



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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January 24, 2020

Breanna Jameson, Administrator
Lewiston Transitional Care Of Cascadia
3315 8th Street
Lewiston, ID 83501-4966

Provider #: 135021

Dear Ms. Jameson:

On **January 9, 2020**, a survey was conducted at Lewiston Transitional Care of Cascadia by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed.

NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 3, 2020**. Failure to submit an acceptable PoC by **February 3, 2020**, may result in the imposition of penalties by **February 26, 2020**.

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 **February 13, 2020 (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 **April 9, 2020**. A change in the seriousness of the deficiencies on **February 23, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been

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achieved by
April 9, 2020 includes the following:

Denial of payment for new admissions effective **April 9, 2020**. [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 **July 9, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; 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 **April 9, 2020** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **February 3, 2020**. If your request for informal dispute resolution is received after **February 3, 2020**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

bd/lj

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

PRINTED: 02/20/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135021	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2020
NAME OF PROVIDER OR SUPPLIER LEWISTON TRANSITIONAL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
(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	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted from January 6, 2020 through January 9, 2020. The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator. Brad Perry, LSW Kim Saccomando, RN Susan Finnell, RN Survey Abbreviations: ADLs = Activities of Daily Living COPD = Chronic Obstructive Pulmonary Disease CNA = Certified Nursing Assistant DON = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams RCM = Resident Care Manager RN = Registered Nurse	F 000			
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578		2/13/20	

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

TITLE

(X6) DATE

Electronically Signed

02/03/2020

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 578	<p>Continued From page 1</p> <p>requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure resident records included an advanced directive, or documentation of an advanced directive being offered. This was true for 3 of 7 residents (#2, #50, and #52) whose records were reviewed for advanced directives. This failed practice created the potential for harm if residents' wishes regarding end of life or</p>	F 578	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Lewiston Transitional Care of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies.</p>		

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F 578	<p>Continued From page 2</p> <p>emergent care were not honored if they became incapacitated. Findings include:</p> <p>The State Operations Manual, Appendix PP, defines an "Advance Directive" as "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." "Physician Orders for Life-Sustaining Treatment for POST) paradigm form" is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POST paradigm form is not an advance directive."</p> <p>The facility's policy for Advance Directives/Health Care Decisions, dated 10/1/17, documented the following:</p> <ul style="list-style-type: none"> * Upon a resident's admission to the facility, the facility determined whether the resident executed an advance directive or gave other instructions to indicate their wishes in case they became incapacitated. * If the resident or their representative had executed an advance directive, a copy was obtained and maintained in the resident's record. * If the resident did not execute an advance directive, the facility advised the resident and their family of their right to establish an advance directive. * The facility documented the discussions 	F 578	<p>The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F578: Request/ Refuse/ Discontinue Treatment</p> <p>Resident Specific: The clinical management team reviewed residents, #2 and #52 for records to advance directives, or documentation of advanced directive being offered. Documentation of Advanced Directives have been added to the resident's medical record. Resident #50 is no longer in the facility.</p> <p>Other Residents: The clinical management team reviewed other resident's medical record for advanced directives or documentation of an advanced directive being offered. Adjustments have been made as indicated.</p> <p>Facility systems: Social services and social service assistant educated on advanced directive documentation requirements. Executive Director and/or designee provided education, to include but not limited to, the facility's policy on advanced directives/ healthcare decisions, documentation requirements for if a resident changes their advanced directives current care decisions, and education regarding executing advanced</p>		

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F 578	<p>Continued From page 3</p> <p>regarding advance directives in the resident's medical record.</p> <p>* The facility identified, clarified, and periodically reviewed at least quarterly, after a life altering event (e.g. diagnosis of terminal illness, etc.) and after return from hospitalization, as part of the comprehensive care planning process, the existing care instructions and whether the resident wished to change or continue those instructions.</p> <p>* If a resident changed their advance directive, the facility documented in a progress note the update and current care decisions.</p> <p>This policy was not followed.</p> <p>1. Resident #2 was admitted to the facility on 7/17/19, with multiple diagnoses including Type 2 diabetes mellitus, hemiplegia and hemiparesis (weakness and paralysis on one side) following a stroke, muscle weakness, and seizures.</p> <p>Resident #2's physician orders documented Do Not Resuscitate (DNR), ordered on 7/17/19.</p> <p>Resident #2's care plan documented she had a DNR POST (Physician Order for Scope of Treatment) in place, and it was initiated on 7/17/19.</p> <p>Resident #2's quarterly MDS assessment, dated 10/4/19, documented she was cognitively intact.</p> <p>Resident #2's record did not include documentation of an advance directive, or that it was offered or discussed with her.</p> <p>On 1/9/20 at 4:13 PM, the Resident Support</p>	F 578	<p>directives. The system is amended to include oversight by the clinical management team with review of new admissions, 72-hour care conferences, and quarterly care conferences to validate residents medical record includes an advance directive, or documentation of an advance directive being offered.</p> <p>Monitor: Social Service Director and/or designee will audit new admissions, 72-hour care conferences, and quarterly care conferences weekly for documentation of advanced directives, or documentation of advanced directive being offered for 12 weeks. Starting the week of Feb 9th 2020, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance: Feb 13, 2020</p>		

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F 578	<p>Continued From page 4</p> <p>Services assistant said there was only a POST in Resident #2's record. The facility had no documentation an advance directive was offered or discussed with Resident #2.</p> <p>2. Resident #50 was admitted to the facility on 4/19/18 and readmitted to the facility on 12/12/19, with multiple diagnoses including COPD (progressive lung disease characterized by increasing breathlessness), congestive heart failure (weakness of the heart leading to a buildup of fluid in the body), and chronic kidney disease.</p> <p>Resident #50's General Power of Attorney, signed on 10/25/12, did not address the power to make decisions for health care.</p> <p>Resident #50's MDS assessment, dated 12/19/19, documented he was severely cognitively impaired.</p> <p>Resident #50's physician orders documented his status was DNR, and it was ordered on 12/12/19.</p> <p>Resident #50's care plan documented his wishes were DNR, he had a POST in place, initiated on 2/20/19.</p> <p>Resident #50's record did not include documentation of an advance directive, or that it was offered or discussed with him or his representative.</p> <p>On 1/9/20 at 4:18 PM, the Licensed Medical Social Worker (LMSW) said Resident #50 only had a General Power Of Attorney. The facility had no documentation that an advance directive</p>	F 578			

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F 578	Continued From page 5 was offered or discussed with Resident #50 or his representative. 3. Resident #52 was admitted to the facility on 1/19/18 and readmitted on 2/15/19, with multiple diagnoses including stroke, hemiplegia and hemiparesis, COPD, and convulsions (medical condition where body muscles contract and relax rapidly and repeatedly, resulting in uncontrolled actions of the body). Resident #52's MDS assessment, dated 12/20/19, documented she was cognitively intact. Resident #52's physician orders documented her status was DNR, ordered on 1/19/18. Resident #52's care plan documented her status was DNR, and it was outlined in her POST. The focus area was initiated on 1/20/18 and updated on 2/7/18. Resident #52's record did not include documentation of an advance directive, or that it was offered or discussed with her. On 1/9/20 at 4:45 PM, the LMSW said she did not see any other documentation regarding advance directives in Resident #52's record. The facility did not provide documentation of an advance directive being offered or discussed with Resident #52 or her representative.	F 578			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		2/13/20	

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F 584	<p>Continued From page 6 but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 584			

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F 584	<p>Continued From page 7</p> <p>Based on observation, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' room temperatures were maintained at a comfortable level. This was true for 2 of 17 residents (#41 and #46) whose environment was observed. This deficient practice created the potential for harm if residents became too cold or hot and it compromised their health status. Findings include:</p> <p>The facility's Resident's Environment policy, dated 11/28/19, directed staff to keep ambient temperatures above 71 degrees F (Fahrenheit).</p> <p>This policy was not followed.</p> <p>On 1/7/20 at 9:33 AM, Resident #46 said his room, which he shared with Resident #41, was cold because the thermostat did not work. Resident #46 said he told facility staff about it and the room was still cold. The wall thermostat control unit was set at 76 degrees F, and the thermostat documented the room temperature was 68 degrees F. The ceiling air register above the room sink was blowing cool air.</p> <p>On 1/8/20 at 9:45 AM, the Maintenance Director said he was not aware the room was cool and said the control unit in Resident #41's and Resident #46's room was set at 76 degrees F. He tested the ambient air with a laser temperature gauge and said it read 66.8 degrees F. The Maintenance Director said the temperature should have been higher and said he would find out why the room was cool.</p> <p>On 1/8/20 at 10:02 AM, the Health Information</p>	F 584	<p>F584: Safe/ Clean/ Comfortable/ Homelike Environment</p> <p>Resident Specific: The maintenance director has reviewed residents #41 and #46 room temperature to validate room temperatures were maintained at a comfortable level. The thermostat has been replaced as indicated.</p> <p>Other Residents: Maintenance director reviewed other residents to validate room temperatures were maintained at a comfortable level with functional thermometers.</p> <p>Facility Systems: Maintenance Director, floor staff, therapy staff, housekeeping, and department heads educated on safe, clean homelike environment. Executive Director and/or designee provided education, to include but not limited to, maintaining a comfortable and safe temperature levels, completing a maintenance request when room temperatures are out of range and/or resident states not comfortable. The system is amended to include staff reporting of room temperatures out of range and oversight by the maintenance director to validate room temperatures are maintained at a comfortable and safe level.</p> <p>Monitor: Maintenance Director and/or designee will audit 5 rooms weekly for comfortable and safe room temperatures for 12 weeks, starting on Feb 9th, 2020. The review will be documented on the QAPI audit tool.</p>		

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

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F 584	Continued From page 8 Director (HID) said she found the window in Resident #41's and Resident #46's room was opened a crack, and she closed it. The window was observed, and it had a small gap near the top of the window. The HID then attempted to re-close the window, and on the third attempt it closed completely. The HID said she would report the window condition to the Maintenance Director. On 1/9/20 at 8:53 AM, in Residents' #41's and Resident #46's room, the wall thermostat control unit was set at 90 degrees F, and the thermostat documented the room temperature was 71 degrees F.	F 584	Any concerns will be addressed immediately and will be reviewed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance: Feb 13, 2020		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		2/13/20	

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NAME OF PROVIDER OR SUPPLIER LEWISTON TRANSITIONAL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
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F 623	<p>Continued From page 9</p> <p>discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual</p>	F 623			

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F 623	<p>Continued From page 10</p> <p>and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident representative and staff interview, it was determined the facility failed to ensure transfer</p>	F 623	F623: Notice Requirements Before Transfer/Discharge Resident Specific:		

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F 623	<p>Continued From page 11</p> <p>notices were provided in writing to residents and their representatives. This was true for 1 of 2 residents (Resident #50) reviewed for transfers. This created the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's policy for Transfer and Discharge, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> * The facility provided sufficient preparation and orientation to residents to ensure safe and orderly discharge from the facility. * The written notice included: the reason for the discharge, effective date of transfer/discharge, location where the resident was being transferred/discharged, a statement of the resident's right to appeal the action of transfer/discharge, the contact information for the state long term care ombudsman, and the mailing address and phone number of the agency responsible for protection and advocacy of developmentally disabled or mentally ill individuals. <p>This policy was not followed.</p> <p>Resident #50 was admitted to the facility on 4/19/18 and readmitted to the facility on 12/12/19, with multiple diagnoses including COPD (progressive lung disease characterized by increasing breathlessness), congestive heart failure (weakness of the heart leading to a buildup of fluid in the body), and chronic kidney disease.</p> <p>Resident #50's Discharge MDS assessment, dated 12/8/19, documented he had an unplanned</p>	F 623	<p>Resident number #50 is no longer in the facility.</p> <p>Other Residents: The clinical management team reviewed other residents, transferred in the last 30 days for documentation of written transfer notification provided to the resident and their representatives. Adjustments have been made as indicated.</p> <p>Facility Systems: Licensed nurses are educated on notice requirements before transfer and discharge. Re-education was provided by the Director of Nursing and/or designee, to include but not limited to, written notification at the time of transfer/ discharge. The system was amended to include review in the clinical meeting of recent transfers to validate timely documentation of transfer notices being provided to the resident and/or designee in writing.</p> <p>Monitor: Director of Nursing and/or designee will audit 3 resident discharges weekly for documentation of transfer notices provided to the resident and/or designee in writing for 12 weeks beginning on February 9th 2020. The review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance: Feb 13, 2020</p>		

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F 623	Continued From page 12 discharge to the hospital. A Progress Note, dated 12/8/19 at 6:46 PM, documented Resident #50 was sent to the Emergency Room by ambulance. The note documented Resident #50's physician order summary, MAR, POST, and facesheet was sent with the resident. There was no documentation in Resident #50's record the facility provided written notification of the transfer to Resident #50 and his representative when he was transferred to the hospital on 12/8/19. On 1/9/20 at 3:28 PM, the DON said Resident #50's family lived in another state, and they were notified verbally of his transfer to the hospital. The DON said the documentation in Resident #50's record was the only documentation regarding the transfer. On 1/9/20 at 3:41 PM, Resident #50's daughter said she did not receive written notification of Resident #50's transfer to the hospital on 12/8/19.	F 623			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and policy review, it was determined the facility failed to ensure resident MDS assessments were accurate regarding falls and anticoagulant use. This was true for 2 of 16 residents (#36 and #57) whose MDS assessments were reviewed. This	F 641	F641 Accuracy of Assessments Specific Residents: Resident #57 is no longer in facility. The clinical management team has reviewed resident #36, modification made to MDS to reflect accurate coding of falls	2/13/20	

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F 641	<p>Continued From page 13</p> <p>deficient practice created the potential for harm if residents received inappropriate care related to inaccurate MDS assessments. Findings include:</p> <p>The facility's policy for Resident Assessment, dated 11/28/17, documented "a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity and needs is conducted using the Resident Assessment Instrument (RAI), which directs the care of the resident based on his or her individual needs."</p> <p>This policy was not followed.</p> <p>1. Resident #57 was admitted to the facility on 8/27/18, with diagnoses including atrial fibrillation (irregular heart rhythm).</p> <p>Resident #57's physician's order, dated 10/23/19, documented Apixaban (an anticoagulant) 5 mg, 1 tablet by mouth two times a day for atrial fibrillation.</p> <p>Resident #57's MAR for December 2019 documented Apixaban tablet 5 mg two times a day related to atrial fibrillation with a start date of 10/23/19. The Apixaban was administered two times a day for the month of December 2019.</p> <p>Resident #57's quarterly MDS assessment, dated 12/20/19, documented he did not receive anticoagulant medication during the past 7 days.</p> <p>On 1/8/20 at 1:31 PM, the MDS Coordinator verified Resident #57 was receiving an anticoagulant, and said the MDS assessment dated 12/20/19 should have documented Resident #57 received anticoagulant medication</p>	F 641	<p>and anticoagulant use.</p> <p>Other Residents: Clinical management team reviewed other residents MDS assessments for accurate coding regarding falls and anticoagulant use. Adjustments have been made as indicated.</p> <p>Facility Systems: MDS Coordinator educated on accurate coding of falls and anticoagulants. Director of Nursing re-educated MDS coordinator on coding of the MDS, to include but not limited to, coding of resident falls and identifying anticoagulants. The system is amended to include, systematic review of the MDS for coding prior to submission with oversight by the Director of Nursing and/or designee. Monitor: Director of Nursing and/or designee will audit 2 residents weekly for MDS accuracy and coding for falls and anticoagulant for 12 weeks beginning on Feb 9th 2020. The review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate</p> <p>Date of Compliance: Feb 13th 2020</p>		

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F 641	<p>Continued From page 14 on 7 out of the past 7 days.</p> <p>2. Resident #36 was admitted to the facility on 1/10/17 and readmitted on 7/6/18, with multiple diagnoses including dementia, unsteadiness on feet, and Parkinson's disease (a progressive disease of the nervous system that affects movement).</p> <p>Resident #36's quarterly MDS assessment, dated 11/29/19, documented she had no falls since admission.</p> <p>Incident and Accident reports, dated 10/12/19 and 11/12/19, documented Resident #36 fell while in the facility.</p> <p>A Progress Note, dated 10/12/19 at 10:47 AM, documented a nurse found Resident #36 on the floor in her room. A CNA was in Resident #36's room with her, and Resident #36 fell backwards and landed on the floor as the CNA turned to pick up a blanket from the floor.</p> <p>A Progress Note, dated 11/12/19 at 4:40 PM, documented Resident #36 was found sitting on the floor on her bottom. The note documented Resident #36 attempted to sit on a coffee table and it moved away from her, resulting in her falling to the floor.</p> <p>On 1/7/20 at 11:03 AM, Resident #36's son said she slipped out of bed a couple times since she was admitted to the facility.</p> <p>On 1/8/20 at 11:41 AM, the DON said Resident #36 had fallen in the facility since her admission.</p>	F 641			

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F 641	Continued From page 15 On 1/8/20 at 2:15 PM, the MDS Coordinator said Resident #36's fall status needed to be updated on her MDS assessment.	F 641			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure care conferences were	F 657	F657 Care Plan Timing and Revision Resident Specific: Clinical management team reviewed	2/13/20	

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F 657	<p>Continued From page 16</p> <p>held after each assessment, including the comprehensive and quarterly assessments. This was true for 1 of 16 residents (Resident #2) whose care plans were reviewed. These failures created the potential for harm if residents and/or their representative were not included in making decisions regarding residents' care, and if care was not provided or care decisions were made based on inaccurate information. Findings include:</p> <p>The facility's policy for Care Plans, dated 11/28/19, documented the following:</p> <ul style="list-style-type: none"> * Care conference meetings were scheduled upon admission, quarterly, and with change of condition. * The care plan included directives for revising and updating the plan of care as needed to reflect the resident's current status. * The facility developed and implemented a comprehensive person-centered care plan for each resident, and it included measurable objectives and time frames to meet the resident's needs as identified in the comprehensive assessment. * The team of qualified persons monitored the resident's condition and effectiveness of the care plan interventions and revised the care plan quarterly, annually, with a significant change assessment or more frequently as needed with input from the resident and/or the representative. <p>This policy was not followed.</p> <p>Resident #2 was admitted to the facility on 7/17/19, with multiple diagnoses including Type 2 diabetes mellitus, hemiplegia and hemiparesis</p>	F 657	<p>resident #2 to validate care conference has been scheduled and completed.</p> <p>Other Residents: Clinical management team reviewed resident's clinical records, to validate care conferences were held or offered after each assessment including the comprehensive and quarterly assessments. Adjustments have been made as indicated.</p> <p>Facility system: Social Service Director, Social Service Assistant are educated on care conference requirements. Director of Nursing and/ or designees, are educated to include but not limited to, scheduling and documentation of resident care conferences at least quarterly and/or with change of condition. This system has been amended to include a review in the clinical meeting of new admissions, change of conditions, and upcoming quarterly assessments to validate care conferences have been scheduled appropriately.</p> <p>Monitor: Social service Director and/or designee will audit 5 residents weekly for admissions, change of condition and quarterly care conference requirements for 12 weeks starting Feb 9th 2020. The review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate</p>		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 657	Continued From page 17 (weakness and paralysis on one side of the body) following a stroke, muscle weakness, and seizures. Resident #2's record documented the most recent care conference was held on 7/18/19. On 1/7/20 at 9:20 AM, Resident #2 said she had not attended care conference meeting recently. On 1/8/20 at 10:17 AM, the Social Services Director said Resident #2's last care conference was held on 7/18/19, and it should be held quarterly.	F 657	Date of Compliance: Feb 13, 2020		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure medication was not left unattended at a resident's bedside. This was true for 1 of 6 residents (Resident #21) who were observed during medication pass. This failure created the potential for harm if residents did not ingest the medication as ordered by the physician resulting in a decrease or change in their health status. Findings include:	F 684	F684 Quality of Care: Resident Specific: Clinical management team reviewed resident # 21. Self- administration assessment completed. Resident is safe to have medication left at bedside. Other residents: The clinical management team reviewed other residents for preference of leaving medication at bedside. Self-administration	2/13/20	

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F 684	Continued From page 18 The facility's Medication Pass Guide, dated 1/1/18, directed staff to "Observe resident ingest medication, do NOT leave at bedside." This policy was not followed. On 1/8/20 at 7:03 AM, LPN #1 was observed administering medications to Resident #21. LPN #1 presented a medicine cup that contained 7 pills and a plastic cup containing Clearlax (a laxative) in water to Resident #21. Resident #21 swallowed the pills from the medicine cup, and then said he did not want to take the Clearlax until he received breakfast. LPN #1 said "okay" and placed the cup of Clearlax on Resident #21's overbed table, which was over his lap. LPN #1 then exited the room and left the Clearlax with Resident #21. On 1/8/20 at 7:29 AM, LPN #1 said she knew Resident #21 was not going to take the Clearlax until he received breakfast, and she should have watched him take it. On 1/8/20 at 8:23 AM, the Clinical Resource Nurse said medication should not be left at the bedside unless the resident was assessed for self-administration of medication. The Clinical Resource Nurse said Resident #21 was not assessed for self-administration of medication, and the nurse should have removed the medication from the room when he said he did not want to take it at that time.	F 684	assessments completed as indicated. Facility System: Licensed nurses educated on proper medication administration management and not leaving medications at bedside. Staff Development Coordinator re-educated licensed nurses, to include but not limited to, validation of a self-administration assessment prior to leaving medications at bed side, and proper disposal of medications. The system is amended it include rounds by department leaders to validation medications are secured for those with self-medication programs and no other meds left unattended. Monitor: Staff Development Coordinator and/ or designee will observe 2 licensed nurses per week for proper medication administration for 4 week, then 2 every other week for 8 weeks starting Feb 9th 2020. The review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance: Feb 13,2020		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	F 688		2/13/20	

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F 688	<p>Continued From page 19</p> <p>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to consistently implement a restorative nursing program (RNP). This was true for 1 of 3 residents (#36) reviewed for restorative nursing services. The failure created the potential for harm if residents experienced a decline in Range of Motion (ROM). Findings include:</p> <p>The facility's policy for Restorative Nursing, dated 2/28/18, documented the following:</p> <p>* Restorative nursing is a program established to help residents progress to a higher level of function and/or rehabilitate function, augment progress made in therapy or during recovery, and assists the resident to live as independently and safely as possible.</p>	F 688	<p>F688 Increase/ Prevent Decrease ROM/Mobility Specific Resident: Clinical Management team reviewed resident # 36. Resident restorative program is consistently being implemented and documented. Other Residents: Clinical management team reviewed other residents for consistent implementation of restorative nursing programs. Adjustments have been made as indicated. Facility System: Licensed nurses and CNAs educated on the implementation of restorative programs. The Director of Nursing and/or designee re-educated on Restorative</p>		

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F 688	<p>Continued From page 20</p> <p>* Restorative nursing is initiated when a resident has been discharged from therapy, when a resident has been admitted to the facility with restorative needs, when a resident is not eligible for rehabilitation therapy, and when restorative needs arise during the resident's stay in the facility.</p> <p>* Integrated restorative nursing services occurred 24 hours a day, 7 days a week. "During the course of the day and during all routine care activities, residents should be encouraged to perform at their optimal functional level ..."</p> <p>* Areas of function may include urinary and/or bowel toileting program, passive and/or active range of motion, splint or brace assistance, bed mobility and/or walking, transfer training, dressing and/or grooming training, eating and/or swallowing training, amputation/prosthesis care, and communication training.</p> <p>This policy was not followed.</p> <p>Resident #36 was admitted to the facility on 1/10/17 and readmitted on 7/6/18, with multiple diagnoses including dementia, unsteadiness on feet, aphasia (loss of ability to understand or express speech) after stroke, and Parkinson's disease (a progressive disease of the nervous system that affects movement).</p> <p>Resident #36's quarterly MDS assessment, dated 11/29/19, documented she required physical assistance of 1 person for locomotion, extensive assistance of 1 person for dressing, personal hygiene, and toileting, and physical assistance of 1 person for bathing.</p> <p>Resident #36's care plan documented she</p>	F 688	<p>Nursing to include but not limited to, staffing restorative program, proper documentation, and consistent implementation of restorative programs. The system is amended to include oversight in the clinical meeting to validate completion of the previous day's restorative programs.</p> <p>Monitor The Resident Care Manager and/or designee will audit 5 residents RNPs for documentation of consistent implementation, weekly for 12 weeks starting Feb 9th 2020. The review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of compliance: February 13th 2020</p>		

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F 688	Continued From page 21 required RNP for ambulation and active ROM, initiated on 4/15/19. The care plan documented Resident #36 was to ambulate outdoors with supervision for 15 minutes, 7 days a week, and she was to perform bilateral upper extremity exercises with supervision for 15 minutes, 7 days a week, initiated on 4/15/19. Resident #36's ADL flowsheet documented she received RNP services 9 times out of 29 opportunities from 12/10/19 through 1/7/20. The flowsheet documented the RNP services were provided for less than 15 minutes on 12/15/19, 12/28/19, 12/31/19, 1/1/20, and 1/7/20. On 1/8/20 at 1:39 PM, CNA #1 said Resident #36 did not receive RNP services on 1/7/20 because the Restorative Aide was pulled to work on the floor. On 1/8/20 at 2:46 PM, the DON said there were 2 aides to provide the RNP, and the facility "hit a bad spot with staffing so we did the programs as best as we could for maintenance." The DON said there were times when the Restorative Aide helped out on the floor, and she would have to talk to the CNAs to find out why Resident #36 did not receive Restorative Nursing services consistently.	F 688			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 732		2/13/20	

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F 732	<p>Continued From page 22</p> <p>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <p>(A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of daily staff posting, policy review, and staff interview, it was determined the facility failed to ensure the posted staffing information was maintained daily, and the posted information was in an easily readable format. This failure had the potential to effect the</p>	F 732	<p>F732 Posted Nurse Staff Information Resident Specific: No residents were identified as being affected by this practice. Other residents: Facility residents have the potential of</p>		

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F 732	<p>Continued From page 23</p> <p>65 residents living in the facility, their family members, and visitors who wanted to know the facility's staffing levels. Findings include:</p> <p>The facility's policy for Posting of Direct Care Staff, dated 11/28/17, documented the facility posted the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for residents' care per shift daily.</p> <p>This policy was not followed.</p> <p>On 1/6/20 at 2:35 PM, the daily staffing bulletin board across from the facility's main entrance was observed from approximately 3 feet away. The board included a posting detailing the daily staffing for 1/5/20. The form was difficult to read due to the small print. The posting included all staff for the 24-hour period with the number of RNs, LPNs, CNAs and the hours worked. It did not delineate staffing for the day, evening, and night shift.</p> <p>On 1/6/20 at 2:41 PM, the Administrator stated the daily posting was too small for anyone to read. She stated the daily posting was for the wrong date.</p> <p>On 1/6/20 at 3:48 PM, the Administrator stated the facility needed a better process for the daily staff posting, and the facility did not break out staffing into day, evening and night shift, but posted it all on one page daily.</p>	F 732	<p>being affected by this practice.</p> <p>Facility System: Department heads and nursing staff educated on required posted nursing staff information. The Executive Director and/or designee provided education to include but not limited to, posting of direct care staff, posting requirements by shift, nursing staffing information, and visual public access to posted nursing staffing data. The system amended to include oversight by the Executive Director to validate the posted staffing information is maintained daily, and in an easily readable format.</p> <p>Monitor: Executive Director and/or designee will audit daily staffing postings 5 days a week for 12 weeks to validate posted accurately and in a easily readable format starting Feb 9th 2020. The review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of compliance: February 13th 2020</p>		
F 758 SS=D	<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</p>	F 758		2/13/20	

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F 758	<p>Continued From page 24 that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <ul style="list-style-type: none"> (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic <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 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>	F 758			

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F 758	<p>Continued From page 25</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: Based on staff interview, record review, and policy review, it was determined the facility failed to ensure an as needed psychotropic medication had a physician evaluation or documented rationale when the medication order extended beyond 14 days . This was true for 1 of 5 residents (Resident #32) reviewed for unnecessary medications. This deficient practice created the potential for harm if residents experienced adverse effects from unnecessary psychotropic medications. Findings include:</p> <p>The facility's policy for Unnecessary Medications and Psychotropic/Antipsychotic Medication, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> * The residents' medication regimen was free of any medication used in excessive dose, excessive duration, without adequate monitoring, and without adequate indication for its use. * PRN psychotropic medications, which were not antipsychotic medications, were limited to 14 days, unless a longer timeframe was deemed appropriate by the attending physician or prescribing practitioner. * PRN orders for psychotropic and antipsychotic medications were used only when necessary to treat a diagnosed specific condition, and PRN use was limited to 14 days. * The PRN order could be extended beyond 14 	F 758	<p>F758- Free from Unnecessary Psychotropic Meds/ PRN use</p> <p>Specific Residents: Clinical management team reviewed resident #32 for unnecessary medications. Physician has provided a documented rationale for the medication extending beyond 14 days, it has been placed in the resident's medical record. Other residents: Clinical management team reviewed other residents with PRN psychotropic medication for stop dates extending beyond the 14 days for required documented rationale. Adjustments have been made as indicated.</p> <p>Facility Systems: Licensed nurses, Social Service Director, Social Service Assistant and the facility's Nurse Practitioner educated on psychotropic medications and the requirements for PRN stop dates exceeding beyond 14 days. Staff Development re-educated on Unnecessary Medication to include but not limited to, PRN psychotropic medications indication for use, PRN orders for psychotropic and antipsychotic</p>		

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F 758	<p>Continued From page 26</p> <p>days if the attending physician or prescribing practitioner believed it was appropriate to extend the order. The attending physician or prescribing practitioner documented the rationale in the resident's record and indicated the specific duration.</p> <p>This policy was not followed.</p> <p>Resident #32 was admitted to the facility on 8/30/19 and readmitted on 11/25/19, with diagnoses including anxiety.</p> <p>Resident #32's physician's order, dated 11/26/19, documented he was to receive lorazepam (antianxiety medication) 0.5 mg by mouth twice a day as needed for anxiety until 5/26/20, a period of six months.</p> <p>A pharmacy note to the attending physician/prescriber, signed by the Nurse Practitioner (NP) on 10/8/19, documented the pharmacist recommended to include a stop date for Resident #32's lorazepam, and to document the rationale in the resident's record if the stop date was more than 14 days. The NP documented "Stop date 6 months from start date." The pharmacy note did not include a rationale from the NP for the extended stop date for Resident #32's lorazepam.</p> <p>On 1/9/20 at 3:55 PM, the RCM confirmed she was unable to find a rationale for Resident #32's lorazepam documented in his record. The RCM said she spoke to the NP, who thought signing the 6-month order was the justification and she did not write an additional note addressing the reason for the extended stop date for the</p>	F 758	<p>medications extending beyond the 14 days, and required physician documentation and rationale. The system is amended to include oversight in the clinical meeting with review of PRN psychotropic medications with a stop date exceeding 14 days for appropriate documented rationale.</p> <p>Monitor: Social service director will audit each resident weekly with PRN psychotropic medications for required documentation for 12 weeks starting Feb 9th 2020. The review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance: February 13, 2020</p>		

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F 758	Continued From page 27 lorazepam.	F 758			
F 761 SS=E	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 listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, manufacturer's instructions, and policy review, it was determined the facility failed to ensure a vial of Tuberculin Purified Protein Derivative (PPD- a solution that is injected under the skin and used to help diagnose tuberculosis) was discarded 30 days after the open date. This was true for 1 of 2	F 761	F761 Label and Store Drugs and Biologicals Specific Resident: No residents were identified as being affected by this practice. Out of date multi use vial of PPD was destroyed. Other Residents:	2/13/20	

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F 761	<p>Continued From page 28</p> <p>medication storage rooms reviewed for outdated medications. This failed practice had the potential to result in decreased potency of the PPD, resulting in a false tuberculosis (TB) test readings, and had the potential to affect all residents who resided on the "A" wing and received the PPD. Findings include:</p> <p>The facility's policy for Medication Management, revised on 2/28/18, documented "medications are discarded by the expiration date unless indicated by the manufacturer's instructions to discard sooner."</p> <p>The undated manufacturer's instructions for the PPD documented "vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency."</p> <p>On 1/9/20 at 12:57 PM, the medication refrigerator on "A" wing was inspected, and an opened vial of PPD was found. The vial had the date 10/28/19 hand written on it.</p> <p>On 1/9/20 at 1:01 PM, LPN #1 verified the date written on the vial of PPD indicated when it was first opened and used.</p> <p>On 1/9/20 at 1:58 PM, RN #1 confirmed the manufacturer's printed instructions for the PPD instructed staff to discard the vial 30 days after opening.</p> <p>On 1/9/20 at 2:20 PM, LPN #1 confirmed the vial of PPD, dated 10/28/19, should have been thrown away.</p>	F 761	<p>Facility residents have the potential of being affected by this practice.</p> <p>Facility System: Licensed nurses educated on drug storage and labeling. Staff development coordinator re-educated on medication management to include but not limited to, medication expiration dates, proper storage of drugs and biologicals, labeling of drugs and biologicals, and proper destruction of expired medications. The system was amended to include oversight by the Resident Care Manager for observation of proper dating and destruction of multiuse vials.</p> <p>Monitor: Resident Care Manager and/or designee will audit med rooms twice weekly for 12 weeks to validate multiuse vials are managed as directed by the manufacturers label beginning Feb 9th 2020. The review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and will be reviewed with QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance: February 13, 2020</p>		

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F 761	Continued From page 29 On 1/9/20 at 2:24 PM, the RCM confirmed the vial of PPD should have been discarded 30 days after opening.	F 761			
F 880 SS=D	<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		2/13/20	

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F 880	<p>Continued From page 30</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 observation, policy review, and staff interview, it was determined the facility failed to ensure staff performed appropriate hand hygiene</p>	F 880	<p>F880 Infection Prevention and Control Resident Specific: Residents #3 and #10 have been found to</p>		

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NAME OF PROVIDER OR SUPPLIER LEWISTON TRANSITIONAL CARE OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501		
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F 880	<p>Continued From page 31</p> <p>during blood glucose (BG) testing. This was true for 1 of 2 nurses (LPN #1) observed during medication pass, and had the potential to affect 2 of 6 residents (#3 and #10) observed during medication pass. This failed practice had the potential for harm due to cross contamination. Findings include:</p> <p>The facility's policy for Hand Hygiene/Handwashing, dated 11/28/17, directed staff to perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items, regardless of whether gloves were worn. The policy also directed staff to perform hand hygiene after handling soiled equipment, after removal of gloves, and intermittently after gloves were removed, between patient contacts, and "when otherwise indicated to avoid transfer of microorganisms to other patients or environments."</p> <p>This policy was not followed.</p> <p>The facility's undated Medication Pass Guide directed staff to wash hands before donning gloves, with glove change, and when removing gloves. The Guide documented the following steps during BG testing: Cleanse the BG meter with 10% bleach, set on a barrier, and wait 2 minutes. Leave the barrier on the cart, remove gloves, and use gel hand cleanser. Wash hands, apply gloves, perform the BG test, then return with supplies to the cart. Set the BG meter on the barrier, dispose of sharps and test strip, remove gloves, and wash hands. Apply gloves and cleanse the meter with 10% bleach. Set the BG meter on a new barrier, and wait.</p>	F 880	<p>not be affected by this practice</p> <p>Other Residents: Facility residents have the potentials of being affected by this practice. Adjustments have been made as indicated.</p> <p>Facility System: Licensed nurses educated on hand hygiene. Staff development Coordinator reeducated licensed nurses on hand hygiene/ hand washing, to include but not limited to as directed on the medication pass guide, hand hygiene during blood glucose testing, blood glucose testing procedures, proper disinfection of equipment, and that resident items should not be placed in uniform pockets. The system is amended to include periodic observations of hand hygiene during blood glucose testing and proper disinfection of equipment.</p> <p>Monitor: Staff Development Coordinator to observe 2 nurses weekly for 4 weeks, then 2 every other week for 8 weeks for proper hand hygiene during blood glucose testing Feb 9th 2020. The review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and will be reviewed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.</p> <p>Date of Compliance: February 13, 2020</p>		

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F 880	<p>Continued From page 32</p> <p>These guidelines were not followed.</p> <p>On 1/8/20 at 7:03 AM, LPN #1 was at the medication cart and prepared to perform BG testing for Resident #10. LPN #1 placed the BG machine and canister of BG test strips in the pocket of her sweater. LPN #1 entered Resident #10's room, applied gloves, and performed the BG test. LPN #1 then removed her gloves, did not perform hand hygiene, wiped the BG machine with an alcohol wipe, and put the BG machine back in her pocket. LPN #1 then exited Resident #10's room, did not perform hand hygiene, and returned to the medication cart.</p> <p>On 1/8/20 at 7:10 AM, LPN #1 said she should have performed hand hygiene after wiping the BG machine and disposing of the lancet (device to puncture the finger to obtain a blood sample) for Resident #10.</p> <p>On 1/8/20 at 7:20 AM, LPN #1 prepared to perform BG testing for Resident #3. LPN #1 wiped the BG machine using a bleach solution without wearing gloves, then she performed hand hygiene, disposed of the used bleach wipe with bare hands, and did not perform hand hygiene. LPN #1 then entered Resident # 3's room, placed the BG machine on a paper towel, donned gloves, and performed the BG test. LPN #1 then removed her gloves, washed her hands, and returned to the medication cart with the BG machine in her hands. LPN #1 then wiped the BG machine using a bleach solution without wearing gloves. LPN #1 said she needed to call Resident #3's physician regarding the BG result, and she walked away from the medication cart without performing hand hygiene.</p>	F 880			

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

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F 880	Continued From page 33 On 1/8/20 at 7:29 AM, LPN #1 said she probably should perform hand hygiene after wiping the BG machine, but she did not think about it because she used a bleach wipe. LPN #1 said she probably should not touch the bleach wipe with bare hands. LPN #1 said she always put the BG machine and canister of BG testing strips in her pocket, and she probably should not. On 1/8/20 at 8:37 AM, the Infection Preventionist (IP) said it was not best practice for the nurse to carry the BG machine and test strips in her pocket. The IP said hand hygiene should always be performed before and after resident contact, when entering and leaving the resident's room, and when changing gloves. The IP said she would have to check the manufacturer's instructions, but she would prefer for the nurse to wear gloves when cleaning the BG machine with bleach wipes.	F 880			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001370	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2020
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NAME OF PROVIDER OR SUPPLIER LEWISTON TRANSITIONAL CARE OF CASCAD	STREET ADDRESS, CITY, STATE, ZIP CODE 3315 8TH STREET LEWISTON, ID 83501
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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey conducted from January 6, 2020 through January 9, 2020.</p> <p>The surveyors conducting the survey were: Cecilia Stockdill, RN, team coordinator. Brad Perry, LSW Kim Saccomando, RN Susan Finnell, RN</p>	C 000		
C 422	<p>02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas</p> <p>vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on observation, Resident Group interview, and staff interview, it was determined the facility failed to ensure each floor or nursing unit was equipped with at least 1 tub or shower for every 12 licensed beds. This affected 16 of 16 residents (#2, #5, #6, #16, #18, #20, #26, #32, #36, #40, #46, #50, #52, #53, #57, and #163) residing in the facility, and had the potential to affect all residents who resided in the facility. Findings include:</p> <p>The facility was licensed for 96 beds, and had 65 residents who lived in the facility.</p>	C 422	<p>C422: Capacity requirements for Toilets/ Bath areas</p> <p>We respectfully request to extend our waiver for bathing facilities. With our current census, calculations exceed the required bathing facilities; however, we do have a portable bathing unit that may be utilized for residents who desire to bathe in their room. This also provides an alternative and may be utilized upon resident choice. As indicated in the CMS-2567, the residents in group</p>	2/13/20

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/03/20
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Bureau of Facility Standards

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C 422	<p>Continued From page 1</p> <p>IDAPA 16.03.02.120.05.p.vii required, in part, "...there shall be at least one (1) tub or shower for every twelve (12) licensed beds..." Therefore, 8 tubs or showers should be present in the facility.</p> <p>On 1/7/20 at 2:05 PM, the residents in the Group interview stated they did not have a problem with receiving baths or showers.</p> <p>On 1/8/20 from 8:01 AM to 8:12 AM, 6 bathing areas were observed, which included two bathing areas in the therapy area.</p> <p>On 1/8/20 at 8:19 AM, the Administrator said the facility wanted to renew their waiver for the tub and shower requirement.</p>	C 422	interview stated that they do not have a problem with receiving baths or showers.	