



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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February 1, 2019

Casey Kemmerer, Administrator  
Teton Post Acute Care & Rehabilitation  
3111 Channing Way  
Idaho Falls, ID 83404-7534

Provider #: 135138

Dear Mr. Kemmerer:

On **January 18, 2019**, a survey was conducted at Teton Post Acute Care & Rehabilitation 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 **February 11, 2019**. Failure to submit an acceptable PoC by **February 11, 2019**, may result in the imposition of penalties by **March 6, 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 **February 22, 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 **April 18, 2019**. A change in the seriousness of the deficiencies on **March 4, 2019**, may result in

a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 18, 2019** includes the following:

Denial of payment for new admissions effective **April 18, 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 **July 18, 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 **April 18, 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:

Casey Kemmerer, Administrator  
February 1, 2019  
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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 **February 11, 2019**. If your request for informal dispute resolution is received after **February 11, 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/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135138</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/18/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>TETON POST ACUTE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>		
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from January 14, 2019 to January 18, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Brad Perry, LSW, Team Coordinator Cecilia Stockdill, RN Wendi Gonzales, RN</p> <p>Survey Abbreviations:</p> <p>CNA = Certified Nursing Assistant DON = Director of Nursing DNR = Do Not Resuscitate DPOA = Durable Power of Attorney ICN = Infection Control Nurse IDT = Interdisciplinary Team LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set assessment NA = Not Applicable PPE = Personal Protective Equipment PRN = As Needed POST = Physician Orders For Scope of Treatment RN = Registered Nurse</p>	F 000			
F 578 SS=E	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p>	F 578		2/18/19	

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

TITLE

(X6) DATE

Electronically Signed

02/11/2019

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 578	<p>Continued From page 1</p> <p>§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.</p> <p>§483.10(g)(12) The facility must comply with the 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: Based on record review, policy review, and staff and resident interview, it was determined the</p>	F 578	<p>Corrective Action: Advanced directive were reviewed with resident and resident</p>		

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F 578	<p>Continued From page 2</p> <p>facility failed to ensure a current copy of a residents' Advance Directives were readily accessible to staff in the residents' record, follow-up procedures were in place, and the residents' record included documentation of this process, or documentation of their decision not to formulate Advance Directives. This was true for 13 of 14 residents (#1, #5, #12, #14, #20, #25, #33, #36, #39, #44, #57, #59, and #217) who were reviewed for advance directives. This failure created the potential for harm if a resident's medical treatment wishes were not followed due to lack of documentation in the record. Findings include:</p> <p>The facility's Advance Directives policy and procedure, dated November 2016, documented upon admission residents or their representative provided a copy of the advance directive for placement in the resident's medical record. Each resident or representative was provided a Resident Handbook containing the Advance Directive Notice and information on advance directives resources. The facility obtained written acknowledgement of the receipt of the information in the Admission Agreement. For each resident who did not have advance directives and wished to prepare one, the facility was to provide information related to the purpose of advance directives. Advance directives were discussed and reviewed during the care plan conference and this was documented in the resident's record.</p> <p>a. Resident #33 was initially admitted to the facility on 9/6/18, and readmitted on 1/2/19, with multiple diagnoses including left side hemiplegia and hemiparesis (paralysis and weakness)</p>	F 578	<p>representative for residents #1, #5, #12, #14, #20, #25, #36, #39, #57, and #217. For residents who don't have advanced directives, the resident and or resident representative was educated on advanced directives. Residents have the option to execute them and if they do we will obtain a copy for their medical records. Resident #33, #44, and #59 has discharge from the facility.</p> <p>Identification of others: An audit of other resident medical records was conducted by the LSW or designee no later than 2/18/19 to validate that other residents have advanced directive or have been notified and educated of advanced directives.</p> <p>Systematic Changes: An in-service was conducted by the NHA on or before 2/18/19. The in-service will educate LSW, and Admission Coordinator on the importance of having advanced directives in the medical records. The in-service will cover education that needs to be provided to resident and resident representative about advanced directives, the expectation of having advanced directives in the medical record if they are executed, and follow up with resident and resident representative to reevaluate advanced directives or educate on advanced directives on a quarterly basis</p> <p>Monitor: An audit tool was developed by the LSW or designee no later than</p>		

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F 578	<p>Continued From page 3 following cerebral infarction (stroke), generalized muscle weakness, and malaise (a feeling of weakness or discomfort).</p> <p>Resident #33's POST, dated 1/9/19, documented a status of Full Code, and the presence of a Living Will and DPOA. The POST was signed by her son on 1/6/19.</p> <p>Resident #33's record included a Care Conference note, dated 1/2/19, which documented admission paperwork was reviewed with her and she had Advance Directives.</p> <p>Resident #33's record did not contain her Advance Directives, and did not include documentation the facility followed-up with her or her representative regarding Advance Directives.</p> <p>b. Resident #39 was admitted to the facility on 10/13/18, with multiple diagnoses including encephalopathy (brain disease), depression, bipolar disorder, generalized muscle weakness, Diabetes Mellitus Type 2, dysphagia (difficult swallowing), and anxiety.</p> <p>Resident #39's POST, dated 10/15/18, documented a status of Full Code and was signed by his father on 10/14/18.</p> <p>Resident #39's record included a Care Conference note, dated 10/16/18, which documented the admission paperwork was reviewed with him and "NA" was documented in the Advance Directives section.</p> <p>Resident #39's record did not contain Advance Directives and did not include documentation the</p>	F 578	<p>2/18/19. The tool will be utilized to monitor current residents with advanced directives, the last time advanced directives were reviewed, and follow up with resident and or resident representative if no advanced directives are created. The audit will be conducted weekly for four weeks than monthly for two more months. The results of the audit will be brought to the monthly Quality Assurance meeting for review and recommendations for three months and as needed beginning with the next Quality Assurance meeting scheduled for 2/20/19.</p>		

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F 578	<p>Continued From page 4 facility followed-up with Resident #39 or his representative regarding Advance Directives.</p> <p>c. Resident #44 was admitted to the facility on 8/30/17, with multiple diagnoses including generalized muscle weakness, dysphagia (difficulty swallowing), and difficulty walking.</p> <p>Resident #44's POST, dated 11/20/18, documented a code status of DNR and the presence of a Living Will, and it was signed by her.</p> <p>Resident #44's record included a Care Conference note, dated 11/20/18, which documented admission paperwork was reviewed with her and her son was bringing a copy of her Advance Directives.</p> <p>Resident #44's record did not contain Advance Directives, and did not include documentation the facility followed-up with Resident #44 or her representative regarding Advance Directives.</p> <p>d. Resident #57 was admitted to the facility on 10/3/18, with multiple diagnoses including end stage renal (kidney) disease, paraplegia (partial paralysis), Diabetes Mellitus Type 2, depression, and amputation of the left leg below the knee.</p> <p>Resident #57's POST, dated 12/18/18, documented a status of Full Code, and was signed by him.</p> <p>Resident #57's record included a Care Conference note, dated 12/20/18, which documented admission paperwork was reviewed</p>	F 578			

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F 578	<p>Continued From page 5 with him and "NA" was documented in the Advance Directives section.</p> <p>Resident #57's record did not contain Advance Directives, and did not include documentation the facility followed-up with Resident #57 regarding Advance Directives.</p> <p>e. Resident #59 was admitted to the facility on 12/27/18, with multiple diagnoses including Diabetes Mellitus Type 2, schizophrenia, bipolar disorder, anxiety, multiple sclerosis, obesity, and left leg fracture.</p> <p>Resident #59's POST, dated 12/27/18, documented a status of Full Code, and it was signed by her.</p> <p>Resident #59's record included a Care Conference note, dated 12/28/18, which documented admission paperwork was reviewed with her and was it noted she did not have Advance Directives.</p> <p>Resident #59's record did not contain Advance Directives, and did not include documentation the facility followed-up with Resident #59 regarding Advance Directives.</p> <p>f. Resident #217 was admitted to the facility on 1/4/19, with multiple diagnoses including Diabetes Mellitus Type 2, right ankle and foot osteomyelitis (bone bacterial infection), depression, and obesity.</p> <p>Resident #217's care conference note, dated 1/8/19, documented admission paperwork was reviewed with her and "NA" was documented in</p>	F 578			

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F 578	<p>Continued From page 6 the Advance Directives section.</p> <p>Resident #217's record did not contain Advance Directives, and it did not include documentation the facility followed-up with Resident #217 regarding Advance Directives.</p> <p>On 1/17/19 at 4:45 PM, Resident #217 stated on admission, the facility provided a packet of information regarding a Living Will and did not assist her with filling it out. Resident #217 stated she did not have a living will.</p> <p>g. Resident #1 was admitted to the facility on 1/12/18, with multiple diagnoses including generalized muscle weakness, obesity, and acute kidney failure.</p> <p>A POST form, dated 1/15/18, documented Resident #1 was a DNR. The POST form was signed by Resident #1 and it was discussed with him on 1/15/18.</p> <p>Resident #1's record did not contain Advanced Directives or other documentation Advanced Directives were periodically reviewed and offered to him. There was no other documentation regarding his wishes other than the POST form.</p> <p>h. Resident #12 was re-admitted to the facility on 4/27/18, with multiple diagnoses, including cerebral infarction (stroke), hemiplegia and hemiparesis (paralysis and weakness on one side), and aphasia (loss of ability to understand or express speech).</p> <p>Resident #12's POST form documented she was a Full Code. The POST form was signed by</p>	F 578			

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F 578	<p>Continued From page 7</p> <p>Resident #12's representative on 4/30/18.</p> <p>Resident #12's record did not contain Advanced Directives or other documentation Advanced Directives were periodically reviewed and offered to her. There was no other documentation regarding her wishes other than the POST form.</p> <p>i. Resident #14 was re-admitted to the facility on 7/19/18, with multiple diagnoses including Diabetes Mellitus Type 2 and end stage renal (kidney) disease.</p> <p>Resident #14's POST documented he was a Full Code. The POST form was signed by Resident #14's representative on 7/19/18.</p> <p>Resident #14's record did not contain Advanced Directives or other documentation Advanced Directives were periodically reviewed and offered to him. There was no other documentation regarding his wishes other than the POST form.</p> <p>j. Resident #20 was re-admitted to the facility on 10/16/18, with multiple diagnoses including Multiple Sclerosis, Diabetes Mellitus Type 2, and chronic diastolic (congestive) heart failure.</p> <p>Resident #20's POST documented she was a Full Code. The POST was signed by her and was signed and dated by the physician on 6/13/18.</p> <p>Resident #20's record did not contain Advanced Directives or other documentation Advanced Directives were periodically reviewed and offered to her. There was no other documentation regarding her wishes other than the POST form.</p>	F 578			

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F 578	<p>Continued From page 8</p> <p>k. Resident #36 was readmitted to the facility on 7/27/18, with multiple diagnoses including heart failure.</p> <p>Resident #36's POST, dated 7/27/18, documented her code status as a Full Code and was signed by her. The POST did not document she had Advanced Directives or a Living Will.</p> <p>Resident #36's care conference note, dated 7/28/18, documented admission paperwork was reviewed with her and "NA" was documented in the Advance Directives section.</p> <p>Resident #36's record did not include the facility followed-up with Resident #36 regarding Advance Directives.</p> <p>On 1/17/18 at 2:35 PM, Resident #36 said she wanted to be resuscitated and had a Living Will. She said no one at the facility had asked for a copy of her Living Will since she was admitted.</p> <p>On 1/18/19 at 10:12 AM, the LSW said she completed Resident #36's care conference documentation, dated 7/28/18, and said the "NA" meant Resident #36 did not have Advance Directives. She said she had not documented what else was discussed regarding Advance Directives.</p> <p>l. Resident #5 was admitted to the facility on 6/17/18, with multiple diagnoses including Diabetes Mellitus Type 2.</p> <p>Resident #5's POST, dated 6/17/18, documented her code status was DNR and was signed by her</p>	F 578			

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NAME OF PROVIDER OR SUPPLIER  <b>TETON POST ACUTE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 578	<p>Continued From page 9 representative. The POST documented she had a Living Will. Resident #5's record did not contain a copy of her Living Will.</p> <p>Resident #5's record included a Social Service note, dated 6/19/18, which documented a care conference was completed. The note did not include documentation Advance Directives were discussed with Resident #5 or her family member.</p> <p>Resident #5's record did not include the facility followed-up with Resident #5 or her family regarding Advance Directives.</p> <p>On 1/17/18 at 8:42 AM, Resident #5 said she had a Living Will and her family took care of that for her.</p> <p>On 1/18/19 at 10:20 AM, the LSW said she did not document if she discussed Advance Directives with Resident #5 or her family during the 6/19/18 care conference.</p> <p>m. Resident #25 was admitted to the facility on 8/24/17, with multiple diagnoses including atrial fibrillation (irregular heart rate) and disorientation.</p> <p>Resident #25's POST, dated 4/20/18, documented his code status was DNR and was signed by his responsible party. The POST documented he did not have Advance Directives.</p> <p>On 1/16/19 at 8:19 AM, the DON said if there was Advanced Directives, it was in the resident's record. The DON said the Advance Directives were handled by the primary care provider, family, or representative, and the facility followed</p>	F 578			

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F 578	Continued From page 10 the direction of the POST.  On 1/16/18 at 9:00 AM, the LSW said Advance Directives were in residents' charts. She said each resident had a POST, and the facility followed the POST. The LSW said, on admission, the resident, family, or representative was asked to provide the facility with a copy of their Advance Directives, and if a resident did not have Advance Directives, information was provided, and the facility did not produce or assist the resident in completing Advance Directives. The LSW stated there was not a note related to Advance Directives, an update, or change unless the resident initiated the request.  On 1/18/19 at 10:25 AM, the Admissions Director said during an admission she made sure there was a POST and talked about Advance Directives with residents and their families. She said if residents had a copy of their Advance Directives, then she asked them for a copy. The Admissions Director said she did not follow-up with residents and/or families regarding Advance Directives and she placed that responsibility on the residents and/or families to follow-up with providing those copies. She said if residents did not have Advance Directives, she referred them and/or their families to the LSW to discuss their options.	F 578			
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		2/18/19	

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F 656	<p>Continued From page 11</p> <p>§483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it</p>	F 656	<p>Corrective Action: Resident-centered</p>		

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F 656	<p>Continued From page 12</p> <p>was determined the facility failed to develop and implement comprehensive resident-centered care plans that included the residents' code status, such as DNR or Full Code. This was true for 13 of 16 residents (#1, #5, #12, #20, #25, #33, #36, #39, #44, #52, #57, #59, and #217) whose care plans were reviewed. This failure created the potential for residents to receive inappropriate or inadequate care and for their resuscitation code status wishes to not be honored. Findings include:</p> <p>a. Resident #33 was initially admitted to the facility on 9/6/18, and readmitted on 1/2/19, with multiple diagnoses including left side hemiplegia and hemiparesis (paralysis and weakness) following cerebral infarction (stroke), generalized muscle weakness, and malaise (a feeling of weakness or discomfort).</p> <p>Resident #33's POST, dated 1/9/19, documented a status of Full Code, and the presence of a Living Will and DPOA. The POST was signed by her son on 1/6/19.</p> <p>Resident #33's current comprehensive care plan did not include documentation of her code status.</p> <p>b. Resident #39 was admitted to the facility on 10/13/18, with multiple diagnoses including encephalopathy (brain disease), depression, bipolar disorder, generalized muscle weakness, Diabetes Mellitus type 2, dysphagia (difficult swallowing), and anxiety.</p> <p>Resident #39's POST, dated 10/15/18, documented a status of Full Code, and was signed by his father on 10/14/18.</p>	F 656	<p>care plans were reviewed for a current code status. Resident #1, #5, #12, #20, #25, #36, #39, #52 #57, #217 comprehensive care plan was updated to reflect current code status. Resident #33, #44, and #59 was discharged from the facility</p> <p>Identification of others: An audit of other resident medical records was conducted by DNS or designee n later than 2/18/19 to validate that other residents have a care plan with the resident's code status. If a resident care plan doesn't have a current code status the care plan was updated to reflect current code status.</p> <p>Systematic Changes: An in-service was conducted to licensed nurses by the DON or designee on or before 2/18/19. An in service educated the license staff about code status care plans and how to update the care plan if a code status is to be changed.</p> <p>Monitor: An audit tool was developed by the DON or designee to monitor all residents code status care plans. The DON or designee will audit ten random charts weekly times four weeks and then monthly times two months to validate that the code status care plan is in place and it reflects the current status of the POST. The results of the audit will be brought to the monthly Quality Assurance meeting for review and recommendations for three months and as needed beginning with the next Quality Assurance meeting</p>		

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F 656	Continued From page 13  Resident #39's current comprehensive care plan did not include documentation of his code status.  c. Resident #44 was admitted to the facility on 8/30/17, with multiple diagnoses including generalized muscle weakness, dysphagia (difficulty swallowing), and difficulty walking.  Resident #44's POST, dated 11/20/18, documented a code status of DNR and the presence of a Living Will, and it was signed by her.  Resident #44's current comprehensive care plan did not include documentation of her code status.  d. Resident #57 was admitted to the facility on 10/3/18, with multiple diagnoses including end stage renal (kidney) disease, paraplegia (partial paralysis), Diabetes Mellitus Type 2, depression, and amputation of the left leg below the knee.  Resident #57's POST, dated 12/18/18, documented a status of Full Code and was signed by him.  Resident #57's current comprehensive care plan did not include documentation of his code status.  e. Resident #59 was admitted to the facility on 12/27/18, with multiple diagnoses including Diabetes Mellitus Type 2, schizophrenia, bipolar disorder, anxiety, multiple sclerosis, obesity, and left leg fracture.  Resident #59's POST, dated 12/27/18, documented a status of Full Code and was	F 656	scheduled for 2/20/19.		

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F 656	<p>Continued From page 14 signed by her.</p> <p>Resident #59's current comprehensive care plan did not include documentation of her code status.</p> <p>f. Resident #217 was admitted to the facility on 1/4/19, with multiple diagnoses including Diabetes Mellitus Type 2, right ankle and foot osteomyelitis (bone bacterial infection), depression, and obesity.</p> <p>Resident #217's current comprehensive care plan did not include documentation of her code status.</p> <p>On 1/17/19 at 9:13 AM, LPN #2 stated the code status should be in the care plan but was unable to provide documentation of the code status for Resident #217.</p> <p>g. Resident #1 was admitted to the facility on 1/12/18, with multiple diagnoses including generalized muscle weakness, obesity, and acute kidney failure.</p> <p>A POST form, dated 1/15/18, documented Resident #1 was a DNR. The POST form was signed by Resident #1 and it was discussed with him on 1/15/18.</p> <p>Resident #1's care plan did not include documentation of his code status.</p> <p>h. Resident #12 was re-admitted to the facility on 4/27/18, with multiple diagnoses including cerebral infarction (stroke), hemiplegia and hemiparesis (paralysis and weakness on one side), and aphasia</p>	F 656			

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F 656	<p>Continued From page 15 (loss of ability to understand or express speech).</p> <p>Resident #12's POST form documented she was a Full Code. The POST form was signed by Resident #12's representative on 4/30/18.</p> <p>Resident #12's care plan did not include documentation of her code status.</p> <p>i. Resident #20 was re-admitted to the facility on 10/16/18 with multiple diagnoses, including Multiple Sclerosis, Diabetes Mellitus Type 2, and chronic diastolic (congestive) heart failure.</p> <p>Resident #20's POST form documented she was a Full Code. The POST was signed by her and was signed and dated by the physician on 6/13/18.</p> <p>Resident #20's care plan did not include documentation of her code status.</p> <p>j. Resident #52 was re-admitted to the facility on 3/7/18 with multiple diagnoses, including Alzheimer's disease and atherosclerotic heart disease.</p> <p>Resident #52's POST documented she was a DNR. The POST was signed by Resident #52 on 2/10/18.</p> <p>Resident #52's Living Will and Durable Power of Attorney for Health Care documented she wished that all medical treatment, care, and procedures should be withheld or withdrawn, including artificial nutrition and hydration.</p> <p>Resident #52's care plan did not include</p>	F 656			

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F 656	<p>Continued From page 16 documentation of her code status.</p> <p>k. Resident #36 was readmitted to the facility on 7/27/18, with multiple diagnoses including heart failure.</p> <p>Resident #36's POST, dated 7/27/18, documented her code status was a Full Code and was signed by her.</p> <p>Resident #36's current care plan record did not include her code status.</p> <p>On 1/17/18 at 2:35 PM, Resident #36 said she wanted to be resuscitated if she were to stop breathing or her heart stopped.</p> <p>l. Resident #5 was admitted to the facility on 6/17/18, with multiple diagnoses including Diabetes Mellitus Type 2.</p> <p>Resident #5's POST, dated 6/17/18, documented her code status was a DNR and was signed by her representative.</p> <p>Resident #5's current care plan did not include documentation of her code status.</p> <p>m. Resident #25 was admitted to the facility on 8/24/17, with multiple diagnoses including atrial fibrillation (irregular heart rate) and disorientation.</p> <p>Resident #25's POST, dated 4/20/18, documented his code status was a DNR and was signed by his responsible party.</p> <p>On 1/17/19 at 2:45 PM, LPN #1 said residents' code status was found on the POST.</p>	F 656			

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F 656	Continued From page 17  On 1/17/19 at 2:49 PM, LPN #4 said residents' code status was found on the POST and was not documented in the care plans.  On 1/17/18 at 4:26 PM, LPN #6 said residents' code status was found on the POST.  On 1/17/19 at 9:13 AM, LPN #2 stated she looked at the chart for the POST of the resident to know their code status.  On 1/18/19 at 8:33 AM, the DON said the residents' code status was indicated on the POST. The DON said the code status was not documented on residents' care plans. The DON said she wanted staff to refer only to the POST for residents' code status. The DON said she was not aware the code status should be on the care plan.	F 656			
F 657 SS=E	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).	F 657		2/18/19	

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F 657	<p>Continued From page 18</p> <p>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 record review and interviews with residents and staff, it was determined the facility failed to ensure care conferences occurred quarterly, care conferences included all members of the IDT, and care plans were revised as a result of the conferences. This was true for 6 of 16 residents (#1, #5, #14, #20, #23, and #36) whose care plans were reviewed. This failure placed residents at risk of harm if their care plans were not reviewed and revised to ensure care and services met their medical, physical, and psychosocial needs. Findings include:</p> <p>1. Residents did not have care conferences quarterly or include all members of the IDT. Examples include:</p> <p>a. Resident #1 was admitted to the facility on 1/12/18, with multiple diagnoses including generalized muscle weakness, obesity, and acute kidney failure.</p> <p>A Social Service note, dated 4/18/18, documented the Social Services Director met</p>	F 657	<p>Corrective Action: Care conferences were schedule for residents #1, #5, #14 #20, #23, #36 and then will follow in a quarterly calendar. Resident #23 care plan was updated to reflect current condition of the resident and will be reviewed quarterly.</p> <p>Identification of others: An audit of other residents care conferences was completed no later than 2/18/2019. Residents in need of a care conference will be notified of next schedule care conference and they can choose to stick to that date or they can request to have one done as soon as possible.</p> <p>Systematic Changes: An in-service was conducted to the Inter Disciplinary Team by the ED or designee before 2/18/19. The in service will educate team members on quarterly care conferences and how they will be scheduled. An in service will be conducted to the license</p>		

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F 657	<p>Continued From page 19 with Resident #1. The note documented Resident #1 was "doing good" and the long term plan was for Resident #1 to remain at the facility in long-term care. Resident rights were reviewed with him, and he had no other concerns.</p> <p>On 1/15/19 at 9:36 AM, Resident #1 said he did not recently attend a care plan meeting.</p> <p>On 1/17/19 at 12:40 PM, the LSW said Resident #1's most recent care plan meeting was on 4/18/18.</p> <p>b. Resident #14 was re-admitted to the facility on 7/19/18, with multiple diagnoses including Diabetes Mellitus Type 2 and end stage renal (kidney) disease.</p> <p>Resident #14's Care Conference note, dated 7/19/18, documented social services and Resident #14 attended the conference. The note documented Resident #14's family member came in prior to the meeting and completed a POST (a document indicating the resident's wishes regarding resuscitation and interventions during an emergency).</p> <p>A Care Conference note, dated 11/9/18, documented Social Services was the only attendee. The note documented "Went over change of room," and Resident #14 agreed to move into a long-term care room.</p> <p>On 1/15/19 at 1:25 PM, Resident #14 said he did not have a care plan meeting after his initial meeting following admission to the facility.</p> <p>On 1/17/19 at 12:00 PM, the LSW said she could</p>	F 657	<p>staff by the DON or designee to educate on care plans.</p> <p>Monitor: An audit tool was developed by the LSW to audit that resident were current on quarterly care conference. The audit will choose 10 random charts to be audited weekly times four weeks than monthly for two months. The DON or designee will create an audit to monitor care plans to validate accurate reflection of resident condition weekly times four weeks than monthly time two months. The results of the audit will be brought to the monthly Quality Assurance meeting for review and recommendations for three months and as needed beginning with the next Quality Assurance meeting scheduled for 2/20/19.</p>		

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F 657	<p>Continued From page 20</p> <p>not find Resident #14's last care conference, and residents should have care conferences quarterly.</p> <p>On 1/17/19 at 12:40 PM, the LSW provided the previously mentioned documentation of Resident #14's last care plan conference, dated 11/9/18, with the LSW as the only attendee. The LSW said she had talked to residents by herself at times for the care plan conference.</p> <p>c. Resident #20 was re-admitted to the facility on 10/16/18, with multiple diagnoses including Multiple Sclerosis, Diabetes Mellitus Type 2, and chronic diastolic (congestive) heart failure.</p> <p>A Care Conference Note, dated 6/12/18, documented Resident #20, Resident #20's responsible party, social services, and a therapy staff member attended the conference.</p> <p>On 1/15/19 at 9:00 AM, Resident #20 said she had not attended a care plan meeting recently.</p> <p>On 1/17/19 at 5:35 PM, the LSW said the 6/12/18 meeting was the last care conference held for Resident #20.</p> <p>d. Resident #5 was admitted to the facility on 6/17/18, with multiple diagnoses including Diabetes Mellitus Type 2.</p> <p>A Social Services note, dated 6/19/18, documented a care conference was conducted with Resident #5, her representative, social services, nursing, and therapy. There was no further documentation of other care conferences in Resident #5's record.</p>	F 657			

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F 657	<p>Continued From page 21</p> <p>On 1/18/19 at 10:20 AM, the LSW said the most recent care conference for Resident #5 was completed on 6/19/18. The LSW said due to schedule challenges, quarterly care conferences were not always conducted.</p> <p>e. Resident #36 was readmitted to the facility on 7/27/18, with multiple diagnoses including heart failure.</p> <p>A Care Conference note, dated 7/28/18, documented a care conference was conducted with Resident #36, social services, nursing, and therapy. There was no further documentation of other care conferences in Resident #36's record.</p> <p>On 1/18/19 at 10:20 AM, the LSW said the most recent care conference for Resident #36 was completed on 7/28/18. The LSW said due to schedule challenges, quarterly care conferences were not always conducted.</p> <p>On 1/17/19 at 2:06 PM, the LSW said she scheduled residents' care conferences. She stated, along with herself, the care conferences were usually attended by a charge nurse and therapy staff member. The LSW said if a resident was cognitively intact, she asked the resident if they wanted her to invite anybody else to the care conference. The LSW said if the resident was not cognitively intact, she called the resident's listed representative and asked if they wanted to come to the care plan conference. The LSW said sometimes with the quarterly care conferences it was difficult to schedule with everybody and she talked to the resident alone.</p>	F 657			

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F 657	<p>Continued From page 22</p> <p>On 1/17/19 at 2:19 PM, the DON said care conferences should be with an IDT. The DON said for residents residing on the short term side of the facility, the IDT should include a nurse, a therapist, and social worker. The DON said for residents residing on the long term side of the facility, the IDT should consist of a nurse, social worker, a therapist (if the resident was receiving therapy), sometimes a dietary staff member if there were concerns, and the resident's family member if they were not able to make their own decisions. The DON said if the resident was able to make their own decisions, facility staff asked the resident if they wanted someone else at the care plan conference. The DON said care plan conferences should occur every quarter for residents residing on the long term side of the facility.</p> <p>2. Resident #23 was admitted to the facility on 4/13/18, with multiple diagnoses including cerebral palsy.</p> <p>Resident #23's quarterly MDS assessment, dated 11/15/18, documented he was severely cognitively impaired, required one staff for transfers and toilet use, and was incontinent of bowel.</p> <p>Resident #23's care plan, dated 5/24/18, directed staff to use one staff member for toileting. The care plan did not document his incontinence status or direct staff when to assist him with his toileting needs. The care plan for Resident #23 was not updated or revised when his toileting status changed.</p> <p>On 1/16/19 at 2:29 PM, CNA #1 said Resident</p>	F 657			

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F 657	Continued From page 23 #23 was incontinent of bowel, used incontinence briefs, and was checked every two hours and before meals.  On 1/16/19 at 2:42 PM, LPN #7 said Resident #23's care plan was not revised to reflect he was incontinent of bowel. LPN #7 said the care plan did not direct staff to check Resident #23 upon rising, before and after meals, at bedtime, and as needed.	F 657			
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)  §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.  §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.  §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on review of facility staffing records and staff interview, it was determined the facility failed to ensure an RN was on duty at least 8 hours a day, 7 days a week. This was true for 1 of 25 days reviewed. The failure created the potential for harm if routine and/or emergency nursing needs went unmet, and had the potential to affect all 65 residents living in the facility. Findings	F 727	Corrective Action: This was an isolated incident and there was no negative outcome. The nursing schedule was reviewed to validate that there was at least eight consecutive hours of RN coverage daily for the month of February  Identification of others: Other residents in	2/18/19	

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F 727	Continued From page 24 include:  The facility provided the nursing schedule for 12/23/18 to 1/16/19. The nursing schedule documented there was no RN coverage on 12/25/18. The time punches for 12/25/18, did not include an RN was on duty.  On 1/18/19 at 10:20 AM, the Administrator said RN hours were to be 8 continuous hours each day, and there was no RN on duty on 12/25/18 due to the holiday.	F 727	the building on 12/25/2019 were not negatively affected by not having a Registered Nurse for eight hours. The nursing schedule was reviewed to validate that there was at least eight consecutive hours of RN coverage daily for the month of February.  Systematic Changes: An in-service was conducted to the nurse management team by the ED that will discuss the requirements of Register Nurse coverage. The education was completed by 02/18/19.  Monitor: An audit tool was created by the DON to validate that there is always eight hours of Register Nurse in the building daily. The audit will be done daily times one month than weekly for two months. The results of the audit will be brought to the monthly Quality Assurance meeting for review and recommendations for three months and as needed beginning with the next Quality Assurance meeting scheduled for 2/20/19.		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §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	F 758		2/18/19	

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F 758	<p>Continued From page 25</p> <p>(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 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</p>	F 758			

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F 758	<p>Continued From page 26</p> <p>by: Based on record review, facility policy review, and staff interviews, it was determined the facility failed to ensure there was adequate behavior monitoring for residents receiving psychotropic medications. This was true for 3 of 5 residents (#14, #20, and #25) who were reviewed for unnecessary medications. This failed practice created the potential for harm should residents experience adverse reactions and behaviors from psychotropic medications. Findings include:</p> <p>The facility's policy and procedure for Psychotropic Drugs, dated September 2017, documented prior to initiating psychotropic drugs, the IDT reviews the medical record, including the Behavior Monitoring Flowsheet.</p> <p>The facility's policy and procedure for Behavior Management, dated May 2002, documented the following:</p> <ul style="list-style-type: none"> <li>* The Behavior Monitor Flowsheet (number of behaviors, trigger, intervention, and outcome) was completed when the indicated behaviors were exhibited.</li> <li>* The IDT reviewed the resident's record and the Behavior Monitor Flowsheet to assess whether the current plan was effective. If further assessment was needed, modifications were made, including changes to the care plan and Behavior Monitor Flowsheet.</li> <li>* The Behavior Monitor Flowsheet was totaled each month and was reviewed quarterly at the behavior meeting, or more frequently as decided by the IDT.</li> </ul> <p>1. Resident #14 was re-admitted to the facility on</p>	F 758	<p>Corrective Action: Psychotropic Medications, behavior monitors, and psychotropic care plans were reviewed for the following residents #14, #20, #25. LSW ensured that each target behavior being monitored (for each of these residents) was also included to reflect the appropriate care plan. LSW ensured that for each medication ordered an appropriate target behavior monitor was in place.</p> <p>Identification of others: Other residents on Psychotropic medications reviewed and had target behaviors reflected on their psychotropic care plans and updated to ensure target behaviors are appropriate for each resident.</p> <p>Systematic Changes: An in-service was conducted with the LSW, nurse managers, MDS nurses, floor nursing staff to ensure that residents on psychotropic medications had the appropriate target behavior being monitored and reflected on their care plan.</p> <p>Monitor: An audit tool was developed by the LSW or designee to validate that the correct target behaviors are identified and reflected on the correct care plan for psychotropic medications. This audit will be done weekly times four weeks and then monthly for two months. The audits will be brought to the monthly Quality Assurance Meeting for review and</p>		

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F 758	<p>Continued From page 27 7/19/18, with multiple diagnoses including major depressive disorder and anxiety disorder.</p> <p>Resident #14's quarterly MDS assessment, dated 10/26/18, documented he was cognitively intact, he received anti-anxiety medication on 5 of the last 7 days, and he received antidepressant medication on 7 of the last 7 days.</p> <p>Resident #14's physician orders included Effexor XR 150 mg (milligrams) once a day for depression, ordered on 7/19/18, and Klonopin 1 mg daily for insomnia with anxiety, ordered on 12/12/18.</p> <p>Resident #14's care plan documented he used anti-anxiety medication related to real or perceived stressful situations and he used antidepressant medication related to a major loss or stressful situation. The care plan directed staff to monitor/document occurrences of target behavior symptoms, such as excessive worrying. There were no directions on the care plan to monitor for target behaviors related to depression.</p> <p>Resident #14's Behavior Monitoring Flowsheet, dated January 2019, documented the monitored behavior was isolation. There were no other behaviors listed to be monitored, which related to either his depression or anxiety.</p> <p>On 1/17/19 at 2:17 PM, the LSW said for residents on psychotropic medications, there was behavior monitoring and it was reflected on the care plan. The LSW said Resident #14 struggled with self isolation related to depression, and there should have been behavior monitoring</p>	F 758	<p>recommendations; next Quality Assurance Meeting is scheduled on 2/20/2019.</p>		

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F 758	<p>Continued From page 28 addressing his anxiety.</p> <p>On 1/17/19 at 2:29 PM, the DON said she expected anxiety behaviors for Resident #14 to be monitored. The DON said if Resident #14 had depression then the Behavior Monitoring Flowsheet should include symptoms or behaviors related to his depression. The DON said self isolation may be adequate behavior monitoring for depression. She said a behavior related to anxiety should be on the Behavior Monitor. The DON said she had known Resident #14 to exhibit anxiety related to his dreams.</p> <p>2. Resident #20 was re-admitted to the facility on 10/16/18, with multiple diagnoses including major depressive disorder.</p> <p>Resident #20's Significant Change MDS assessment, dated 1/23/18, documented she received antidepressant medication on 7 of the last 7 days.</p> <p>Resident #20's physician orders included the following:</p> <ul style="list-style-type: none"> <li>* Elavil 50 mg once a day for depression, ordered on 10/16/18.</li> <li>* Wellbutrin SR 150 mg once daily for depression, ordered on 10/16/18.</li> <li>* Zoloft 200 mg once daily for depression, ordered on 10/16/18.</li> </ul> <p>Resident #20's care plan documented she used antidepressant medication. The care plan directed staff to monitor and document for target behavior symptoms, and the intervention was initiated on 6/13/18. The care plan did not include</p>	F 758			

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F 758	<p>Continued From page 29</p> <p>specific behaviors for staff to monitor related to Resident #20's depression.</p> <p>Resident #20's January 2019 Behavior Monitoring Flowsheet documented the behavior being monitored was agitation. There were no other behaviors documented for monitoring.</p> <p>On 1/18/19 at 8:50 AM, the LSW said Resident #20 struggled with self isolation and irritable mood. The DON said depression could be exhibited by crying or being upset, but she had not observed Resident #20 crying. The DON said she observed Resident #20 being angry and resistive to care.</p> <p>3. Resident #25 was admitted to the facility on 8/24/17 with multiple diagnoses, including psychosis and disorientation.</p> <p>Resident #25's current physician orders, dated 8/29/18, documented Seroquel 50 mg once a day for psychosis.</p> <p>Resident #25's December 2018 MAR documented he received the Seroquel daily and had behavior monitors for agitation, delusions, and hallucinations. His January 2019 MAR documented he received the Seroquel daily and did not have behavior monitors for delusions or hallucinations.</p> <p>Resident #25's current care plan documented he used psychotropic medication related to psychosis. His care plan directed staff to monitor target behavior symptoms, including verbal aggression toward others.</p>	F 758			

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F 758	Continued From page 30 On 1/17/19 at 3:44 PM, LPN #6 said Resident #25's January MAR included behavior monitors for his agitation, and she was not sure why his delusions or hallucinations were not monitored.  On 1/18/19 at 11:43 AM, the LSW said she was not sure why Resident #25's behavior monitors for delusions and hallucinations related to the Seroquel usage were not monitored in January. The LSW said Resident #25 had delusions of being at home, would expose himself in public and would yell at others for being in his house, which distressed him and others.	F 758			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §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.  §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:  §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	F 880		2/18/19	

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NAME OF PROVIDER OR SUPPLIER  <b>TETON POST ACUTE CARE &amp; REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3111 CHANNING WAY IDAHO FALLS, ID 83404</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 31 standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> <li>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</li> <li>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</li> <li>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</li> <li>(iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> <li>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</li> <li>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</li> </ul> </li> <li>(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</li> <li>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</li> </ul> <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</p>	F 880			

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F 880	<p>Continued From page 32 infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff used PPE appropriately to prevent contamination and the possible spread of infection. This was true for 2 or 2 staff (ICN and LPN #3) who were observed using PPE. This failure created the potential for harm if residents developed infection from cross-contamination. Findings include: According to the Association for Professionals in Infection Control and Epidemiology (APIC), website accessed 2/1/19, the brochure for "Infection Prevention and You" stated respiratory hygiene and cough etiquette are infection prevention measures to decrease the transmission of respiratory illness such as influenza or colds. APIC stated the use of a mask when coughing are part of the standard precautions which should be taken to prevent the spread of disease. The Centers for Disease Control and Prevention (CDC), website accessed 2/1/19, stated a mask should fully cover the nose and mouth in a training "Guidance for the Selection and Use of Personal Protective Equipment (PPE) in Healthcare Settings." On 1/15/19 at 10:30 AM, 1:26 PM and 2:06 PM and on 1/16/19 at 3:04 PM and 3:32 PM, the ICN and LPN #3 were observed wearing masks which did not cover their noses. Both were working among staff and residents, in the nursing station, and in the facility's charting room.</p>	F 880	<p>Corrective Action: All resident in the building on 1/15/19, 1/16/19, and 1/17/19 could have been affected with staff members not wearing PPE mask correctly. Staff were corrected on proper use of PPE mask.</p> <p>Identification of others: Other residents in the building on 1/15/19, 1/16/19, and 1/17/19 could have been affected with staff members not wearing PPE mask correctly. Staff were corrected on proper use of PPE mask.</p> <p>Systematic Changes: An in-service to staff was conducted by the DON or designee to discuss the proper use of PPE's. The education was completed before 2/18/19.</p> <p>Monitor: An audit tool was developed by the DON or designee to validate that PPE mask are being used properly. The audit will be done weekly times four weeks than monthly for two months. The results of the audit will be brought to the monthly Quality Assurance meeting for review and recommendations for three months and as needed beginning with the next Quality Assurance meeting scheduled for 2/20/19.</p>		

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F 880	<p>Continued From page 33</p> <p>On 1/17/19 at 9:16 AM, LPN #3 was observed without a mask and she stated she should have had a mask on while sitting at the nursing station. LPN #3 stated she was wearing a mask because she seemed to be "catching what was going around." LPN #3 stated she had only worn the mask below her nose only in the room for charting, however, during survey, she was observed among staff and residents going in and out of the charting room. She stated she knew the mask was not effective if it was not covering her nose.</p> <p>On 1/17/19 at 9:42 AM, the ICN stated she was wearing the mask because she had a viral infection. The ICN stated she was not aware the mask was not covering her nose on several occasions.</p> <p>On 1/17/19 at 4:47 PM, the ICN and LPN #3 were observed wearing masks below their nose.</p>	F 880			