tube feeding not connected for 3 hours, CNAs not providing two person assistance, having to ask for Zofran [anti-nausea medication], no free water (on schedule now), went without beta protein for several days, nursing has to be reminded to use PICC line, feeding tube has</p>	F 610	QA&A Committee quarterly meeting.		

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F 610	Continued From page 29 been clogged, catheter not completely emptied and causing leaking." The summary of the care plan conference documented Resident #83's daughter completed a formal grievance and requested someone help resolve their concerns.  On 11/30/18 at 10:30 AM, the LSW stated when concerns were voiced during a care conference, she documented on the care plan conference summary report and if there was a concern in nursing, they wrote it down and addressed the concerns, but did not make it a formal grievance. The LSW thought the concerns for Resident #83 were resolved. The LSW was unable to provide documentation the concerns in Resident #83's care conference were investigated or resolved with Resident #83 or his family.  On 11/30/18 at 10:48 AM, the Administrator stated there were no grievances filed for Resident #83 during his stay. The Administrator was not aware Resident #83 and his family had concerns that were documented on the care plan conference summary. The Administrator stated the LSW should have given him a copy of the care plan conference summary report to investigate as a grievance.	F 610			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)  §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;	F 622		1/15/19	

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F 622	<p>Continued From page 30</p> <p>(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;</p> <p>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;</p> <p>(D) The health of individuals in the facility would otherwise be endangered;</p> <p>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer</p>	F 622			

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F 622	Continued From page 31 or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c) (1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:	F 622			

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F 622	<p>Continued From page 32</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure information was provided to the receiving hospital for an emergent situation for 1 of 2 residents (Resident #30) who were reviewed for transfers. This deficient practice had the potential to cause harm if the resident was not treated in a timely manner due to a lack of information. Findings include:</p> <p>Resident #30 was readmitted to the facility on 11/8/18, with multiple diagnoses including respiratory failure and weakness.</p> <p>A discharge MDS assessment, dated 11/2/18, documented Resident #30 was discharged to a hospital.</p> <p>A nurse's progress note, dated 11/2/18 at 9:31 AM, documented Resident #30 was having notable changes in her level of consciousness, functional ability, mood and behavior, bladder function, and respiratory function. Resident #30 was transferred to a local hospital.</p> <p>Resident #30's record did not include documentation her physician or family were notified of the transfer to a hospital, a physician's order to be transferred to the hospital, who transported the resident to the hospital, a verbal report to the hospital, or information regarding Resident #30 and her status was sent with her to the hospital.</p> <p>On 11/28/18, at 3:50 PM, the Unit Manager stated she recalled the incident on 11/2/18, when Resident #30 was transferred and admitted to the hospital. The Unit Manager stated Resident #30's</p>	F 622	<p>F- 622 SS=D Transfer and Discharge Requirements</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #30's record was updated with a late progress note to include documentation of physician notification, physician order obtained, family notification, transportation information, resident medical documentation sent out and reason for admission to the hospital related to the 11/2/2018 incident.</p> <p>(The nurse in charge did complete all of the above listed steps on 11/2/2018 but did not document in the resident record that they were completed)</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. Although no other residents were affected by this deficient practice, any residents with the need to be transferred to the hospital have the potential to be affected.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p>		

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F 622	Continued From page 33 record did not have documentation the physician and family were notified, there was a physician's order to transport her to the hospital, who transported Resident #30 to the hospital, paperwork was given to the paramedics, and the reason for admission to the hospital. The Unit Manager stated when a resident was transferred to the hospital they sent the resident's face sheet, diagnoses, medication list, advance directive, physician's orders for transfer to the hospital, and verbal report to the paramedics and called the hospital with a verbal report.	F 622	By 1/1/2019 an in-service education will be given to all licensed nurses regarding the process of documentation in the resident's record for transfer to the hospital, including: documentation of physician notification; physician order obtained; family notification; transportation information (who, how, when); resident medical documentation sent; reason for admission to the hospital.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur:  Monitoring will be done through the Director of Nursing or designee who will perform a visual observation of at least three (3) resident records of residents that have been transferred to the hospital to ensure the proper documentation is included in the record.  Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.  The Director of Nursing or designee will submit to the Administrator or designee and to the QA&A Committee the findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.  Compliance, continuation/discontinuation of monitoring will be discussed during the		

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F 622	Continued From page 34	F 622	QA&A Committee quarterly meeting.		
F 625 SS=D	<p>Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§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-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure a second bed-hold notice was provided to a resident or their representative upon transfer to</p>	F 625	F- 625 SS= D Notice of Bed Hold Policy Before/Upon Transfer	1/15/19	

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F 625	<p>Continued From page 35</p> <p>an acute care hospital. This was true for 1 of 2 residents (Resident #30) who were reviewed for transfers. This 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 and may cause psychosocial distress if not informed they may be charged to reserve their bed/room. Findings include:</p> <p>Resident #30 was readmitted to the facility on 11/8/18, with multiple diagnoses including respiratory failure and weakness.</p> <p>Resident #30 was transferred to the hospital on 11/2/18, and readmitted to the facility on 11/8/18. Resident #30's record did not include documentation Resident #30 or her family received a second bed-hold notification when she was transferred to the hospital.</p> <p>On 11/28/18 at 3:50 PM, the Unit Manager stated Resident #30 and her family did not receive a second bed-hold notification and she returned to her same room on 11/8/18.</p> <p>On 11/29/18 at 9:30 AM, the Administrator stated the facility did not have a policy for bed holds. He stated a notice was given to residents in their Resident Admission Agreement.</p>	F 625	<p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>No corrective action able to be performed.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. Although no other residents were directly affected by this deficient practice, any residents with the need to be transferred to the hospital have the potential to be affected.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>On 12/3/2018 a 1:1 in-service education was given to the Social Services Director regarding the responsibility of providing a second bed hold notification to the resident or responsible party within 24 hours and/or the next business day of any resident transferring to the hospital;</p> <p>By 1/1/2019 an in-service education will be given to all licensed nurses regarding their role in obtaining a second bed hold notification for all residents transferring to the hospital before they leave the facility</p>		

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F 625	Continued From page 36	F 625	<p>but no later than 24 hours and/or the next business day from the time of transfer from the facility when Social Services Director is not available to do so.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through the Administrator or designee who will perform a visual observation of at least three (3) resident records to ensure the second bed hold notification was provided to a resident or responsible party within 24 hours of a resident transferring to the hospital.</p> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee will submit to the QA&amp;A Committee the findings and/or corrective actions taken during the quarterly QA&amp;A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive</p>	F 684		1/15/19	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 684	<p>Continued From page 37</p> <p>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 staff interview and record review, it was determined the facility failed to ensure a physician order was followed for 1 of 14 residents (Resident #83) who were reviewed for standards of practice. This failed practice had the potential to adversely affect residents health and condition if physician orders for laboratory tests were not followed and cares were not provided. Findings include:</p> <p>Resident #83 was admitted to the facility on 12/26/17, with multiple diagnoses including cancer and diabetes.</p> <p>A physician's order, dated 1/18/18, documented staff were to obtain a UA (urinalysis) for a diagnosis of UTI (Urinary Tract Infection).</p> <p>Resident #83's record did not include documentation the UA was obtained as ordered, or laboratory results of the UA.</p> <p>On 11/30/18 at 1:30 PM, the Unit Manager, LPN #1, and the Medical Records Supervisor were unable to provide documentation for the results of the ordered UA.</p>	F 684	<p>F- 684 SS=D Quality of Care</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #83 is no longer a resident in the facility.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. Although no other residents were directly affected by this deficient practice, any residents with physician orders for laboratory testing have the potential to be affected,</p> <p>Therefore by 1/4/2019 a review of any resident records with current physician orders for laboratory testing to ensure the documentation includes that the laboratory tests were completed and also the results of the laboratory testing.</p>		

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F 684	Continued From page 38	F 684	<p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following: By 1/1/2019 an in-service education will be provided to all licensed nurses related to proper and timely documentation in the resident record following physician orders for laboratory tests, that the laboratory tests were completed and also the results of the laboratory testing.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through the Director of Nursing or designee who will perform a visual observation of at least three (3) resident records to ensure proper and timely documentation in the resident record following physician orders for laboratory tests, that the laboratory tests were completed and the results of the laboratory testing are included.</p> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Director of Nursing or designee will submit to the Administrator or designee and to the QA&amp;A Committee the findings and/or corrective actions taken during the quarterly QA&amp;A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the</p>		

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F 684	Continued From page 39	F 684	QA&A Committee quarterly meeting.		
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 record review, staff interview, resident interview, and facility policy review, it was determined the facility failed to ensure restorative services were provided as ordered for 1 of 12 residents (Resident #11) who received restorative services. This failure had the potential for harm if a resident's range of motion and activity decreased from lack of treatment. Findings include:  The facility's policy Coordination of Specialized Rehabilitative Services, undated, stated a licensed professional can initiate a maintenance</p>	F 688	<p>F- 688 SS=D Increase/Prevent Decrease in ROM/Mobility</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:  Resident #11 was started on the restorative program for ROM exercises on 11/26/2018.</p>	1/15/19	

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F 688	<p>Continued From page 40</p> <p>program where nursing or restorative aides will implement to ensure the resident maintains his/her functional and physical status.</p> <p>Resident #11 was admitted to the facility on 9/20/18, with diagnoses of injuries from a motor vehicle accident which included multiple facial fractures, laceration of the head and right ear, and a tibia (lower leg) fracture.</p> <p>A physical therapy progress note, dated 11/23/18, documented Resident #11 was referred to a restorative program five days a week for active range of motion.</p> <p>A Care Plan Conference Summary, dated 11/26/18, documented options for rehabilitation services with her insurance benefits for Resident #11. The summary did not include the referral from physical therapy to a restorative nursing program.</p> <p>On 11/27/18 at 9:53 AM, Resident #11 stated she had not received therapy for four days because her rehabilitation service benefits were exhausted. Resident #11 stated she was told by the facility staff she was to have the aides provide range of motion to prevent her joints from getting stiff.</p> <p>On 11/28/18 at 11:15 AM, Physical Therapist #1 stated Resident #11 was referred to the restorative program on 11/23/18. Physical Therapist #1 stated the DNS was the restorative nurse and he made a copy of the referral, with exercises and frequency of the program to be provided by the restorative aides, and placed it in the DNS' mailbox.</p>	F 688	<p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. Although no other residents were directly affected by this deficient practice, any residents with therapy orders for restorative program for ROM have the potential to be affected.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 1/1/2019 a systematic change will be implemented regarding the process for residents transitioning to the restorative program from rehabilitation therapy services:</p> <ul style="list-style-type: none"> <li>-Any potential restorative candidates will be discussed in morning IDT meetings within the week prior to the transition from rehabilitation therapy services to the restorative program;</li> <li>-Paperwork for residents transitioning from rehabilitation therapy services to the restorative program will be started and submitted to the Director of Nursing for review within the week before rehabilitation therapy services ends;</li> <li>Any RNA training necessary will take place during the week before a resident</li> </ul>		

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F 688	Continued From page 41  On 11/28/18 12:05 PM, the Administrator stated Resident #11 was not actually discharged from therapy, but did confirm she was not receiving treatment from therapy related to a payment source.  On 11/28/18 12:06 PM, the Activity Director (AD) stated she was the person who previously handled the restorative program until 7/31/18, when the DNS took over the program. The DNS was on vacation and not available for interview. The AD verified Resident #11 was not currently part of the restorative program.	F 688	transition from rehabilitation therapy services to the restorative program. How the corrective action(s) will be monitored to ensure the deficient practice will not recur:  Monitoring will be done through the Administrator or designee who will perform a visual observation of at least three (3) residents <input type="checkbox"/> records to ensure no time delay in transition from rehabilitation therapy services to the restorative program.  Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.  The facility Administrator or designee will submit to the QA&A Committee the findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.  Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		1/15/19	

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F 695	<p>Continued From page 42 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, and record review, it was determined the facility failed to ensure staff changed residents' oxygen humidifiers and nasal cannula tubing per physician orders. This was true for 1 of 2 residents (Resident #30) who were reviewed for respiratory care. This failure created the potential for harm from respiratory infections due to the growth of pathogens in oxygen humidifiers and nasal cannula tubing. Findings include:</p> <p>Resident #30 was readmitted to the facility on 11/8/18, with multiple diagnoses including heart failure.</p> <p>Resident #30's care plan, dated 11/8/18, documented staff were to change the oxygen tubing and humidifier weekly, and as needed.</p> <p>On 11/27/18 at 2:50 PM, Resident #30's oxygen humidifier and nasal cannula tubing were dated 11/8/18.</p> <p>Resident #30's November 2018 MAR documented oxygen was administered continuously at 1-4 liters per minute via nasal cannula.</p> <p>Resident #30's November 2018 TAR documented the oxygen humidifier and tubing were to be changed every week, on 11/14/18 and 11/21/18.</p> <p>On 11/28/18 at 12:00 PM, LPN #1 stated oxygen humidifiers and nasal cannulas were changed</p>	F 695	<p>F- 695 SS=D Respiratory/Tracheostomy Care and Suctioning</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #30's oxygen tubing, nasal cannula and humidifier bottle were replaced.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. Although no other residents were directly affected by this deficient practice, any residents that currently have orders for oxygen therapy have the potential to be affected.</p> <p>Therefore, by 12/21/2018 all residents that are on oxygen therapy will have the oxygen tubing, nasal cannula and humidifier bottle checked to ensure they have been changed according to the changing schedule.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not</p>		

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F 695	Continued From page 43 every seven days. LPN #1 confirmed Resident #30's oxygen humidifier and nasal cannula tubing were dated for 11/8/18, and stated they should have been changed on 11/22/18.  On 11/28/18 at 1:53 PM, the Administrator stated the facility's Oxygen Administration policy did not document how often the oxygen humidifier and tubing were to be changed, but the nursing staff changed them every Wednesday on the night shift.	F 695	recur includes the following:  On 12/21/2018 a 1:1 written education was given to both nurses that documented related to the oxygen tubing, nasal cannula and humidifier bottle being changed and updated for resident #30. By 1/1/2019 an in-service education will be given to all nursing staff regarding the changing of oxygen tubing, nasal cannula and humidifier bottles according to schedule. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through the Director of Nursing or designee who will perform a visual observation of at least three (3) residents currently on oxygen therapy to ensure oxygen tubing, nasal cannula and humidifier bottles are changed according to schedule.  Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.  The Director of Nursing or designee will submit to the Administrator or designee and to the QA&A Committee the findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.  Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 697 SS=D	Pain Management CFR(s): 483.25(k)	F 697		1/15/19	

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F 697	Continued From page 44  §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and facility policy review, it was determined the facility failed to provide pain management for 2 of 14 residents (#11 and #19) who were reviewed for cares. This failed practice placed residents at risk for harm when their pain was not managed as ordered by their physician to prevent sustained or prolonged periods of pain. Findings include:  1. Resident #11 was admitted to the facility on 9/20/18, with diagnoses of injuries from a motor vehicle accident which included multiple facial fractures, laceration of the head and right ear, and a tibia (lower leg) fracture.  A Pain Assessment Tool, completed on 09/20/18, documented the Resident #11 had pain daily of the back, head, joint, and bone. The assessment documented the quality of the pain as dull, stabbing, ache, continuous, and intermittent. The emotional impact of pain was documented as "frustrated." The Pain Assessment Tool documented Resident #11's pain was relieved by her prescribed medication.  Resident #11's care plan, dated 9/20/18, documented she was at risk for pain related to	F 697	F- 697 SS=D Pain Management  Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:  RN #1 is no longer employed at the facility.  Resident #11 PRN pain medication regimen will be reviewed by 12/21/2018 for possible change to scheduled.  Resident #19 PRN pain medication regimen will be reviewed by 12/21/2018 for possible change to scheduled.  Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:  No other residents were directly affected by this deficient practice, however all residents that have physician orders for PRN pain medications have the potential		

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F 697	<p>Continued From page 45</p> <p>multiple fractures, abrasions, and lacerations. The goal was for Resident #11 to be as comfortable as possible regarding any pain issues. The interventions on the care plan included medications and treatment as ordered by the physician and to reassess after pain medication was provided for effectiveness.</p> <p>An MDS assessment, dated 10/3/18, documented Resident #11 was cognitively intact and capable of decision making about her care.</p> <p>On 11/27/18 at 9:41 AM, Resident #11 stated "I have to wait for my pain medicine up to an hour when [RN #1] works. When I ask again, the aide will say I told her and she gets angry when I tell her again. If I don't take my pain medicine every 4 hours, it gets so bad and then the medicine doesn't help. I set my phone alarm when I'm awake, so I don't ask too early to have my pain medicine. I can't sleep when she works because I worry if she will give me my medicine when I need it." Resident #11 also stated, "I wrote a letter to the Administrator and put it under his door Sunday [11/25/18]. I checked with him on Monday [11/26/18] and he said he got my letter. I told him about not getting my pain medication when I ask for it and how rude she [RN #1] is to me and my family. He didn't come and talk to me on Monday, [11/26/18], but he did say he got my letter."</p> <p>Resident #11's record included a physician order for Oxycodone (a narcotic pain medication) 5-325mg 1-2 tablets every 4 hours as needed for pain.</p> <p>A Narcotic Record, dated November 2018, for</p>	F 697	<p>to be affected.</p> <p>Therefore by 1/4/2019 an interview will be performed with any residents that have current pain medications to ensure they are being received in a timely manner and upon request by the resident.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 1/1/2019 an in-service education will be provided to all licensed nurses to ensure timely administration of PRN pain medications especially when requested by residents.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through the Director of Nursing or designee who will perform an interview with at least three (3) residents to ensure PRN pain medications are received in a timely manner.</p> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee will submit to the Administrator or designee and to the QA&amp;A Committee the findings and/or corrective actions taken during the quarterly QA&amp;A Committee Meeting.</p>		

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F 697	<p>Continued From page 46</p> <p>Resident #11 documented the times RN #1 administered pain medication. Examples include:</p> <ul style="list-style-type: none"> <li>- On 11/11/18 the Resident received Hydrocodone 5/325 mg two tablets at 11:30 AM and not again until 5:20 PM. A span of 5.75 hours passed between the administration of pain medication.</li> <li>- On 11/14/18 the pain medication was administered at 1:30 PM and not again until 9:15 PM. A span of 7.75 hours passed between pain medication administration.</li> <li>- On 11/15/18 the resident received her pain medication at 1:25 PM and not again until 9:45 PM, a span of 8.25 hours passed between the administration of the pain medication.</li> <li>- On 11/20/18 the resident received her pain medication at 2:00 PM and not again until 9:55 PM, a span of 8 hours passed between pain medication administration.</li> <li>- On 11/21/18 the resident received pain medication at 11:30 AM and not again until 9:30 PM, a span of 10 hours passed between the administration of pain medication.</li> </ul> <p>There was no documentation in the Narcotic Record for Resident #11 of her pain level when her medication was administered.</p> <p>On 11/28/18 at 9:43 AM, during a second interview Resident #11 stated "Doing better, the Administrator came in today and had me sign a paper on the note I wrote to him. The note read going to do a disciplinary action on the nurse [RN</p>	F 697	Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		

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F 697	<p>Continued From page 47</p> <p>#1]. Last night [11/27/18] I had to wait 45 minutes after requesting pain medicine from [RN #1] and I did not get my medicine. I saw [LPN #1] and told her I had not had my medicine I had asked for 45 minutes ago for pain. [LPN #1] went to [RN #1] and I got my medicine." LPN #1 was interviewed on 11/30/18 at 3:00 PM, and she confirmed the event as described by the resident.</p> <p>On 11/29/18 at 10:00 AM, Resident #11 stated "I slept so good last night. I got my medication within 10 minutes when I requested. [RN #1] did not work last night. She's not coming back is she?"</p> <p>On 11/28/18 at 1:00 PM, Resident #11's record was reviewed with the MDS nurse and they confirmed the documentation was accurate.</p> <p>2. Resident #19 was admitted to the facility on 10/1/18, with multiple diagnoses including a fracture of the left tibia and neuropathy (damage to the peripheral nerves).</p> <p>Resident #19 physician's order, dated 10/1/18, documented she received Dilaudid 2 mg one tablet every 4 hours as needed for moderate pain and two tablets for severe pain.</p> <p>An admission MDS assessment, dated 10/15/18, documented Resident #19 was cognitively intact and capable of decision making about her care. The pain section portion of the assessment documented Resident #19 received pain medication as needed and was able to vocalize the expression of pain.</p> <p>Resident #19's care plan, dated 10/25/18,</p>	F 697			

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F 697	Continued From page 48 documented she was at risk for pain related to a left tibia fracture. The goal was for Resident #19 to be as comfortable as possible regarding any pain issues. The interventions on the care plan included medications and treatment as ordered by the physician and to reassess after pain medication was provided for effectiveness.  Resident #19's narcotic record documented the following administration of Dilaudid by RN #1:  *11/23/18 at 8:45 PM *11/26/18 at 9:45 PM *11/27/18 at 9:02 PM  On 11/29/18 at 8:52 AM, Resident #19 said "I like to go to bed at 7:00 PM. I asked for my pain medication at 7:00 to 7:30 PM. [RN #1] comes in my room flips on the bright overhead light between 9:00 and 9:30 PM and brings my pain medication 2 hours after I ask for the medicine. This has happened multiple times, I cannot remember the exact dates."	F 697			
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4)  §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.  §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.  §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician	F 712		1/15/19	

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F 712	<p>Continued From page 49 visits must be made by the physician personally.</p> <p>§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, it was determined the facility failed to ensure residents were provided with physician visits every 60 days as required to ensure an appropriate program of care. This was true for 3 of 12 residents (#2, #18, and #20) reviewed for frequency of physician visits. This failure had the potential for harm should residents' care needs change without the awareness or involvement of their physician. Findings include:</p> <p>The facility's policy for physician visits, revised 6/2004, documented the attending physician must visit at least every 30 days for the first 90 days following the resident's admission, and then at least every 60 days thereafter. The attending physician must review the resident's total program of care and appropriate documentation.</p> <p>1. Resident #2 was admitted to the facility on 11/4/16, with multiple diagnoses including chronic kidney disease, diabetes, and hypertension.</p> <p>Resident #2's record included a physician progress note, dated 10/7/17. There were no subsequent physician progress notes in the record between 10/7/17 to 4/6/18, and from</p>	F 712	<p>F- 712 SS=D Physician Visits-Frequency/Timeliness/Alt NPP</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #2 attending physician visit is scheduled for 12/19/2018;</p> <p>Resident #18 attending physician visit happened on 12/17/2018 and a progress note is in the resident record;</p> <p>Resident #20 attending physician visit happened on 12/03/2018 and a progress note is in the resident record;</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>All current residents have the potential to be affected by this deficient practice, therefore by 1/4/2019 a review of</p>		

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F 712	<p>Continued From page 50</p> <p>4/6/18 to 9/17/18. There was no documentation other visits from the physician, nurse practitioner, or physician assistant were provided during those time periods.</p> <p>On 11/29/18 at 12:26 PM, the Medical Records Supervisor stated Resident #2 went to the physician's office for her appointments. The Medical Records Supervisor stated it was difficult sometimes to get a progress note from Resident #2's physician.</p> <p>On 11/30/18 at 11:03 AM, the Medical Director stated he was unaware Resident #2 was not seen by her primary physician every 60 days and would work to ensure Resident #2 was seen by her primary physician every 60 days.</p> <p>2. Resident #18 was admitted to the facility on 1/28/14, with multiple diagnoses including hypertension, thyroid disorder, and spinal stenosis.</p> <p>Resident #18's record included physician progress notes by a Nurse Practitioner, dated 7/9/18 and 11/12/18. There were no physician progress notes between 7/9/18 and 11/12/18, by the Nurse Practitioner or a physician.</p> <p>On 11/29/18 at 12:46 PM, the Medical Records Supervisor stated she made a list of residents that the Nurse Practitioner or the Physician needed to see every week. The Medical Records Supervisor was unable to find documentation of physician visits for Resident #18 during the months of August 2018, September 2018, or October 2018.</p>	F 712	<p>physician visits for all current residents will be completed to ensure physician visits are every 60 days to ensure an appropriate program of care.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 1/1/2019 an in-service education will be given to the Medical Records Director regarding:</p> <ul style="list-style-type: none"> <li>- monthly tracking of physician visits to ensure the attending physicians visit residents every 60 days;</li> <li>- attending physician visit progress notes are documented in the resident record accordingly.</li> </ul> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through the Administrator or designee who will perform a visual observation of at least three (3) current resident records to ensure attending physician visits are happening every 60 days and documentation of the visits are in the residents records.</p> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee will submit</p>		

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F 712	Continued From page 51 3. Resident #20 was admitted to the facility on 11/5/10, with multiple diagnoses including, COPD and venous insufficiency.  Resident #20's record included a physician progress note, dated 12/25/17. Resident #20 was seen by the Nurse Practitioner on 4/16/18, then by the Medical Director on 8/28/18. There were no physician or provider progress notes between 12/25/17 to 4/16/18, and 4/16/18 to 8/28/18.  On 11/30/18 at 10:38 AM, the Medical Records Supervisor was unable to provide documentation of physician or midlevel provider visits for Resident #20 during the months of February 2018 or June 2018.  On 11/30/18 at 10:59 AM, the Medical Director stated he had taken over the care of the long term residents earlier this year. The Medical Director stated between him and his Nurse Practitioner he was unaware Resident #18 and Resident #20 were not seen every 60 days.	F 712	to the QA&A Committee the findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.  Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)  §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  §483.45(c)(2) This review must include a review of the resident's medical chart.  §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.	F 756		1/15/19	

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F 756	<p>Continued From page 52</p> <p>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure pharmacy recommendations were followed or addressed by the attending physician. This was true for 1 of 12 residents (Resident #2) who were reviewed for medications. This failure had the potential for harm if residents' medications were administered without a clinical rationale. Findings include:</p>	F 756	<p>F- 756 SS=D Drug Regimen Review, Report Irregular, Act On</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #2's record was updated to</p>		

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F 756	<p>Continued From page 53</p> <p>Resident #2 was admitted to the facility on 11/4/16, with multiple diagnoses including depression.</p> <p>A Psychotropic Drug Review, dated 6/27/18, documented the facility's committee which included the pharmacist, recommended to discontinue Resident #2's daily Zoloft (an antidepressant) due to no documented signs or symptoms of depression. The physician placed a checkmark next to the statement "Disagrees with committee recommendations," and signed the form the same day as the recommendation. There was no documentation of a clinical rationale for the ongoing use of Zoloft by the physician.</p> <p>On 11/29/18 at 9:32 AM, the LSW stated the DNS follows up on the pharmacy recommendations to the physician.</p> <p>On 11/29/18 at 11:30 AM, the Administrator stated he was unable to find documentation of the physician's clinical rationale to continue the Zoloft for Resident #2.</p>	F 756	<p>include physician's clinical rationale for the ongoing use of anti-depression medication.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. Although no other residents were directly affected by this deficient practice, any residents that currently have physician orders for psychotropic medications have the potential to be affected.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 1/1/2019 an in-service education will be given to the Director of Nursing regarding the importance of tracking PDR (Psychotropic Drug Review) recommendations to physicians to ensure clinical rationale is documented related to the physician's disagreement with recommendations for trial reduction or discontinuation of psychotropic medication use.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through the Administrator or designee who will</p>		

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F 756	Continued From page 54	F 756	<p>perform a visual observation of at least three (3) resident records that have orders for psychotropic medications:</p> <ul style="list-style-type: none"> <li>- to ensure facility physicians provide documented clinical rationale for the ongoing use of psychotropic medications when a trial reduction or discontinuation is recommended;</li> <li>-to ensure proper tracking of PDR recommendations from the physicians and documentation of clinical rationale for the ongoing use of psychotropic medications when a trial reduction or discontinuation is recommended.</li> </ul> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee will submit to the QA&amp;A Committee her findings and/or corrective actions taken during the quarterly QA&amp;A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		
F 757 SS=D	<p>Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)</p> <p>§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p>	F 757		1/15/19	

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F 757	<p>Continued From page 55</p> <p>§483.45(d)(2) For excessive duration; or</p> <p>§483.45(d)(3) Without adequate monitoring; or</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure residents receiving psychotropic medications were monitored for side effects of the medications. This was true for 1 of 6 residents (Resident #30) who were reviewed for unnecessary medications. This deficient practice created the potential for adverse consequences if residents received medications and were not monitored adequately for adverse reactions. Findings include:</p> <p>Resident #30 was readmitted to the facility on 11/8/18, with multiple diagnoses including respiratory failure and weakness.</p> <p>An admission MDS assessment, dated 11/15/18, documented Resident #30 was cognitively intact and had minimal depression.</p> <p>Resident #30's November 2018 MAR documented Resident #30 received Zoloft 25 mg</p>	F 757	<p>F- 757 SS=D Drug Regimen is Free from Unnecessary Drugs</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #30's record was updated to include:</p> <ul style="list-style-type: none"> <li>- nursing staff to monitor adverse side effects of anti-anxiety medication;</li> <li>- assessment, monitoring and evaluation of the efficacy of Zoloft.</li> </ul> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of</p>		

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F 757	<p>Continued From page 56</p> <p>daily for depression and Ativan 0.5 mg at bedtime for anxiety. Resident #30's November 2018 MAR and TAR did not include nursing staff were to monitor adverse side effects of the antianxiety medication.</p> <p>Resident #30's record did not include assessment, monitoring, and evaluation of the efficacy of the Zoloft.</p> <p>On 11/28/18 at 5:17 PM, the Unit Manager stated Resident #30's November MAR should have included documentation she was monitored each shift for adverse side effects from her antianxiety medication. The Unit Manager stated they were not monitoring Resident #30's depression.</p>	F 757	<p>deficiencies-form CMS-2567. Although no other residents were directly affected by this deficient practice, any residents that currently have orders for anti-anxiety medication or anti-depression medication have the potential to be affected by this deficiency.</p> <p>Therefore, by 1/4/2019 a review of all residents currently taking psychotropic medication to ensure nursing staff are monitoring for any adverse side effects; to ensure assessment, monitoring and evaluation of the efficacy of the psychotropic medication are included in the residents records.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 1/1/2019 an in-service education will be given to all licensed nurses regarding: - the importance of including psychotropic medication monitoring for any adverse side effects in the residents records; -the importance of including psychotropic medication assessment, monitoring and evaluation of efficacy in the residents records.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through the Director of Nursing or designee who will perform a visual observation of at least</p>		

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F 757	Continued From page 57	F 757	<p>three (3) residents records: - that are on psychotropic medication to ensure monitoring for any adverse side effects are included in the residents records; -that are on psychotropic medication to ensure assessment, monitoring and evaluation of efficacy are included in the residents records.</p> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee will submit to the Administrator or the designee and to the QA&amp;A Committee the findings and/or corrective actions taken during the quarterly QA&amp;A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		
F 812 SS=E	<p>Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility</p>	F 812		1/15/19	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 812	<p>Continued From page 58</p> <p>gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, it was determined the facility failed to ensure the preparation and serving of food was completed in a manner to maintain food sanitation and prevent cross contamination between the resident's food and hard surfaces in the kitchen. This affected 27 of 29 residents in the facility who received food from the kitchen. This failure had the potential for harm if residents became infected due to cross contamination during food service. Findings include:</p> <p>The facility's policy Personnel Adherence to Sanitary Procedures, revised 4/2006, documented food service personnel shall follow appropriate sanitary procedures and must wash their hands after each trip to the restroom, after leaving storage rooms, washrooms, after touching the hair, mouth, or nose, and at any other time when contamination could occur. The policy also stated if gloves were used in food preparation, personnel will wash hands before donning gloves and if a task was interrupted, gloves will be removed, and clean gloves donned when the task was resumed.</p> <p>On 11/26/18 at 5:44 PM, during an observation</p>	F 812	<p>F- 812 SS=E Food Procurement, Store/Prepare/Serv-Sanitary</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>On 12/5/2018 Dietary cook #1 received an in-service education related to proper changing of gloves and appropriate sanitary procedures for food service personnel.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>All residents in the facility had the potential to be affected by this deficiency.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p>		

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F 812	<p>Continued From page 59</p> <p>Cook #1 was preparing food trays for the evening meal. Cook #1 was observed wearing gloves and touching food with his gloved hands after touching multiple kitchen surfaces which included the oven door handle, refrigerator door handles, and the freezer door handles. Cook #1 was observed picking up bread buns with the same gloved hands.</p> <p>On 11/26/18 at 6:00 PM, the Food Service Supervisor (FSS) confirmed Cook #1 touched multiple solid surfaces in the kitchen with the gloved hands and failed to wash hands and change gloves before picking up food with the same gloves. The FSS instructed Cook #1 to take his gloves off and wash his hands. Cook 1 removed the dirty gloves washed his hands and put clean gloves on.</p> <p>At 6:05 PM on 11/26/18, the observation continued and Cook #1 continued to touch multiple hard surfaces in the kitchen and then touch the food. Cook #1 opened the freezer door, picked up a frozen patty with his gloved hands, then picked up a resident's garlic toast, with the same gloved hands, and he continued to serve the evening meal.</p> <p>On 11/26/18 at 6:20 PM, the FSS verified Cook #1 continued his practice of touching potentially contaminated and dirty surfaces in the kitchen and then touching residents' food during food service.</p>	F 812	<p>On 12/5/2018 all dietary staff received an in-service education related to proper changing of gloves and appropriate sanitary procedures for food service personnel.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through the Administrator or designee who will perform a random audit of proper changing of gloves and appropriate sanitary procedures for food service personnel.</p> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Administrator or designee will submit to the QA&amp;A Committee the findings and/or corrective actions taken during the quarterly QA&amp;A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		
F 842 SS=D	<p>Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)</p> <p>§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is</p>	F 842		1/15/19	

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F 842	<p>Continued From page 60</p> <p>resident-identifiable to the public.</p> <p>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p>	F 842			

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F 842	Continued From page 61  §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.  §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.  §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure a) each resident's resuscitation code status of Full Code or DNR was consistently and accurately documented in their records and b) blood glucose results were documented in the resident's record. This was true for 2 of 14 residents (#17 and #83) whose records were reviewed. This deficient practice created the potential for harm should inappropriate care and/or treatment be provided based on	F 842	F- 842 SS=D Resident Records – Identifiable Information  Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:  Resident #17's record was updated to include documentation related to resident's current code status of DNR;		

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F 842	<p>Continued From page 62</p> <p>inaccurate information. Findings include:</p> <p>1. Resident #17 was admitted to the facility on 1/29/16, with multiple diagnoses including cerebral palsy.</p> <p>A quarterly MDS assessment, dated 10/12/18, documented Resident #17 was cognitively intact.</p> <p>Resident #17's Face Sheet documented Resident #17's POA for health care was his sister.</p> <p>A quarterly care conference, dated 11/1/18, documented Resident #17 was present and requested to change his code status from a Full Code to a DNR. Resident #17's POST, signed and dated by his sister on 11/16/18, documented Resident #17 was a DNR with comfort measures as interventions.</p> <p>Resident #17's record had an undated and untitled document which stated he was a Full Code and wanted aggressive measures performed. The document included the following measures; a feeding tube, intravenous (IV) fluids, blood products, and antibiotics. Resident #17's November 2018 physician orders also documented Resident #17 was a Full Code with aggressive interventions.</p> <p>Resident #17's care plan, dated 11/9/18, documented Resident #17 was a Full Code with aggressive interventions including a feeding tube, IV fluids, antibiotics, and blood products.</p> <p>On 11/27/18 at 3:15 PM, the LSW stated Resident #17's code status changed to a DNR</p>	F 842	<p>Resident #83's closed record was updated to include printouts of the MAR from the previous EMAR system.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>No other residents were directly affected however all residents have the potential to be affected by this deficient practice.</p> <p>Therefore by 1/4/2019: -a review will be performed of all current residents' code status to ensure that code status is updated and consistent with current advance directives;</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 1/1/2019 an in-service education will be given to the Medical Records Director to ensure closed resident records are complete and accurate. By 1/1/2019 an in-service education will be given to all licensed nurses regarding the process for code status change for any residents. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through the Administrator or designee who will</p>		

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F 842	<p>Continued From page 63 after the care conference on 11/1/18.</p> <p>On 11/27/18 at 3:53 PM, the Unit Manager stated Resident #17 was a DNR and she forgot to change Resident #17's untitled document from a Full Code to a DNR, to update his care plan, and notify the physician.</p> <p>2. Resident #83 was admitted to the facility on 12/26/17, with multiple diagnoses including cancer and diabetes.</p> <p>Resident #83's record included a physician's order, dated 12/26/17, which documented a licensed nurse was to obtain blood glucose checks for Resident #83 four times a day.</p> <p>Resident #83's December 2017 and January 2018 MARs documented his blood glucose checks were completed four times a day but there was no documentation of the results of the blood glucose readings. The results of the blood glucose check determined the amount of Lispro insulin Resident #83 received according to a sliding scale ordered by his physician. A sliding scale for insulin is used as a set of instructions for adjusting insulin based on blood glucose test results according to the American Diabetes Association, website accessed on 12/12/18.</p> <p>On 11/30/18 at 1:17 PM, the Unit Manger and LPN #1 stated the blood glucose results were hand written on Resident #83's December 2017 and January 2018 MARs. They stated the facility had a different electronic system and they documented in the electronic system and also documented on a paper MAR for the results of the blood glucose readings.</p>	F 842	<p>perform a visual observation of at least three (3) resident records:</p> <ul style="list-style-type: none"> <li>-to ensure that code status is updated and consistent with current advance directives;</li> <li>- to ensure closed resident records are complete and accurate.</li> </ul> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee will submit to the Administrator or designee and to the QA&amp;A Committee the findings and/or corrective actions taken during the quarterly QA&amp;A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>		

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F 842	Continued From page 64	F 842			
F 880 SS=F	<p>On 11/30/18 at 1:20 PM, the Medical Records Supervisor stated the paper MARs for Resident #83 were not in his closed record file.</p> <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 persons in the facility;</p>	F 880		1/15/19	

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F 880	<p>Continued From page 65</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: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</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 determined the facility failed to ensure staff</p>	F 880	F- 880 SS=F Infection Prevention & Control		

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F 880	<p>Continued From page 66</p> <p>handled, processed, and transported linens in a sanitary manner, and staff administer medications in a manner that would prevent the spread of infection. This was true for 13 of 13 residents (#2, #10, #11, #17, #18, #20, #21, #25, #29, #30, #31, #84, and #134) reviewed for infection control and had the potential to impact all residents residing in the facility. These failures created the potential for the residents to develop infection from cross-contamination of linens and lack of appropriate infection control practices during medication administration. Findings include:</p> <p>On 11/29/18 at 2:42 PM, Laundry Staff #1 stated her duties were laundry and housekeeping for the facility. Laundry Staff #1 stated she applied an apron, a mask, and gloves to transport dirty laundry into the washer, then removed the gloves, gown, and mask and then washed her hands. Laundry Staff #1 stated she either cleaned the dining room or residents' rooms while the laundry was in the washer. After the wash cycle was completed, she returned to the laundry area and stated she transferred the washed laundry from the washer to the dryer and stated she did not wear gloves and a gown when transferring the laundry from the washer to the dryer. After the dryer cycle was completed, she stated she transferred the laundry from the dryer to the folding area without wearing gloves and a gown.</p> <p>On 11/29/18 at 2:50 PM, Laundry Staff #1 stated she understood by not wearing a gown and gloves during the transferring of laundry, she was potentially cross contaminating the laundry and/or herself.</p>	F 880	<p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>By 12/21/2018 Unit Manager will be given a verbal counseling/write-up related to not wearing gloves when administering an injection to a resident, and removing the cap of an insulin syringe with her teeth;</p> <p>By 12/21/2018 Laundry staff #1 will be given a 1:1 in-service regarding proper handling, processing and transporting of linens in a sanitary manner to prevent cross-contamination.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>No other residents were directly affected by this deficient practice, however all residents had the potential to be affected.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>On 12/13/2018 an in-service education was given to all laundry staff regarding proper handling, processing and transporting of linens in a sanitary manner to prevent cross-contamination;</p> <p>By 1/1/2019 an in-service education will be given to all licensed nurses regarding proper medication administration process</p>		

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F 880	Continued From page 67  On 11/29/18 at 6:18 PM, the Maintenance/Housekeeping Supervisor was not aware of the cross contamination risk during transferring of the laundry and supplied gowns and gloves for the laundry staff.  2. A facility policy Intradermal Injection, revised 9/2003, documented staff were to put on gloves and remove the needle cap by pulling it straight off. This policy was not followed.  a. The Unit Manager was observed on 11/29/18 at 12:19 PM administering an intradermal injection to Resident #134 without wearing gloves.  On 11/29/18 at 12:20 PM, the Unit Manager confirmed she did not wear gloves for the intradermal injection.  b. On 11/29/18 at 12:34 PM, the Unit Manager was observed removing the cap of an insulin syringe, prepared for an injection to Resident #10, by putting the cap between her teeth and pulling the cap off of the syringe.  On 11/29/18 at 12:35 PM, the Unit Manager confirmed the correct method to remove the needle cap was to pull it straight off using a hand.	F 880	to prevent the spread of infection. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through the Director of Nursing or designee who will:  - perform a visual observation of three (3) medication administrations to ensure the proper medication administration process is followed to prevent the spread of infections;  -perform a random audit of laundry services to ensure all laundry staff are properly handling, processing and transporting linens in a sanitary manner to prevent cross-contamination.  Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.  The facility Director of Nursing or designee will submit to the Administrator or designee and to the QA&A Committee the findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.  Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 883 SS=F	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)  §483.80(d) Influenza and pneumococcal immunizations	F 883		1/15/19	

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F 883	<p>Continued From page 68</p> <p>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative</p>	F 883			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/30/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>QUINN MEADOWS REHABILITATION AND CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>		
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F 883	<p>Continued From page 69</p> <p>has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, the facility failed to have a process for tracking each residents' pneumococcal vaccination status. Specifically, The facility did not implement an immunization program to ensure residents' pneumococcal vaccine status was tracked so immunizations could be offered or provided, as indicated by CDC guidelines for 3 of 5 residents (Resident #11, #29, and #30) reviewed for pneumococcal vaccination.</p> <p>This failed practices represented a systemic failure which increased residents' risk for contracting pneumonia with its associated complications of infection of the blood and covering of the brain and spinal cord which could cause death or brain damage. Findings include:</p> <p>The CDC website, updated 11/22/16, included recommendations for the Pneumococcal vaccination (PCV13 or Prevnar13®, and PPSV23 or Pneumovax23®) for all adults 65 years or older included the following:</p>	F 883	<p>F- 883 SS=F Influenza and Pneumococcal Immunizations</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #11's record has been updated to be included in the Immunization report;</p> <p>Resident #29 is no longer a resident in the facility;</p> <p>Resident #30's record has been updated to reflect PCV13 has been received and included in the immunization report;</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>All residents in the facility have the</p>		

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F 883	<p>Continued From page 70</p> <p>* Adults 65 years or older who have not previously received PCV13, should receive a dose of PCV13 first, followed 1 year later by a dose of PPSV23.</p> <p>* If the patient already received one or more doses of PPSV23, the dose of PCV13 should be given at least 1 year after they received the most recent dose of PPSV23.</p> <p>The facility's policy for Immunization of Residents, revised 2017, documented residents shall be offered Pneumococcal Polysaccharide Vaccine (PPSV23) and/or Pneumococcal Conjugate Vaccine (PCV13) per the CDC guidelines unless it was medically contraindicated or the resident was already immunized.</p> <p>On 11/29/18 at 2:47 PM, the facility provided an Immunization Report, dated 4/1/09 to 11/30/18, which documented the type of immunizations each resident received. The Immunization Report did not include 10 of the 29 residents, including Resident #11 and Resident #29, who currently resided in the facility. Examples include:</p> <p>1. Resident #29 was admitted to the facility on 11/7/18, for multiple diagnoses including renal failure.</p> <p>The Admission MDS assessment, dated 11/20/18, documented Resident #29 was up to date on pneumococcal vaccinations.</p> <p>Resident #29's pneumococcal immunization consent form, dated 11/7/18, documented she declined the pneumococcal vaccinations.</p>	F 883	<p>potential to be affected by this deficient practice, therefore by 1/4/2019 a review of all current residents immunizations will be performed to ensure they are current.</p> <p>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</p> <p>By 1/1/2019 the infection preventionist will receive an in-service education related to the importance of accurate tracking of immunizations for all residents in the facility. By 1/1/2019 a tracking tool will be implemented to keep resident immunizations current.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through the Administrator or designee who will perform a visual observation of immunization tracking to ensure immunization tracking is accurate and all residents are current with immunizations they consented to receive.</p> <p>Monitoring will start on 1/11/2019. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or designee will submit to the Administrator or designee and to the QA&amp;A Committee the findings and/or corrective actions</p>		

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F 883	Continued From page 71  The facility's Immunization Report, dated 4/1/09 to 11/30/18, did not include Resident #29 on the report.  On 11/29/18 at 2:50 PM, the Administrator was unaware Resident #29 was not included on the Immunization Report.  2. Resident #30 was readmitted to the facility on 11/8/18, with multiple diagnoses including respiratory failure.  The admission MDS assessment, dated 11/22/18, documented Resident #30 was not up to date on the pneumococcal vaccine and she was not eligible due to medical contraindication.  Resident #30's pneumococcal immunization consent form, dated 11/8/18, documented she gave consent for the pneumococcal vaccine. Resident #30's record documented she received PCV13 on 11/10/18.  The facility's Immunization Report did not include documentation Resident #30 received the PCV13.  3. Resident #11 was admitted to the facility on 9/20/18, with multiple diagnoses including heart failure.  Resident #11's admission MDS assessment, dated 9/27/18, documented she was not up to date on the pneumococcal vaccine and she was not eligible.  Resident #11's pneumococcal vaccine consent	F 883	taken during the quarterly QA&A Committee Meeting.  Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		

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F 883	<p>Continued From page 72</p> <p>form, dated 9/20/18, documented she received the PCV13 vaccine in 2016 and had not received the PPSV23 vaccine. Resident #11 declined the pneumococcal vaccine because she was current. Resident #11 was not included in the Immunization Report from the facility.</p> <p>On 11/29/18 at 4:15 PM, the Administrator stated the DNS was the Infection Control Specialist and she replied to the Administrator via text the facility was not currently tracking pneumococcal vaccinations. The Administrator was told by the DNS she used the Immunization Report, which was provided, dated 4/1/09 to 11/30/18. The Administrator acknowledged the Immunization Report was not up to date and did not include all residents residing in the facility.</p>	F 883			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

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

June 12, 2019

Steve Gannon, Administrator  
Quinn Meadows Rehabilitation and Care Center  
1033 West Quinn Road  
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Gannon:

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

**Complaint #ID00007916**

**ALLEGATION #1:**

A resident was dropped when being assisted by a member of the facility staff and was not appropriately assessed after the fall.

**FINDINGS #1:**

During the investigation, 14 resident records were reviewed, observations were conducted, interviews were conducted with residents, the Ombudsman, staff and two family members. A meeting was held with the Resident Council and 6 months of Resident Council minutes were reviewed. Facility incident and accident reports and grievances were also reviewed.

Steve Gannon, Administrator  
June 12, 2019  
Page 2 of 4

There were no complaints of abuse by residents who attended the Resident Council meeting. The Resident Council minutes were reviewed and there were no reports of abuse or neglect by residents during the meetings.

The incident/accident log and the grievances filed in the past year were reviewed and there were no complaints found related to resident abuse or neglect.

Review of the medical record for one resident did not include documentation of a fall in the first week of admission to the facility. The resident ' s record documented in the admission assessment she had a history of falls prior to admission to the facility. The assessment identified diagnoses that included weakness, left artificial hip joint and depressive disorder. The assessment documented the resident was dependent on two persons for ambulation in her room.

The resident's record also included a care plan, initiated the date she was admitted, which identified her risk for falls and interventions which stated to keep the area free of clutter, plan activities with adequate rest periods as needed, provide the necessary assistance with transferring, and to remind the resident/family regarding safety precautions when oxygen is in use to avoid potential trip and/or falls.

A progress note in the resident ' s record dated she fell in her room a month after her admission to the facility. The note stated the resident was on her left side and abdomen and was very angry. The note documented, "went flying. Staff tried to assess but she began yelling and hitting. After a few minutes staff was able to get sling under her and Hoyer (mechanical lift) her back into bed. She continues to be angry and confused per her usual. Unable to console or redirect her. Has a hematoma (###) on Lt (###) side of forehead at hairline. Won't allow ice pack or any treatment at this time. VS, (###), stable. Neuro checks wnl, (###). Admin (###) notified. Will continue to monitor her."

A subsequent progress note, later the same day, documented, "the resident was checked on and she was on floor again, laying on Lt side. Unable to determine if there are injuries ...Very combative, hitting and screaming out. Delusional and has been hallucinating most of night. Admin (###) notified."

Based on investigative findings the allegation could not be substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2: :

The resident did not have an inhaler available on admission and it was never administered.

FINDINGS #2:

During the investigation 14 resident records were reviewed for medication orders and administration of medication as ordered by their physician.

Review of on resident record documented there was a physician's order for an inhaler and a note that documented the resident was provided the inhaler 3 days after admission, upon the request of the resident's daughter per a phone conversation. The resident refused to return the inhaler and kept it away from the staff.

The physician's orders from the hospital along with the hospital discharge instructions included documentation the medications on discharge from the hospital and the medications on the admission orders at the facility matched. The diagnoses also matched. The resident was identified as a diabetic and instructions for care were provided.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The staff were not aware a resident had diabetes and her diet was not monitored.

FINDINGS #3 :

During the investigation 14 resident records were reviewed for care related to their diagnoses.

One resident's record documented upon admission a diagnosis of Diabetes Mellitus was identified and medications to control her blood glucose levels were ordered. The physician's orders included blood glucose checks before meals and at bedtime each day. The resident's record included documentation her blood sugar was checked as ordered by the physician. The blood sugar levels reflected no significant change from her levels on admission. The resident is not provided food by the facility which does not follow the physician orders.

Based on investigative findings the allegation could not be substantiated.

Steve Gannon, Administrator  
June 12, 2019  
Page 4 of 4

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson", is positioned above the typed name.

Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj



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HEALTH & WELFARE

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PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

July 24, 2019

Steve Gannon, Administrator  
Quinn Meadows Rehabilitation and Care Center  
1033 West Quinn Road,  
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Gannon:

On **November 30, 2018**, an unannounced on-site complaint survey was conducted at Quinn Meadows Rehabilitation and Care Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00007785**

ALLEGATION #1

The facility did not have sufficient and competent staff to care for the residents needs.

FINDINGS #1

During the investigation, residents were observed for quality of care and staffing concerns. Resident Council meeting minutes were reviewed, facility grievances were reviewed, and residents and family members were interviewed regarding staffing.

During observations of residents and staff members interacting, no concerns were identified. The residents' call lights were answered timely, assistance with activities of daily living was provided, hydration was offered, activities were offered, and other cares were offered and provided by staff.

Steve Gannon, Administrator  
July 24, 2019  
Page 2 of 5

Resident Council Meeting minutes and Grievances documented that staffing was not an issue. Staff competencies were reviewed and staff were completing multiple areas to ensure the care they provided was up to date with current standards of practice.

Several residents and two family members said staff was competent and there was enough staff to meet the residents needs. The residents stated their call lights were answered in a timely manner, meals arrived on time, and their needs were met. Multiple CNAs and nurses said the staff numbers were good and they had time to spend with the residents to ensure their needs were met. The Director of Nursing and the Executive Director also said the facility had enough staff and the staff were meeting residents' needs.

The allegation was unsubstantiated due to lack of evidence regarding competent staff and sufficient staff.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2

Physician orders are not followed and emergency diabetic medication is not available.

#### FINDINGS #2:

Fourteen resident records were reviewed for standards of practice. Resident Council meeting minutes were reviewed, observations were conducted, and family members and residents were interviewed.

Fourteen resident records were reviewed for physician orders, including treatments and medications. One resident's record documented he had a rash all over his body and he received treatment orders for medication and was referred to the dermatologist for further evaluation.

Thirteen of the 14 records documented they received medications as ordered. However, the record of 1 resident, admitted December 2017, included a physician's order, dated 12/26/17, which documented a licensed nurse was to obtain blood glucose checks for the resident four times a day.

The resident's December 2017 and January 2018 medication administration records (MARs) documented his blood glucose checks were completed four times a day but there was no documentation of the results of the blood glucose readings. The results of the blood glucose check determined the amount of Lispro insulin the resident received according to a sliding scale

Steve Gannon, Administrator  
July 24, 2019  
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ordered by his physician. A sliding scale for insulin is used as a set of instructions for adjusting insulin based on blood glucose test results according to the American Diabetes Association, website accessed on 12/12/18.

The resident's record also documented a physician's order which stated staff were to obtain a urinalysis for a diagnosis of a urinary tract infection. However, the resident's record did not include documentation the urinalysis was obtained as ordered.

Several staff members interviewed were unable to provide documentation for the results of the ordered urinalysis. Several staff members were also interviewed regarding blood glucose results. Staff stated the blood glucose results were hand written on the resident's December 2017 and January 2018 MARs. They stated the facility had a different electronic system and they documented in the electronic system and also documented on a paper MAR for the results of the blood glucose readings.

However, the hand written documentation of the blood sugars were not found in the resident's record.

The staff members also stated the emergency diabetes medications were provided when residents needed. For example, the record of a resident admitted in January 2016, included a physicians orders for emergency diabetic medication such as Glucagon. The resident's record documented the resident never required the use of the emergency medications.

It could not be determined that the facility failed to have emergency medication available. However, it was determined the facility failed to ensure a resident's medications were administered according to physicians orders and that physician orders were followed for urinary tract infection identification. Therefore, the allegation was substantiated and deficient practice was cited at F842 and F684.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #3

The facility failed to ensure staff were knowledgeable of the care and use of Dobhoff tubes (nasogastric feeding tubes), and that residents' nutritional needs were not neglected.

#### FINDINGS #3

An unannounced onsite recertification and complaint survey was conducted from 11/26/18 to

11/30/18. During the investigation 10 residents were observed and 14 residents' records, which included 3 closed records, were reviewed for quality of care and abuse. Interviews were conducted with residents and family members. Staff members were interviewed and observed regarding abuse and incidents and the facility abuse allegations, grievances, and Resident Council minutes were reviewed.

During observations of residents and staff members interacting, no concerns were identified. The residents' call lights were answered timely and care was offered and provided by staff. Multiple staff members were interviewed regarding feeding tubes and were able to state the correct procedure for managing tube feeding. Multiple interviews were also conducted with residents, family members, and staff, regarding the cost of supplies. Concerns related to extra billing for supplies needed by residents were not identified.

All 14 residents' records were reviewed for allegations of abuse and neglect and potential abuse and neglect concerns. Three of 14 resident records documented a concern with an allegation of abuse or neglect. The record of one resident, admitted December 2017, included a care plan conference summary which documented the resident's tube feeding was not connected and running for 3 hours. The summary of the care plan conference documented the resident's daughter completed a formal grievance and requested someone to help resolve their concerns.

On 11/30/18 at 10:30 AM, the LSW stated when concerns were voiced during a care conference, she documented on the care plan conference summary report and if there was a concern in nursing, they wrote it down and addressed the concerns, but did not make it a formal grievance. The LSW thought the concerns for the resident were resolved. The LSW was unable to provide documentation the concerns expressed in the resident care conference were investigated or resolved.

The resident's record documented his nasogastric tube did become dislodged and the resident was sent to the hospital so the nasogastric tube could be adjusted and an x-ray was completed to ensure it was placed properly. Concerns related to the staff's use and care of the nasogastric tube, or being sent to the hospital for nasogastric tube adjustment were not identified.

While it could not be determined that staff were not knowledgeable of the use of nasogastric feeding tubes, it was determined the facility failed to ensure concerns expressed in the resident care conference were investigated or resolved. Therefore, the allegation was substantiated and deficiencies were cited at F585, F600, and F610.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Steve Gannon, Administrator  
July 24, 2019  
Page 5 of 5

Thank you for the courtesies and assistance extended to us during our visit.

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

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

Sincerely,

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

LAURA THOMPSON, RN, Supervisor  
Long Term Care Program

LT/slj