



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS 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

December 28, 2018

Scott Morehouse, Administrator
Life Care Center Of Coeur D'Alene
500 West Aqua Avenue
Coeur D Alene, ID 83815-7764

Provider #: 135122

Dear Mr. Morehouse:

On **December 14, 2018**, a survey was conducted at Life Care Center Of Coeur D'Alene by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 7, 2019**. Failure to submit an acceptable PoC by **January 7, 2019**, may result in the imposition of penalties by **January 30, 2019**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **January 18, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 14, 2019**. A change in the seriousness of the deficiencies on **January 28, 2019**, may result in a

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change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **March 14, 2019** includes the following:

Denial of payment for new admissions effective **March 14, 2019**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 14, 2019**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **March 14, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

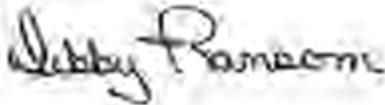
- BFS Letters (06/30/11)

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

This request must be received by **January 7, 2019**. If your request for informal dispute resolution is received after **January 7, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

dr/

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

PRINTED: 01/24/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/14/2018
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COEUR D'ALENE			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST AQUA AVENUE COEUR D ALENE, ID 83815		
(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>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted December 10, 2018 to December 14, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Presie Billington, RN Karen Gray, RD Karen George, RN</p> <p>Survey Abbreviations:</p> <p>C-diff - Clostridium difficile (an inflammation of the colon caused by the clostridium difficile bacteria) CNA - Certified Nursing Assistant DON- Director of Nursing lbs - Pounds LPN - Licensed Practical Nurse LSW - Licensed Social Worker MAR - Medication Administration Record MDS - Minimum Data Set MSW - Master's Prepared Social Worker mg - milligrams PO - by mouth RCM - Resident Care Manager RD - Registered Dietitian RN - Registered Nurse SED - Senior Executive Director</p>	F 000			
F 580 SS=D	<p>Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)</p> <p>§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify,</p>	F 580		1/10/19	

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

TITLE

(X6) DATE

Electronically Signed

01/02/2019

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

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

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F 580	<p>Continued From page 2</p> <p>§483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure a resident's physician was notified of a resident's significant weight gain. This was true for 1 of 2 residents (#44) reviewed for nutritional changes and weight gain. This failure had the potential for harm if the physician was not provided with information necessary to make decisions to initiate and/or alter interventions to meet a resident's changing needs. Findings include:</p> <p>Resident #44 was readmitted to the facility on 04/18/18, with multiple diagnoses including congestive heart failure and pulmonary edema.</p> <p>An admission MDS, dated 4/19/18, documented Resident #44 was cognitively intact and she required set-up only for eating.</p> <p>The facility's policy and procedure for monitoring weight, revised on 3/1/13, documented weight variances were to be reviewed for residents with a 5% weight change in 30 days, 7.5% weight change in 90 days, and 10% weight change in 180 days, which included gain or loss. The policy stated the physician and responsible party was to be notified of an unplanned weight loss, significant weight change, or undesirable weight change. The policy stated an unplanned weight gain may have significant health implications for</p>	F 580	<p>Individual Residents: Resident #44 had weights reviewed and reported to physician for needed follow-up. Care plan was reviewed and updated as needed.</p> <p>Residents in Similar Situations: Residents with significant weight changes were reviewed through IDT meeting to ensure physician notification was completed and follow-up addressed as needed.</p> <p>Measures to Prevent Reoccurrence: The ED or designee educated LNs and IDT members on the physician notification requirements related to significant weight changes.</p> <p>Plans to Monitor On-going Compliance: The IDT will review resident weights for significant weight changes weekly through the IDT meeting. Physician notification will be audited through this meeting to ensure compliance. Negative trends related to notifications regarding significant weight changes will be brought to monthly QAPI for review and further education and training identification for three months.</p>		

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F 580	Continued From page 3 the resident and was to be addressed. A Dietitian Progress Note, dated 11/16/18, documented Resident #44 had a weight gain of 25.15% in 34 days. Documentation that the physician had been notified was not present. On 12/13/18 at 10:50 AM, RCM #1 said she could not find documentation that the physician had been informed of Resident #44's significant change in weight. On 12/14/18 at 9:03 AM, the Nurse Practitioner said he would have expected to be notified of a resident weight change of more than 5 pounds. The Nurse Practitioner said he did not trust the weights documented in the medical record because there were so many variables that could affect the weights, such as clothing and wheelchairs. The Nurse Practitioner also said if he had been told of Resident #44's weight gain, he would have ordered the resident be re-weighed to confirm the weight gain and treat, if indicated.	F 580	Individuals to maintain compliance: The DON or designee will ensure on-going compliance.		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		1/10/19	

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F 583	Continued From page 4 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident's privacy was maintained in his room. This was true for 1 of 19 residents (#20) reviewed for privacy. This failure resulted in the potential for a resident to experience psychosocial harm due to the posting of private health information on the resident's bedroom wall which was in view of any person who entered the room. Findings include: Resident #20 was admitted to the facility on 10/29/18, with multiple diagnoses including depression and diabetes mellitus.	F 583	Individual Residents: Resident #20 had pictures removed at time of discovery. Residents in Similar Situations: Resident rooms were audited to identify any potential privacy/dignity violations related to postings of care instructions. Negative findings were removed at time of discovery. Measures to Prevent Reoccurrence: Staff were educated by the ED on the requirements to maintain resident areas		

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F 583	Continued From page 5 Resident #20's quarterly MDS assessment, dated 9/18/18, documented he was severely cognitively impaired and required extensive assistance from 2 staff members with activities of daily living. Resident #20's December 2018 physician orders directed staff to position his left upper extremity using a blue positioning wedge, per the pictures in his room. On 12/13/18 at 11:00 AM and 3:44 PM, 3 pictures of a hand were observed posted on Resident #20's wall above his head with instructions on how to apply his left hand splint when he was in bed and when he was up in his wheelchair. On 12/13/18 at 4:07 PM, RCM #1 observed the pictures and instructions on Resident #20's wall and said it should not be there. RCM #1 removed the pictures and placed them behind the Resident #20's closet door.	F 583	free of care directed photos or instructions and to utilize care directives/care plans. Plans to Monitor On-going Compliance: Room audits will be conducted weekly x2 weeks and then monthly x3 months for resident care instructed postings. Negative findings will be corrected at time of discovery and negative trends will be brought to monthly QAPI x3 months for further education and training opportunities. Individuals to maintain compliance: The ED or designee will ensure on-going compliance		
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	F 610		1/10/19	

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F 610	<p>Continued From page 6</p> <p>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 observation, review of clinical records the facility's policy and procedure, and resident and staff interviews, it was determined the facility failed to ensure investigation for injuries of unknown origin were initiated in a timely manner. This was true for 1 of 1 resident (#73) reviewed for resident incidents. This failure created the potential for harm due to a lack of an investigation. Findings include:</p> <p>The facility's Abuse Policy and Procedure, revised on 2/2018, stated all reports of abuse, including injuries of unknown source, were to be thoroughly investigated. The policy stated an injury should be classified as an injury of unknown source when the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury was suspicious due to the extent of the injury or the location of the injury.</p> <p>The policy stated any incident of resident abuse or suspected resident abuse was to be immediately reported to the supervisor and/or the charge nurse. The supervisor and/or charge nurse was to obtain information when the incident was reported which included the name of the resident involved, the date and time the incident occurred, where the incident took place, the name(s) of the person(s) committing or involved in the incident, if known, the name(s) of</p>	F 610	<p>Individual Residents: Resident #73 had his bruise investigated per facility practices.</p> <p>Residents in Similar Situations: A review of the most recent weekly skin checks was completed to identify any potential uninvestigated injuries of unknown origin and none were noted.</p> <p>Measures to prevent reoccurrence: The DON or designee educated LNs on the facility policy for reporting and investigating injuries of unknown origin and the required actions to take upon discovery.</p> <p>Plans to Monitor On-going Compliance: The nursing leadership team will review potential injuries of unknown origin daily (M-F) through the Grand Rounds process with the direct care staff. Negative findings will be corrected at discovery and negative trends will be reported through monthly QAPI x3 months.</p> <p>Individuals to maintain compliance: The DON or designee will ensure on-going compliance.</p>		

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F 610	<p>Continued From page 7</p> <p>any witnesses to the incident, the type of abuse and/or neglect that was committed (verbal, physical, or sexual) and any additional information that may be pertinent to the incident.</p> <p>The policy stated the charge nurse was to complete and sign the Incident Report and notify the physician and the resident's representative of the occurrence. The policy stated reporting was to occur immediately, but not later than 2 hours after the allegation was made.</p> <p>The policy was not implemented, as follows:</p> <p>Resident #73 was admitted to the facility on 1/26/18 and was readmitted on 9/23/18, with multiple diagnoses including chronic obstructive pulmonary disease, depression and muscle weakness. A 60-day scheduled MDS assessment, dated 11/19/18, documented Resident #73 was cognitively intact and he required the assistance of 1 staff member for his activities of daily living.</p> <p>On 12/11/18 at 10:41 AM, Resident #73 showed the surveyor a bruise about 3 x 3 cm on his right flank and was purplish in color. Resident #73 said it was not painful and did not remember how he got the bruise. Resident #73 said he just felt a lump on his back and when he asked a staff about it he was told it was a bruise.</p> <p>Documentation of Resident #73's right flank bruise was not present in his clinical record or in the facility's December 2018 Incident and Accident Reports.</p> <p>On 12/12/18 at 9:44 AM, CNA #1, who was</p>	F 610			

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F 610	<p>Continued From page 8</p> <p>working as the Shower Aide said she noticed Resident #73's bruise during his shower and reported the bruise to LPN #5. RCM #1 initiated an I&A data entry questionnaire on 12/12/18 /2 11:00 AM for the bruise on the right flank.</p> <p>On 12/13/18 at 10:38 AM, LPN #5 said she did not remember a Shower Aide reporting that Resident #73 had a bruise. LPN #5 said if she had known Resident #73 had a bruise she would have assessed him, made a report and notified the RCM, the DON, the physician and Resident #73's family.</p> <p>On 12/13/18 at 11:25 AM, RCM #1 said she was just made aware Resident #73 had a bruise on his right flank. RCM #1 said the nurse to whom it was reported, should have assessed Resident #73 and completed a report right away. RCM #1 said she would start an investigation and interview all the staff who provided care to Resident #73.</p> <p>On 12/13/18 at 11:42 AM, the DON said if a CNA reported any skin issue or incident to a nurse, the nurse should assess the resident as soon as she was made aware of the skin issue or incident. The DON stated the nurse should make a complete report, inform the DON or the RCM, notify the physician and the family representative and add it on the 24-hour report. The DON reviewed the 24-hour reports for 12/11/18 through 12/13/18. The reports did not include information related to Resident #73 right flank bruise.</p>	F 610			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		1/10/19	

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F 657	<p>Continued From page 9</p> <p>§483.21(b) Comprehensive Care Plans</p> <p>§483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed ensure resident care plans were regularly reviewed and revised as needed. This was true for 1 of 19 residents (#44) reviewed for care plan revisions. This failure resulted in the potential for harm if care was not provided or decisions were made based on inaccurate or outdated information. Findings include:</p>	F 657	<p>Individual Residents: Resident #44 had their care plan updated related to significant weight changes.</p> <p>Residents in Similar Situations: Residents with identified significant weight changes had care plans reviewed for needed updates and accuracy. Changes were made with discovery.</p>		

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F 657	<p>Continued From page 10</p> <p>Resident #44 was readmitted to the facility on 04/18/18, with multiple diagnoses including congestive heart failure and pulmonary edema. An admission MDS, dated 4/19/18, documented Resident #44 was cognitively intact and required set-up only for eating.</p> <p>Resident #44's weight history documented she had an average weight from 180 lbs to 188 lbs until 10/4/18 when it changed to 167 lbs. On 11/7/18 Resident #44's weight was 200 lbs and she remained over 200 lbs from that point forward.</p> <p>A Dietitian Progress Note, dated 11/16/18, documented Resident #44 had a weight gain of 25.15% in 34 days. Resident #44's current intake was 83% to provide 1,909 kcal (kilocalories) and 75 grams of protein. The note stated, per nursing, she had been eating better and monitoring would continue routinely and as needed.</p> <p>However, a Nutrition care plan, dated 5/14/18, documented Resident #44 was at nutritional risk with a goal that she would not experience a significant weight loss through the next review date (1/31/19). An updated Nutrition care plan based on Resident #44's change in status was not present.</p> <p>On 12/12/18 at 3:52 PM, the RD said she did not update Resident #44's care plan. The RD also said updating the care plans was the responsibility of the Certified Dietary Manager or possibly the MDS coordinator.</p>	F 657	<p>Measures to Prevent Reoccurrence: The DON or designee educated LNs and the IDT on care plan revisions as it relates to significant weight changes.</p> <p>Plans to Monitor On-going Compliance: The IDT will review residents for significant weight changes weekly through the clinical meeting and in conjunction with their MDS schedule. Residents identified with significant changes will have care plans reviewed for needed updates.</p> <p>Individuals to maintain compliance: The DON or designee will ensure on-going compliance.</p>		

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F 657	Continued From page 11 On 12/13/18 at 10:50 AM, RCM #1 said care plans were sometimes updated electronically and sometimes updated on the paper copy found on the resident's chart. RCM #1 said she did not know why the Nutrition care plan was not updated when Resident #44 had the significant weight gain. On 12/13/18 at 3:10 PM, the Certified Dietary Manager said he did not write the care plan, and the RCM would have been notified of Resident #44's weight gain. On 12/14/18 at 8:45 AM, the DON was asked about reviewing and revising the care plan, the DON stated, it was a "definite break in the system."	F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents received assistance with bathing in accordance with their needs. This was true for 1 of 2 residents (#70) reviewed for bathing. This failure resulted in the potential for harm due to a resident's physical and/or psychosocial well-being being compromised. Findings include: Resident #70 was admitted to the facility on 11/21/18, with multiple diagnoses including	F 677	Individual Residents: Resident #70 no longer resides in the facility. Residents in similar situations: Interviewable residents were interviewed for bathing preferences and care plans and care directives were updated. Measures to prevent reoccurrence: Shower aides were educated on ensuring shower schedules were followed per care	1/10/19	

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F 677	Continued From page 12 chronic obstructive pulmonary disease, colon cancer, Clostridium difficile (an inflammation of the colon caused by the clostridium difficile bacteria) and anxiety. Resident #70's admission MDS assessment, dated 11/28/18, documented her cognition was minimally impaired and she required assistance from staff for cares. Her Activities of Daily Living (ADL) Care Plan, dated 11/21/18, documented Resident #70 required extensive assistance for showers, washing her face and hands and combing/brushing her hair. On 12/10/18 at 11:00 AM and at 3:19 PM, Resident #70 was sitting in a wheelchair at her bedside. Resident #70's hair was uncombed and appeared dirty and greasy. A November 2018 ADL flowsheet documented Resident #70, who was to bathe each Monday and Thursday, was bathed twice from 11/21/18 to 11/30/18. The December 2018 ADL flowsheet documented Resident #70 was bathed twice from 12/1/17 to 12/14/17. On 12/14/18 at 9:00 AM, the DON stated 2 showers and 1 bed bath was not an acceptable number of showers for 22 days. At 12/14/18 at 9:44 AM, Resident #70 was sitting in her wheelchair at her bedside. She stated she had received a "spit bath in her room last night." When asked if her hair was shampooed, Resident #70 stated "They have a cap that washes my hair. I would really like a shower."	F 677	plan and care directives as reflected by resident preferences. Plans to monitor on-going compliance: The IDT will audit 10% of resident population weekly x4 weeks and then monthly x2 months through daily "Angel Rounds" (M-F) to ensure resident satisfaction and compliance with bathing preferences. Negative findings will be reported to the ED and presented to monthly QAPI x3 months for further education and training opportunities. Individual to ensure compliance: The ED or designee will ensure on-going compliance.		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679		1/10/19	

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F 679	<p>Continued From page 13</p> <p>§483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family member, and staff interview, and record review, it was determined the facility failed to ensure there was an ongoing activity program to meet individual resident social needs. This was true for 1 of 1 resident (#70) reviewed for quality of life concerns. This failure resulted a resident's social needs being unmet due to a lack of meaningful engagement being provided throughout the day. Findings include:</p> <p>Resident #70 was admitted to the facility on 11/21/18, with multiple diagnoses including chronic obstructive pulmonary disease, colon cancer, C-diff (an inflammation of the colon caused by the clostridium difficile bacteria) and anxiety.</p> <p>Resident #70's admission MDS assessment, dated 11/28/18, documented the resident's cognition was minimally impaired, hearing intact and had minimal to no depressive symptoms. Resident #70 was able to make herself understood and understood others. The</p>	F 679	<p>Individual Residents: Resident #70 no longer resides in the facility.</p> <p>Residents in Similar Situations: Residents with isolation precautions were interviewed for activity preferences and satisfaction with activity participation.</p> <p>Measures to prevent reoccurrence: Activity staff were educated by the ED on isolation precautions, facility policy and activity participation.</p> <p>Plans to monitor on-going compliance: Residents on isolation precautions will be interviewed weekly x4 weeks and then monthly x2 months through daily "Angel Rounds" (M-F) for satisfaction and preferences related to activity participation. Negative findings will be reported to the ED and brought to monthly QAPI x3 months for further education and training opportunities.</p>		

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F 679	<p>Continued From page 14</p> <p>assessment documented it was very important to Resident #70 to go outside, to get fresh air when the weather was good, and to participate in religious services or practices.</p> <p>The activity care plan, dated 11/28/18, documented Resident #70 was able to express activity needs and interest during interaction and she required assistance and set-up for in room activities. The care plan documented Resident #70 said she liked to just sit quietly and her family was supportive. The care plan goals were for Resident #70 to continue engaging in daily room activities of interest and to attend and participate in reading and discussion groups of interest each week and maybe music events. The plan also stated she was on contact precautions.</p> <p>The interventions directed the activity staff to invite, inform, and assist Resident #70 to music events like oldies, special events, pet therapy, fancy nails, reading and discussion groups, movies, church, and religious services. Staff were directed to offer one to one interaction with an activity staff 1- 2 times per week to introduce Resident #70 to the dayroom, library, and activity cart. Staff were to engage and reassure Resident #70 that it was okay for her to get out and about.</p> <p>On 12/10/18 at 11:01 AM, Resident #70 was observed sitting in a wheelchair at her bedside. The over bed table was positioned in front of her. The room was quiet. Resident #70 asked "Do I still have C-Diff?" At 2:30 PM, Resident #70 was observed lying in bed.</p>	F 679	<p>Individual to ensure compliance: The ED or designee will ensure ongoing compliance.</p>		

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F 679	<p>Continued From page 15</p> <p>On 12/11/18 at 9:04 AM, Resident #70 was observed sitting in a wheelchair at her bedside. The room was quiet, a magazine and television remote laid on the over bed table in front of her.</p> <p>On 12/11/18 at 3:19 PM, Resident #70 stated she did not leave her room because the staff told her she was on "lock down" because of the C-diff. Resident #70 was sitting in her wheelchair. The room was quiet, a magazine and television remote laid on the over bed table in front of her.</p> <p>On 12/12/18 at 9:05 AM, Resident #70 was sitting in her wheelchair at her bedside with the overbed tray in front of her. The room was quiet.</p> <p>The Resident Daily Participation Record documented between 11/22/18 and 11/30/18, Resident #70, had one episode of active participation documented as 1:1 activity. The Resident Daily Participation Record documented Resident #70 was "unable" to participate in pet therapy, Bingo, movies, music, religious services, and social/parties. The record documented Resident #70's activities were "passive" participation in "some" reading, "some" television, and "wheelchair in room."</p> <p>The Resident Daily Participation Record documented between 12/1/18 and 12/12/18, Resident #70, had three episodes of active participation documented as 1:1 activity. The Resident Daily Participation Record documented Resident #70 was "unable" to participate in pet therapy, Bingo, movies, music, Resident Council, and social/parties. The record documented Resident #70 refused to attend religious services on 2 occasions. The record documented</p>	F 679			

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F 679	<p>Continued From page 16</p> <p>Resident #70's activities were "passive" participation in "some" reading, "some" television, and "wheelchair in room."</p> <p>On 12/12/18 at 3:47 PM, the Activity Director stated Resident #70 was set up with books on tapes and if she could not operate the tape player, her Activity Assistant would set her up. The Activity Director stated she did not know why Resident #70 did not come to activities. Upon review of Resident #70 activity record, the Activity Director stated Resident #70 was on isolation precautions. The Activity Director stated the activity staff would need to look at the door before entering Resident #70's room. The Activity Director stated Resident #70 was not able to go out of her room because of her C diff, "that comes from nursing."</p> <p>However, the undated Isolation Precautions information sheet posted on Resident #70's door, directed staff that Resident #70 was able to go to Therapy/Activities without personal protective equipment. Information related to Resident #70 not being able to leave her room due to infection, was not present.</p> <p>On 12/12/18 at 6:00 PM, the Activity Director documented Resident #70 liked to just sit in a quiet room, still refusing books on tape even with activity set up and help. The Activity Director reassured Resident #70 that she could come to music events out of her room at this time. Resident #70 stated she didn't want to come out of her room and get people sick.</p> <p>The Activity Assistant stated activity was not provided to Resident #70 at this time. The Activity</p>	F 679			

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F 679	<p>Continued From page 17</p> <p>Assistant stated Resident #70 was checked on to see if she needed anything, such as mail or water. The Activity Assistant stated gowns, gloves, masks, and boots were worn when entering Resident #70's room.</p> <p>On 12/13/18 at 10:15 AM, Resident #70's son was visiting with her in her room. Resident #70 was sitting in a wheelchair at the side of the bed with the over bed table tray in front of her. Resident #70's son sat in a chair facing her, approximately 4 feet away. He had a disposable gown and gloves on. He stated he had to wear a mask only if he had physical contact with his mother. The television was off and the telephone was in a nightstand drawer behind her. Resident #70 stated she watched television sometimes and could read books with large print. Resident #70 stated she liked to play games on her computer. Resident #70 had books and magazines on the table in front of her. The TV remote was on the table in front of her. Resident #70 stated, other than the laptop computer, there wasn't anything she would want to do.</p> <p>When asked if she would like to get out of her room, Resident #70 stated "I can't." Resident #70's son stated the facility was waiting for the results of a test to see if his mother's C-diff infection had resolved. The son said to his mother if resolved, then "we could take you out and walk around in the facility, would you like that?" Resident #70 said "yes."</p> <p>Resident #70's clinical record was reviewed. A single laboratory result, completed on 11/1/18, documented negative results for C-diff toxin. There were no other laboratory test results</p>	F 679			

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F 679	Continued From page 18 provided that indicated a C-diff infection. Information related to why Resident #70 was placed on contact precautions, per her 11/28/18 activity care plan was not documented. Further, a facility's communication form dated 12/11/18, documented Resident #70 was having formed stool and remained on C-diff precautions. The physician ordered repeat C-diff testing on 12/11/18. On 12/14/18, the DON stated the test results were negative for C-diff. The facility failed to ensure Resident #70's opportunities to participate in social activities of her preference and choice were not restricted unnecessarily.	F 679			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for 7 of 19 residents (#2, #20, #44, #50, #61, #69 and #142) reviewed for standard of practice. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to	F 684	Individual Residents: Resident #20 was assessed for significant changes with edema in lower extremity and no significant changes were noted. Resident #61 was provided a neck pillow for positioning. Residents #50 & 142 no longer reside in facility.	1/10/19	

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F 684	<p>Continued From page 19</p> <p>accepted standards of clinical practices. Findings include:</p> <p>1. Resident #20 was admitted to the facility on 10/29/18, with multiple diagnoses including traumatic brain injury with quadriplegia and edema.</p> <p>An annual MDS assessment, dated 9/18/18, documented Resident #20 was severely cognitively impaired and he required extensive assistance of 2 staff member for his activities of daily living.</p> <p>Resident #20's December 2018 Physician summary report and Resident #20's care plan, dated 11/26/18, directed staff to apply his thrombo embolic deterrent (TED) hose in the morning and remove the TED hose each evening.</p> <p>Resident #20's MAR documented his TED hose was applied each morning and removed each evening from 12/1/18 through 12/12/18.</p> <p>However, on 12/11/18 at 3:42 PM and on 12/13/18 at 9:48 PM, 11:00 AM, and 4:01 PM, Resident #20 was observed in bed. His legs and feet were elevated, and he was not wearing TED hose.</p> <p>On 12/13/18 at 4:07 AM, RCM #1 said if Resident #20 was in bed his legs and feet were elevated staff would not apply TED hose. RCM #1 said the staff put Resident #20's TED hose on when he was up in his wheelchair. When asked if this was consistent with the physician order, RCM #1 reviewed the physician order and said</p>	F 684	<p>Resident #2 had no negative effects from medication pass as all medications were provided.</p> <p>Resident #44 has had a re-weigh, physician notification and care plan revisions.</p> <p>Residents in Similar Situations: Residents with Tylenol orders were reviewed through monthly recaps to ensure that orders were correct and validated as needed. Residents with ted hose orders had their most recent weekly skin checks reviewed for any skin related issues secondary to ted hose compliance. No negative findings were noted. Residents with significant weight changes were reviewed to ensure re-weighs were conducted per policy. Weights were redone as indicated. Angel rounds were conducted to review positioning of residents and needed referrals to therapy were completed.</p> <p>Measures to prevent reoccurrence: The LNs were educated on following physician orders related to ted hose, proper documentation related to medication pass and clarifying orders for Tylenol when greater than recommended totals by DON or designee. LNs and NACs were provided education on proper positioning of residents who present with contractures or positioning challenges secondary to condition. LNs and NACs were provided education by DON or designee on necessary re-weighing at</p>		

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F 684	<p>Continued From page 20</p> <p>no, the order was to put Resident #20's TED hose on in the morning and to remove the TED hose in the evening.</p> <p>2. Resident #61 was admitted to the facility on 12/22/16, with multiple diagnoses including traumatic brain injury.</p> <p>An annual MDS assessment, dated 11/10/18, documented Resident #61 was severely cognitively impaired and required extensive assistance of 2 staff members for her activities of daily living.</p> <p>The facility's policy and procedure for Activities of Daily Living (Bed/Wheelchair Mobility), dated 12/11/18, directed staff to assists residents with bed/wheelchair repositioning as necessary to promote good body alignment and to prevent skin breakdown.</p> <p>On 12/11/18 at 8:15 AM and at 9:12 AM, Resident #61 was observed in bed sleeping. Her head was leaned to her right side almost at 90 degrees with no support.</p> <p>On 12/12/18 at 1:31 PM, Resident #61 was observed in bed sleeping. She had 2 pillows on the back of her head and her head was leaned to her right side. The head of Resident #61's bed was slightly elevated.</p> <p>On 12/12/18 at 1:55 PM, CNA #2 entered the room and emptied Resident #61's urinary bag. CNA #2 was not observed to reposition Resident #61's head.</p> <p>On 12/12/18 at 2:14 PM, LPN #5 was observed</p>	F 684	<p>time of discovery with significant changes in weights.</p> <p>Plans to monitor compliance: Nursing leadership will review Tylenol orders monthly with recaps to ensure compliance with FDA regulations and clarify orders at the time of initiation or with discovery. Residents with ted hose and neck positioning challenges will be audited weekly x4 weeks and then monthly x2 months for compliance with orders and proper positioning. Weights will be reviewed weekly through clinical IDT meeting to ensure that significant changes present with re-weights per facility policy. Daily Grand Rounds (M-F) will be conducted by leadership with direct care staff for open discussion of these areas for rapid identification of changes and/or resident needs. Negative trends of all findings will be presented to the DON for review and identification of further training and education opportunities.</p> <p>Individual to ensure compliance: DON or designee will ensure ongoing compliance.</p>		

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F 684	<p>Continued From page 21</p> <p>setting up Resident #61's feeding tube. Resident #61 was sleeping in bed. The head of her bed was slightly elevated, and she was observed to turn her head towards the middle and then leaned her head again to her right side almost at 90 degrees. When LPN #5 finished setting up Resident #61's feeding tube, she sanitized her hands and left the room. LPN #5 was not observed to reposition Resident #61's head.</p> <p>On 12/13/18 at 3:59 PM, Resident #61 was observed in bed sleeping. Her head was leaned on her right side almost at 90 degrees.</p> <p>On 12/13/18 at 4:10 PM, RCM #1 observed Resident #61 in bed sleeping with her head leaned on her right side. RCM #1 said she would ask the Physical Therapy to evaluate Resident #61's head positioning. RCM #1 then took a clean towel, rolled it and placed it on the right side under Resident #61's neck.</p> <p>On 12/14/18 at 8:03 PM, the Physical Therapy Director said Resident #61 would benefit from repositioning every 2 hours. The Physical Therapy Director stated placing a neck pillow just like a rolled towel under Resident #61's neck would help. The Physical Therapy Director also said the neck pillow or travel pillow might not stay because Resident #61 was still able to move her neck but it would at least provide good alignment as tolerated.</p> <p>3. On 12/13/18 at 4:24 PM, the DON said the facility had APAP/Tylenol policy not to exceed 3,000 mg in 24 hours in any form. The DON said the medical personnel would transcribed the physician order and 2 RCMs would review the</p>	F 684			

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F 684	<p>Continued From page 22</p> <p>orders and the final review would be done by the floor nurse.</p> <p>a. Resident #50 was admitted to the facility on 11/30/18, with multiple diagnoses which included cutaneous abscess of his right lower extremity and pain.</p> <p>Resident #50's December 2018 physician orders summary report included orders for Tylenol 500 mg, by mouth, four times a day for unspecified pain. The summary report also stated APAP was not to exceed 3000 mg per 24 hours in any form.</p> <p>On 12/13/18 8:45 AM, LPN #4 was observed to administer Resident #50's medications which included 2 tablets of Tylenol 500 mg.</p> <p>Resident #50's MAR documented he received Tylenol 1,000 mg every 6 hours each day from 12/1/18 through 12/12/18. This was not consistent with Resident #50's physician orders and resulted in a total of 4,000 mg of Tylenol per day.</p> <p>b. Resident #142 was admitted to the facility on 12/7/18, with multiple diagnoses which included thoracic spine (back of the body) pain.</p> <p>Resident #142's December 2018 physician orders summary report included orders for Tylenol 1,000 mg, by mouth, every 6 hours for unspecified pain. The summary report also stated APAP was not to exceed 3000 mg per 24 hours in any form.</p> <p>On 12/13/18 at 8:30 AM, LPN #4 was observed to administer Resident #142's medications which</p>	F 684			

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F 684	<p>Continued From page 23 included 2 tablets of Tylenol 500 mg.</p> <p>Resident #142's MAR for 12/8/18-12/12/18 documented he received Tylenol 1,000 every 6 hours each day from 2/8/18 through 12/12/18. This was a total of 4,000 mg of Tylenol per day.</p> <p>On 12/13/18 at 9:04 PM, LPN #4 reviewed Resident #50 and Resident #142's physician orders and said Resident #50 and Resident #142 were receiving more than 3,000 mg of Tylenol in 24 hours. LPN #4 said the order should have been clarified with the physician. LPN #4 said APAP/Tylenol was not good for the liver.</p> <p>On 12/14/18 at 8:36 AM, the Pharmacist said most of the nursing facility lowered their dose of APAP/Tylenol to 3,000 mg in 24 hours. The Pharmacist said she did not address the physician order for APAP/Tylenol with the facility protocol of 3,000 mg on her monthly review of the residents' medications.</p> <p>4. The facility's policy and procedure for Medication Administration, revised 4/2/13, stated licensed personnel were to initial each medication in the correct box on the MAR after the medication was given. This was not followed:</p> <p>a. On 12/12/18 at 8:08 AM, during the medication pass observation, RN #1 was observed initialing the MAR as she prepared Resident #2's medications: multivitamin, Lovenox 80 mg/ml 0.7 cc, Pantoprazole 40 mg, Senna, Losartan 50 mg, Metoprolol ER (extended release) 25 mg, Aspirin 81 mg, Potassium Chloride 20 meq, Furosemide 40 mg and acetaminophen 500 mg, prior to actual administration.</p>	F 684			

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F 684	<p>Continued From page 24</p> <p>b. On 12/12/18 at 8:24 AM, during the medication pass observation, RN #1 was observed initialing the MAR as she prepared Resident #69's medications: Metformin 500 mg, Trajenta 5 mg, Senna, Tamsulosin 0.4 mg, Aspirin 81 mg, Lyrica 75 mg, Carbidopa-levodopa tablet and escitalopram 10 mg, prior to actual administration.</p> <p>On 12/12/18 at 8:44 AM, RN #1 said she initialed the MAR as she "popped" the resident's medications from the medication cards.</p> <p>5. The facility's Weight Monitoring policy and procedure, dated 3/1/13, documented that a designated licensed nurse reviewed weights for accuracy and compared current weight to the previous weight. If the weight varied by 5 lbs in a month or 3 lbs in a weekly or bimonthly weight, the resident was to be reweighed. The policy stated reweighs were to occur on the same shift but no more than 24 hours after the first weighing.</p> <p>The policy documented that weight variances were to be reviewed for residents with a 5% weight change in 30 days, a 7.5% weight change in 90 days, and a 10% weight change in 180 days, which included gain or loss. The physician and responsible party was to be notified of any resident who experienced an unplanned weight loss, significant weight change, or undesirable weight change. The policy documented unplanned weight gain may have significant health implications and would be addressed and "Each identified resident with a weight change has a current nutrition assessment/progress</p>	F 684			

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F 684	<p>Continued From page 25 note."</p> <p>The policy and procedure was not implemented, as follows:</p> <p>Resident #44 was readmitted to the facility on 04/18/18, with multiple diagnoses congestive heart failure and pulmonary edema. An admission MDS, dated 4/19/18, documented Resident #44 was cognitively intact and she required set-up only for eating.</p> <p>Resident #44's weight history record showed a greater than 5 pound weight difference from her prior documented weight on 10/4/18, 11/7/18, and 12/7/18. Resident #44's weight differences being 21 lbs, 42 lbs, and 9 lbs respectively. There was no documentation in Resident #44's clinical record her weight was rechecked when her weights were noted to be greater than 5 lbs difference or that the physician had been notified of Resident #44's significant change in weight.</p> <p>On 12/14/18 at 9:03 AM, the Nurse Practitioner said he would have expected to be notified of a resident weight change of more than 5 pounds. The Nurse Practitioner said he did not trust the weights documented in the medical record because there were so many variables that could affect the weights, such as clothing and wheelchairs. The Nurse Practitioner also said if he had been told of Resident #44's weight gain, he would have ordered the resident be re-weighed to confirm the weight gain and treat, if indicated.</p> <p>On 12/12/18 at 3:52 PM, the RD said the CNAs were responsible in weighing the residents. The</p>	F 684			

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F 684	Continued From page 26 RD said she thought the RCM or the DON stated there was a "Definite break in the system."	F 684			
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident, family, and staff interview, and record review, it was determined the facility failed to provide medically-related social services for 1 of 2 residents (#70) reviewed for mental health related social services. This result in a lack of timely assessment being conducted to determine the psychosocial effects of unwarranted isolation precautions. Findings include: Resident #70 was admitted to the facility on 11/21/18, with multiple diagnoses including chronic obstructive pulmonary disease, colon cancer, C-diff (an inflammation of the colon caused by the clostridium difficile bacteria) and anxiety. Resident #70's admission MDS assessment, dated 11/28/18, documented the resident's cognition was minimally impaired, hearing intact and had minimal to no depressive symptoms. Resident #70 was able to make herself understood and understood others. The assessment documented it was very important to Resident #70 to go outside, to get fresh air when the weather was good, and to participate in religious services or practices.	F 745	Individual Residents: Resident #70 no longer resides in facility. Residents in Similar Situations: Residents on isolation precautions were educated to their specific isolation precautions to ensure understanding that they are able to leave their room. Measures to prevent reoccurrence: Staff were educated by ED on C-diff precautions and the ability for residents to leave their rooms when on these measures. Review of the policy and department specific measures was completed including social service assessment and education. Plans to monitor compliance: Residents with isolation precautions will be educated and interviewed through the "Angel Rounds" process by IDT leadership as needed. IDT members will ensure understanding and education of facility offerings outside of the resident's room to meet resident personal preferences. Negative findings from	1/10/19	

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F 745	<p>Continued From page 27</p> <p>Resident #70's active C-diff care plan, dated 11/21/18, documented she had an active infection with C-diff. The interventions included contact precautions.</p> <p>However, Resident #70's clinical record included a single laboratory result, completed on 11/1/18 which documented negative results for C-diff toxin. There were no other laboratory test results provided that indicated a C-diff infection.</p> <p>Resident #70's activity care plan, dated 11/28/18 also documented she was on contact precautions. The plan documented she was able to express activity needs and interest during interaction and she required assistance and set-up for in room activities. The care plan documented Resident #70 said she liked to just sit quietly and her family was supportive. The care plan goals were for Resident #70 to continue engaging in daily room activities of interest and to attend and participate in reading and discussion groups of interest each week and maybe music events.</p> <p>The interventions directed the activity staff to invite, inform, and assist Resident #70 to music events like oldies, special events, pet therapy, fancy nails, reading and discussion groups, movies, church, and religious services. Staff were directed to offer one to one interaction with an activity staff 1- 2 times per week to introduce Resident #70 to the dayroom, library, and activity cart. Staff were to engage and reassure Resident #70 that it was okay for her to get out and about.</p> <p>However, on 12/11/18 at 3:19 PM, Resident #70</p>	F 745	<p>these rounds will be discussed daily (M-F) in stand up for further clinical follow up.</p> <p>Individual to ensure compliance: Ed of designee will ensure ongoing compliance.</p>		

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F 745	<p>Continued From page 28</p> <p>was sitting in her wheelchair in her room. Resident #70 stated she did not leave her room because the staff told her she was on could not leave her room because of the C-diff.</p> <p>The Resident Daily Participation Record documented between 11/22/18 and 11/30/18, Resident #70, had one episode of active participation documented as 1:1 activity. The Resident Daily Participation Record documented Resident #70 was "unable" to participate in pet therapy, Bingo, movies, music, religious services, and social/parties. The record documented Resident #70's activities were "passive" participation in "some" reading, "some" television, and "wheelchair in room."</p> <p>The Resident Daily Participation Record documented between 12/1/18 and 12/12/18, Resident #70, had three episodes of active participation documented as 1:1 activity. The Resident Daily Participation Record documented Resident #70 was "unable" to participate in pet therapy, Bingo, movies, music, Resident Council, and social/parties. The record documented Resident #70 refused to attend religious services on 2 occasions. The record documented Resident #70's activities were "passive" participation in "some" reading, "some" television, and "wheelchair in room."</p> <p>On 12/12/18 at 3:47 PM, the Activity Director stated Resident #70 was set up with books on tapes and if she could not operate the tape player, her Activity Assistant would set her up. The Activity Director stated she did not know why Resident #70 did not come to activities. Upon review of Resident #70 activity record, the Activity</p>	F 745			

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F 745	<p>Continued From page 29</p> <p>Director stated Resident #70 was on isolation precautions. The Activity Director stated the activity staff would need to look at the door before entering Resident #70's room. The Activity Director stated Resident #70 was not able to go out of her room because of her C-diff, "that comes from nursing."</p> <p>However, the undated Isolation Precautions information sheet posted on Resident #70's door, directed staff that Resident #70 was able to go to Therapy/Activities without personal protective equipment. Information related to Resident #70 not being able to leave her room due to infection, was not present.</p> <p>The Activity Assistant stated activity was not provided to Resident #70 at this time. The Activity Assistant stated Resident #70 was checked on to see if she needed anything, such as mail or water.</p> <p>It was not evident that the Activity Director or the Activity Assistant were aware that Resident #70 was not restricted to her room prior to 12/12/18.</p> <p>A Social Service note completed by the MSW/Senior Executive Director, dated 12/12/18 at 6:00 PM, documented she met with Resident #70 to identify any concerns she may have. The note stated, "Resident presents quiet, without motivation, and with failure to thrive." The MSW/Senior Executive Director documented Resident #70 refused activity choices offered but did "finally agree" to let the MSW/Senior Executive Director assist with turning the television on. The MSW/Senior Executive Director recommended a licensed clinical</p>	F 745			

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F 745	<p>Continued From page 30</p> <p>psychologist assessment to determine psychosocial harm or emotional distress. Resident #70 agreed to the assessment.</p> <p>On 12/12/18 at 6:00 PM, the Activity Director documented Resident #70 liked to just sit in a quiet room, still refusing books on tape even with activity set up and help. The Activity Director reassured Resident #70 that she could come to music events out of her room at this time. Resident #70 stated she didn't want to come out of her room and get people sick.</p> <p>On 12/13/18 at 10:15 AM, Resident #70's son was visiting with her in her room. Resident #70 was sitting in a wheelchair at the side of the bed with the over bed table tray in front of her. Resident #70's son sat in a chair facing her, approximately 4 feet away. He had a disposable gown and gloves on. He stated he had to wear a mask only if he had physical contact with his mother. The television was off, and the telephone was in a nightstand drawer behind her. Resident #70 stated she watched television sometimes and could read books with large print. Resident #70 stated she liked to play games on her computer. Resident #70 had books and magazines on the table in front of her. The TV remote was on the table in front of her. Resident #70 stated, other than the laptop computer, there wasn't anything she would want to do.</p> <p>When asked if she would like to get out of her room, Resident #70 stated "I can't." Resident #70's son stated the facility was waiting for the results of a test to see if his mother's C-diff infection had resolved. The son said to his mother if resolved, then "we could take you out</p>	F 745			

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F 745	<p>Continued From page 31 and walk around in the facility, would you like that?" Resident #70 said "yes."</p> <p>It was not evident that Resident #70 and her son were aware that Resident #70 was not restricted to her room.</p> <p>On 12/13/18 at 4:44 PM, the DON stated that a resident with C-diff can come out of their rooms. "We sent a sample of her stool to the lab and it came back negative."</p> <p>On 12/13/18 at 5:20 PM, LSW #1 stated she had not witnessed Resident #70 attending activities at any time. LSW #1 stated Resident #70 came out of her room for showers, but that "she was pretty down when she came here, it took her awhile to even get out of bed." LSW #1 stated she was aware that Resident #1 could come out of her room. She stated she was not aware that Resident #70 did not leave her room.</p> <p>On 12/13/18 at 6:30 PM, the facility provided an assessment a Licensed Clinical Psychologist completed on 12/13/18 at 4:45 PM. The handwritten assessment documented he was asked to evaluate Resident #70 to assess the possibility of emotional/psychological harm due to recent isolation due to C-diff infection. The assessment documented Resident #70 denied any harm suffered from her experience. The Licensed Clinical Psychologist documented there was no indication of emotional or psychological harm from the recent isolation.</p> <p>The assessment was the only documentation from the Licensed Clinical Psychologist found in Resident #70's record. Information related to the</p>	F 745			

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F 745	Continued From page 32 psychosocial impacts of being subjected to isolation prior to 12/13/18 was not present in Resident #70's record.	F 745			
F 758 SS=D	<p>The facility failed to ensure Resident #70 was not restricted to her room unnecessarily and that the psychosocial impacts of the isolation was thoroughly assessed in a timely manner.</p> <p>Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)</p> <p>§483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive</p>	F 758		1/10/19	

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F 758	<p>Continued From page 33</p> <p>psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interview, and facility's policy review, it was determined the facility failed to ensure that potential medication side effects were routinely monitored for residents receiving psychotropic medication and that non-pharmacological approaches were attempted prior to increasing the dose of psychotropic medications. This was true for 2 of 5 residents (#20 and #52) reviewed for psychotropic medications. These failed practices created the potential for harm should residents receive psychotropic medications that were unnecessary, ineffective, or should residents experience adverse reactions from psychotropic medications. Findings include:</p> <p>1. Resident #20 was admitted to the facility on</p>	F 758	<p>Individual Residents: Residents #20 and 52 had behavior monitoring flow sheets reviewed and updated with specific side effects and non-pharmacological interventions. They were also reviewed through the IDT behavior meeting to ensure appropriate medication and care plan revisions.</p> <p>Residents in Similar Situations: Residents receiving psychotropic medications had their behavior monitoring flow sheets reviewed with the monthly recap process to ensure necessary documentation related to side effects and interventions were present for nursing review.</p>		

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F 758	<p>Continued From page 34 10/29/15, with multiple diagnoses including traumatic brain injury and depression.</p> <p>An annual MDS assessment, dated 9/18/18, documented Resident #20 was severely cognitively impaired, he had no hallucinations or delusions, he had no physical or verbal behaviors, and he received psychotropic medications daily.</p> <p>Resident #20's December 2018 physician orders included the following:</p> <ul style="list-style-type: none"> - Ativan (antianxiety) 0.5 mg by mouth prior to bathing, ordered on 7/23/18. - Zoloft (antidepressant) 50 mg by mouth for depression, ordered on 10/23/17. - Risperdal (antipsychotic) 0.75 mg twice daily for psychotic features, harming himself and others, ordered on 11/19/18. <p>a. Resident #20's care plan dated 11/10/15, addressed his behavior problems and documented he was physically abusive, potentially harmful to himself and to others due to flailing his limbs, throwing items, striking out during cares and squeezing the fingers of others and refusing to let go. Interventions included in the care plan documented staff were to anticipate Resident #20's care needs, explain care to him, approached him in calm manner, divert his attention, take him to another location, observe his behavior episodes, attempt to determine the underlying cause and provide a non-confrontational environment for care.</p> <p>Resident #20's Behavior Monthly Monitoring Flow Sheets for November and December 1 through</p>	F 758	<p>Measures to prevent reoccurrence: SS and LNs were educated by ED and DON on the requirements for documenting side effects and non-pharmacological interventions related to resident behaviors and psych medication usage.</p> <p>Plans to monitor compliance: SS staff will monitor residents behavior flow sheets through monthly IDT meeting to ensure that LNs are documenting behaviors, interventions and potential side effects are needed prior to any medication adjustments or alterations. Monthly behavior meetings will occur to review for trends and further education and training opportunities. Daily Grand Rounds (M-F) with clinical leadership and direct care staff members will occur to discuss changes in resident behaviors or medications.</p> <p>Individual to ensure compliance: DON or designee will ensure ongoing compliance.</p>		

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F 758	<p>Continued From page 35</p> <p>11, 2018, documented he was being monitored for depression as evidenced by withdrawal from activities and harm to himself or others as evidenced by hitting and throwing items. The Behavior Monthly Monitoring Flow Sheet, documented Resident #20 had not demonstrated any of these behaviors.</p> <p>However, a Nursing Note, dated 11/11/18 at 12:08 PM, documented a family representative reported Resident #20 had increased agitation over minor things while at church since his Risperdal was decreased.</p> <p>A Nursing Note, dated 11/18/18 at 11:32 PM, documented Resident #20 was more agitated while cares were being done. He pushed the staff hands away and hit the side rails with his fist.</p> <p>Resident #20's Nursing Notes were not consistent with the Resident #20's Behavior Monthly Monitoring Flow Sheet for November 2018.</p> <p>b. Resident #20's care plan, dated 11/4/18, documented he was taking an antidepressant and antipsychotic medications. The care plan directed staff to observe Resident #20 for side effects, document and report to physician.</p> <p>Resident #20's Behavior Monthly Flow Sheets included a space to document the presence or absence of side effects of his psychotropic medications. The specific side effects to monitor for Resident #20 were not identified and documentation of whether Resident #20 experienced side effects was not documented.</p>	F 758			

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F 758	<p>Continued From page 36</p> <p>On 12/13/18 at 9:59 AM, the LSW assistant/Case Manager (CM,) said the nurses documented the side effects on the Behavior Monthly Monitoring Flow Sheet by exception only. No documentation indicated no side effects occurred. When asked why the nursing notes were not consistent with Resident #20's Behavior Monitoring Flow Sheet, the CM said if there was a behavior documented on the Behavior Monthly Monitoring Flow Sheet it should also be documented on the nursing notes. The CM said she did not know why there were no behaviors documented on the Behavior Monitoring Flow Sheet.</p> <p>On 12/13/18 at 5:57 PM, LPN #6 was asked to identify side effects specific to Zoloft. LPN #6 mentioned sedation and sleepiness. LPN #6 said she needed to look at the Nursing Drug Handbook for the other side effects of the medication and said if she noticed anything different with a resident's baseline she would document it.</p> <p>2. Resident #52 was admitted to the facility on 8/1/17, with multiple diagnoses including depression.</p> <p>A quarterly MDS assessment, dated 10/31/18, documented Resident #52 was moderately cognitively impaired, she did not experienced hallucination or delusions, she had no physical or verbal behaviors and she received antipsychotic and antidepressant medication almost daily.</p> <p>Resident #52's December 2018 Physician Orders included the following:</p> <ul style="list-style-type: none"> - Trazodone (antidepressant) 100 mg by mouth 	F 758			

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F 758	<p>Continued From page 37</p> <p>at bedtime for insomnia and depression, ordered on 7/11/18.</p> <ul style="list-style-type: none"> - Zoloft (antidepressant) 100 mg by mouth daily for depression, ordered on 8/10/17. - Seroquel (antipsychotic) 25 mg by mouth daily at bedtime, for behavioral and psychological symptoms of dementia, ordered on 3/2/18. <p>a. A Behavior care plan dated 8/2/17, documented Resident #52 exhibited behaviors such as biting herself, making negative statements about herself, making accusatory and untrue statements about staff and others and she experienced hallucinations and delusions.</p> <p>The care plan directed staff to provide a 1:1 visit with Resident #52, establish rapport by inquiring about her social past, maintain a familiar care giver as possible, explain all cares prior to performing the task and ensure a quiet peaceful setting at night. The care plan documented staff were not to contradict Resident #52's hallucinations and delusions.</p> <p>The care plan did not identify the type of hallucinations Resident #52 experienced or how her hallucinations affected her daily living.</p> <p>Resident #52's Behavior Monthly Monitoring Flow Sheets for October 2018, documented she was being monitored for negative statements about herself, her life and situation, depression as evidenced by not sleeping at night, being harmful to herself as evidenced by biting herself, hallucinations and delusions. The October 2018 Behavior Monthly Monitoring Flow Sheet, documented Resident #52 had not demonstrated any of these behaviors.</p>	F 758			

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F 758	<p>Continued From page 38</p> <p>A Physician order, dated 10/8/18, documented a decreased of Resident #52's Zoloft 100 mg daily to Zoloft 75 mg every morning.</p> <p>Resident #52's Behavior Monthly Monitoring Flow Sheets for November 2018, documented she was being monitored for negative statements about herself, her life and situation, being harmful to herself as evidenced by biting herself, hallucinations and delusions. The November 2018 Behavior Monthly Monitoring Flow Sheet, documented Resident #52 had not demonstrated any of these behaviors.</p> <p>However, a nursing note, dated 11/4/18, documented Resident #52's friend had asked staff to bring Resident #52 to the restroom before going to a church service. Resident #52 became very agitated and refused to go to the restroom. Resident #52 said she did not need to go to the toilet. Resident #52 was redirected and re-approached with no change.</p> <p>A subsequent physician order, dated 11/5/18, documented an order to increase Resident #52's Zoloft 75 mg to Zoloft 100 mg daily due to failed GDR (gradual dose reduction).</p> <p>On 12/12/18 at 3:07 PM, the CM was asked if increasing Resident #52's Zoloft to 100 mg was justified with one episode of agitation with no other behavior documented, the CM said, "No not in paper, I don't know."</p> <p>b. Resident #52's care plan, dated 11/4/18, documented he was taking an antidepressant and antipsychotic medications. The care plan</p>	F 758			

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F 758	Continued From page 39 directed staff to observe Resident #52 for side effects, document and report to physician. Resident #52's Behavior Monthly Flow Sheets included a space to document the presence or absence of side effects of his psychotropic medications. The specific side effects to monitor for Resident #20 were not identified and documentation of whether Resident #52 experienced side effects was not documented. On 12/12/18 at 3:07 PM, the CM said nurses documented the side effects on the Behavior Monthly Monitoring Flow Sheet by exception only. No documentation indicated no side effects occurred.	F 758			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs	F 761		1/10/19	

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F 761	<p>Continued From page 40</p> <p>listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure expired medications were removed from the medication carts and not available for administration to residents. This was true for 2 of 6 medication carts. This failed practice created the potential for residents to receive expired medications with decreased efficacy. Findings include:</p> <p>On 12/12/18 at 4:35 PM, during the inspection of Medication Cart #2 with LPN #3, 60 tablets of Tramadol 50 mg, which expired on 11/30/18, were found. LPN #3 verified the expiration date and said he would dispose of the expired medications with another nurse.</p> <p>On 12/12/18 at 5:00 PM, during the inspection of Medication Cart #5 with LPN #2, 4 tablets of Coumadin 2.5 mg, which expired on 12/4/18, were found. LPN #2 verified the expiration date and said she would dispose of the expired medications.</p>	F 761	<p>Individual Residents: No individual residents identified.</p> <p>Residents in Similar Situations: Residents have the potential to be effected by this practice. No additional expired medication was discovered with no impact to residents.</p> <p>Measures to prevent reoccurrence: LNs were educated on the requirements of removing/destroying medications past their expiration dates from carts and medication storage areas by DON or designee.</p> <p>Plans to monitor compliance: Medication storage areas will be audited weekly x4 then monthly x3 for expired medications. Audits will be presented to the DON for review and negative trends will be reviewed through monthly QAPI x3 months for further education and training opportunities.</p> <p>Individual to ensure compliance: DON or designee will ensure ongoing compliance.</p>		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		1/10/19	

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F 842	Continued From page 41 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (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. §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- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §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- (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,	F 842			

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F 842	<p>Continued From page 42</p> <p>and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</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 accurate and complete clinical records were maintained for each resident. This was true for 2 of 19 residents (#25 and #34) whose immunizations were reviewed. This created the potential for harm should inappropriate care and/or treatment be provided based on</p>	F 842	<p>Individual Residents:</p> <p>Resident #25 had her declination of the influenza vaccine obtained from dialysis and filed in her record.</p> <p>Resident #34 had influenza vaccine with no negative side effects.</p> <p>Residents in Similar Situations:</p>		

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F 842	<p>Continued From page 43</p> <p>inaccurate information in the residents' clinical records. Findings include:</p> <p>1. Resident #25 was admitted to the facility on 5/2/18, with multiple diagnoses including hypertension and heart failure.</p> <p>A review of Resident #25's medical record did not show she consented to receive or had refused the Influenza vaccination for the 2018 flu season.</p> <p>On 12/13/18 at 9:27 AM, the DON provided a copy of Resident #25's Informed Consent for Influenza Vaccine. The consent form dated 11/6/17, documented Resident #25's Durable Power of Attorney gave a verbal consent for the Influenza vaccine. The DON said she did not know why Resident #25 did not received the Influenza vaccine.</p> <p>On 12/13/18 at 2:13 PM, the Senior Executive Director provided a copy of "Adult Vaccination Consent-Flu" signed at the dialysis clinic where Resident #25 received dialysis services. The Senior Executive Director said they had just received the copy of the consent dated 11/8/18 from the dialysis clinic and it documented Resident #25 had declined the Influenza vaccination.</p> <p>2. Resident #34 was admitted to the facility on 3/28/06, with multiple diagnoses including seizure disorder.</p> <p>Resident #34's MAR documented Resident #34 was administered an Influenza vaccine on 10/9/18.</p>	F 842	<p>Influenza vaccine consents were audited to ensure that residents had them in their medical records. No other negative findings were noted.</p> <p>Measures to prevent reoccurrence: LNs were educated by DON or designee on the requirement of having vaccine consents present for residents and that documented consent must be obtained prior to administering the vaccine.</p> <p>Plans to monitor compliance: Influenza vaccines will be audited during administration of vaccine season with new admissions to ensure that medical records are complete and consents/declinations are completed timely. New admissions will be reviewed by clinical leadership team and negative findings will be presented to the DON for further training and education opportunities.</p> <p>Individual to ensure compliance: DON or designee will ensure ongoing compliance.</p>		

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F 842	Continued From page 44 The Informed Consent for Influenza Vaccine form, documented Resident #34 signed the consent on 10/10/18.	F 842			
F 880 SS=F	<p>Infection Prevention & 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; (ii) When and to whom possible incidents of</p>	F 880		1/10/19	

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F 880	<p>Continued From page 45</p> <p>communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on policy review and staff interview, it was determined the facility failed to ensure infection control measures were consistently implemented</p>	F 880	<p>Individual Residents: Residents #70 and #142 no longer reside in the facility.</p>		

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F 880	<p>Continued From page 46 for 2 of 19 sampled residents (#70, #142) and potentially all residents residing at the facility. These failures resulted in the potential for the spread of infection among residents due to cross-contamination. Findings include:</p> <p>1. Resident #70 was admitted to the facility on 11/21/18, with multiple diagnoses including chronic obstructive pulmonary disease and C-diff (an inflammation of the colon caused by the clostridium difficile bacteria).</p> <p>Resident #70's active C-diff care plan, dated 11/21/18, documented she had an active infection with C-diff. The interventions included contact precautions.</p> <p>The Centers for Disease Control and Prevention's Guideline for Environmental Infection Control in Health-Care Facilities (2003,) Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC,) last updated 2/15/17, documented the direct exposure to contaminated patient-care items (e.g., rectal thermometers) and high-touch surfaces in patients' bathrooms (e.g., light switches) have been implicated as sources of infection. The guideline states "Clean room surfaces thoroughly on a daily basis while treating a patient with C. difficile and upon patient discharge or transfer. Supplement cleaning as needed with use of bleach or another EPA-approved, spore-killing disinfectant."</p> <p>Additionally, the 12/23/09 clostridium difficile Infections Toolkit Activity, provided by the CDC, provided limited data that directed cleaning with</p>	F 880	<p>Residents in Similar Situations: Residents have the potential to be effected by this practice. A review of the November and December infection control logs was completed and no negative trends were noted related to glucometer or housekeeping practices.</p> <p>Measures to prevent reoccurrence: Housekeeping associates were educated by ED on required cleaning practices for C-diff areas. Review of the CDC recommendations and facility polices was conducted. LNs were educated by the DON or designee on proper glucometer cleaning practices.</p> <p>Plans to monitor compliance: LNs will complete glucometer cleaning competencies annually and upon hire to ensure proper techniques and infection control practices are completed. Infection control logs will be reviewed monthly through QAPI to assess for negative trends related to housekeeping practices. Negative findings will be trended and education will be provided.</p> <p>Individual to ensure compliance: DON or designee will ensure ongoing compliance.</p>		

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F 880	<p>Continued From page 47</p> <p>bleach (1:10 dilution prepared fresh daily) reduced C-diff transmission. Most EPA-registered hospital disinfectants have a label contact time of 10 minutes.</p> <p>However, the facility's Clostridium Difficile (C-diff) policy, revised 4/17, the facility's Standard Precautions policy, last revised 2/27/17, and the facility's Housekeeping Services policy, last revised 4/1/15, were reviewed. The policies did not specific the product, the product strength, or the contact time of the product that was to be used for suspected or actual C-diff infections.</p> <p>The facility's Housekeeping Services policy referenced information from the Centers for Disease Control and Prevention (CDC) but did not include specific direction from the CDC for the management and disinfection of C-diff.</p> <p>On 12/12/18 at 8:59 AM, Housekeeper #2 stated he knew a resident was on isolation precautions if there was a personal protective equipment cart sitting outside the room. He stated if the resident had C-diff or norovirus, he would "put a little bleach on the floor as well, just in case." Housekeeper #2 stated he tried to use as little water as possible, so it would dry faster. He stated each mop was used in one room only. He stated using a rag mop, he would change out the water and put a little bleach in it.</p> <p>On 12/12/18 at 3:10 PM, the Housekeeping Director stated new housekeeping staff were trained for 3 days with current housekeeping staff. The Housekeeping Director stated if a resident had C-diff, everything was bleached, 200 parts per million (ppm) on all contact</p>	F 880			

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F 880	<p>Continued From page 48</p> <p>surfaces. The Housekeeping Director stated a spray bottle with 1/3-1/4th of bleach was used for surfaces and Stride was used on the floors. The Housekeeping Director stated Stride was not a bleach solution.</p> <p>On 12/13/18 at 8:18 AM, Housekeeper #1 stated she cleaned surfaces in an isolation rooms with C-diff, with 1 part bleach to 3 parts water. She stated it would kill C-diff in about 2 minutes.</p> <p>The facility failed to ensure policies and procedures were sufficiently developed and implemented to minimize the environmental cross-contamination risks of C-diff for all residents residing at the facility.</p> <p>2. On 12/13/18 at 11:45 AM, RN #2 was observed placing a glucometer on top of the medication cart without a barrier. RN #2 then washed her hands, went back to the medication cart and picked up the glucometer.</p> <p>RN #2 was observed to enter Resident #142's room, placed the glucometer on top of the bedside table without a barrier, and told Resident #142 she would check his blood glucose. RN #2 put on gloves and was about to prick Resident #142's finger when the surveyor stopped RN #2 and asked her to please step outside of the room.</p> <p>Outside Resident #142's room, RN #2 said she sanitized the glucometer after she used it with another resident and therefore, it was clean when she placed it on top of the medication cart and then on top of Resident #142's bedside table. When asked if she put a barrier between the</p>	F 880			

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F 880	Continued From page 49 glucometer and the top of the medication cart. RN #2 said she did not put a paper towel between the glucometer and the top of the medication cart and there was also no paper towel between the glucometer and the top of the Resident #142's bedside table.	F 880			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001390	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/14/2018
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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the licensing survey conducted on December 10, 2018 to December 14, 2018.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Presie Billington, RN Karen Gray, RD Karen George, RN</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) attendance records, it was determined the facility failed to ensure the Pharmacist and the Dietary Manager, or a representative from the dietary department, participated in ICC meetings at least quarterly. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included:</p> <p>On 12/13/18 at 4:45 PM, the facility's Infection Control Program was reviewed with the DON. The DON said the ICC met monthly. Review of the sign-in sheets from January 2018 to November 2018, covering the last 4 quarters, showed the Pharmacist did not attend the monthly meetings during the first quarter (January 2018 to March 2018). The Dietary</p>	C 664	<p>Individual Residents: No individual residents were identified.</p> <p>Residents in Similar Situations: No residents were impacted by this practice and facility corrected findings prior to survey.</p> <p>Measures to prevent reoccurrence: IDT was educated by ED on requirements for participation in infection control committee meetings.</p> <p>Plans to monitor compliance: The ED will monitor attendance of required participants on a quarterly basis to ensure that IC meetings meet regulations. Negative findings will be</p>	1/10/19

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

Electronically Signed

TITLE

(X6) DATE
01/02/19

Bureau of Facility Standards

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C 664	Continued From page 1 Manager, or a representative from the dietary department, did not attend the monthly meetings during the second quarter (April 2018 to June 2018.) On 12/14/18 at 9:00 AM, the Executive Director stated the sign in sheets were accurate for the ICC meeting.	C 664	reviewed through the QAPI meeting as needed. Individual to ensure compliance: The ED or designee will ensure ongoing compliance.	
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