



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

February 7, 2020

Eric Miller, Administrator
Coeur d'Alene Health & Rehabilitation of Cascadia
2514 North Seventh Street
Coeur d'Alene, ID 83814-3720

Provider #: 135052

Dear Mr. Miller:

On **January 24, 2020**, a survey was conducted at Coeur d'Alene Health & Rehabilitation 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 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.

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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 18, 2020**. Failure to submit an acceptable PoC by **February 18, 2020**, may result in the imposition of penalties by **March 11, 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 28, 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 24, 2020**. A change in the seriousness of the deficiencies on **March 9, 2020**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **April 24, 2020** includes the following:

Denial of payment for new admissions effective **April 24, 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 24, 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 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 24, 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:

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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 18, 2020**. If your request for informal dispute resolution is received after **February 18, 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,



Laura Thompson, RN, Supervisor
Long Term Care Program

lt/lj

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

PRINTED: 02/28/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/24/2020
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814		
(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 21, 2020 through January 24, 2020. The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator Sallie Schwartzkopf, LCSW Survey Abbreviations: ADL = Activities of Daily Living CNA = Certified Nursing Assistant DON = Director of Nursing GERD = gastroesophageal reflux disease MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams RN = Registered Nurse SDC = Staff Development Coordinator SSD = Social Services Director	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 requirements specified in 42 CFR part 489,	F 578		2/24/20	

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

TITLE

(X6) DATE

Electronically Signed

02/17/2020

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 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 residents received information and assistance to exercise their rights to formulate an advance directive. This was true for 3 of 8 residents (#19, #23, and #100) whose records were reviewed for advance directives. This failed practice created the potential for harm if residents' wishes regarding end of life or emergent care were not honored if they became</p>	F 578	<p>This Plan of Correction is prepared is prepared and submitted as required by law. By submitting this Plan of Correction, Coeur d'Alene of Cascadia does not admit that the deficiencies listed on the CMS Form 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to</p>		

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F 578	<p>Continued From page 2 incapacitated. Findings include:</p> <p>The State Operations Manual, Appendix PP, defined an advance directive" as "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." "Physician Orders for Life-Sustaining Treatment for POST-Physician Orders for Scope of Treatment) 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"> * The facility determined on admission whether the resident had executed an advance directive or had given other instructions to indicate what care the resident desired in case of subsequent incapacity. * If the resident or the resident's legal representative had executed one or more advance directive(s), or executed one upon admission, the facility obtained a copy, incorporated and consistently maintained it in the resident's record, and it was readily retrievable by any facility staff. * If the resident had not executed an advance 	F 578	<p>challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>Resident Specific Resident #19, #23, #100 advance directive information was reviewed with the resident and responsible party to validate there were no changes or additional education resources needed. No further information or requests made at this time</p> <p>Other Residents Current residents were reviewed for date of last advance directive review conducted with resident and/or family to validate compliance. Findings were addressed as indicated.</p> <p>Facility Systems Social Services and Unit Managers were re-educated by the CNO and/or designee on the facility advance directives to include but not limited to the need to review advance directive information upon admission, at least quarterly and with change of condition and document review. The system is amended to include weekly review of residents who have had care plan conferences and/or change of condition to validate advanced directives were discussed.</p> <p>Monitoring Medical Records and/or designee will audit 5 residents with change of condition and/or care conferences for</p>		

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F 578	<p>Continued From page 3</p> <p>directive, the facility advised the resident and family of their right to establish an advance directive, including assisting the resident if they wished to execute one or more directives. The facility advised the resident of the option to execute advance directives and did not require them to do so.</p> <p>* The facility documented in the resident's record discussions regarding advance directives and any healthcare decisions the resident executed.</p> <p>* The facility identified, clarified, and periodically reviewed the existing care instructions and whether the resident wished to change or continue these instructions at least quarterly, after a life altering event (e.g. diagnosis of terminal illness, etc.), and after returning from hospitalization, as part of the comprehensive care planning process,</p> <p>* If a resident changed their advance directives, the facility documented in a progress note the update and current care decisions.</p> <p>This policy was not followed.</p> <p>1. Resident #19 was admitted to the facility on 4/16/19, with multiple diagnoses including multiple sclerosis (a disabling disease of the brain and spinal cord), difficulty in walking, other abnormalities of gait and mobility, schizoaffective disorder (a condition where one feels detached from reality and affects mood), and epilepsy (a chronic disorder characterized by recurrent, unprovoked seizures).</p> <p>Resident #19's physician orders documented Do Not Resuscitate (DNR), dated 4/18/19.</p> <p>Resident #19's quarterly MDS assessment, dated</p>	F 578	<p>documentation that advanced directives were reviewed, and education/resources provided as indicated weekly for 4 weeks, then 3 residents weekly for 8 weeks. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.</p>		

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F 578	<p>Continued From page 4</p> <p>11/12/19, documented she was moderately cognitively impaired.</p> <p>Resident #19's care plan documented her code status was DNR. The care plan directed staff to review advanced directives, code status, and Physician Orders for Scope of Treatment (POST) with her or her representative on admission, with change of condition, and at least quarterly, dated 4/18/19.</p> <p>Resident #19's record did not include documentation of an advance directive, or that it was offered or discussed with her.</p> <p>On 1/24/19 at 10:07 AM, the SSD reviewed Resident #19's record and said she only saw a POST form, and no advance directive was found. The SSD said Resident #19 was moderately cognitively impaired and made her own decisions. The SSD said there was no documentation of a discussion regarding advance directives with Resident #19 at the time of admission. The SSD said a team shared the admission tasks, the advance directive was part of the admission process, and the facility was not in the habit of documenting a discussion took place regarding advance directives.</p> <p>2. Resident #23 was admitted to the facility on 11/1/17, with multiple diagnoses including Type 1 diabetes mellitus with diabetic chronic kidney disease, chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease), chronic viral hepatitis C (viral infection causing liver inflammation), and paranoid schizophrenia (a psychosis where one's mind does not agree with reality and includes delusions and</p>	F 578			

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F 578	<p>Continued From page 5 hallucinations).</p> <p>An Advance Directive Discussion Document, dated 11/2/17, documented Resident #23 did not have an advance directive but he did have a POST.</p> <p>Resident #23's physician orders documented his code status was Full Code, ordered on 6/26/18.</p> <p>Resident #23's Annual MDS Assessment, dated 11/10/19, documented he was cognitively intact.</p> <p>Resident #23's care plan documented his code status was Full Code, and staff were directed to review advanced directives with him and/or his representative on admission and at least quarterly, dated 9/11/18.</p> <p>Resident #23's record did not include an advance directive or documentation it was discussed with him or his representative since 11/2/17.</p> <p>On 1/24/20 at 10:05 AM, the SSD said Resident #23 was cognitively intact, did not have a advance directive, and a discussion regarding developing an advance directive was not documented.</p> <p>3. Resident #100 was admitted to the facility on 1/6/20, with multiple diagnoses including heart failure and dementia.</p> <p>Resident #100's POST documented his wishes were DNR, and it was signed by his wife on 12/27/19.</p> <p>Resident #100's admission MDS assessment,</p>	F 578			

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F 578	Continued From page 6 dated 1/13/20, documented he was moderately cognitively impaired. Resident #100's physician orders documented DNR, dated 1/3/20. Resident #100's baseline care plan documented his code status was DNR. A Social Services note, dated 1/6/20 at 3:12 PM, documented Resident #100's code status was confirmed as DNR at the time of admission. Resident #100's record did not contain documentation of an advanced directive being offered or discussed with him or his representative. On 1/23/20 at 3:07 PM, the SSD said there was only a POST in Resident #100's record. The facility did not ensure residents received information and assistance to exercise their rights to formulate an advance directive.	F 578			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;	F 622		2/24/20	

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F 622	<p>Continued From page 7</p> <p>(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;</p> <p>(D) The health of individuals in the facility would otherwise be endangered;</p> <p>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;</p> <p>or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p>	F 622			

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F 622	<p>Continued From page 8</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c) (1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</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 pertinent information was provided to the receiving facility when a resident was transferred</p>	F 622	<p>Resident Specific</p> <p>Resident #36 is currently a resident of the facility and need to send documentation to a receiving facility is no longer needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/24/2020
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814		
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F 622	<p>Continued From page 9</p> <p>to the hospital. This was true for 1 of 1 resident (Resident #36) who was reviewed for transfer to the hospital. This deficient practice had the potential to cause harm if the resident was not treated appropriately or in a timely manner due to a lack of information. Findings include:</p> <p>The facility's policy for Transfer and Discharge, dated 11/28/17, documented the information provided to the receiving provider included the following:</p> <ul style="list-style-type: none"> * Contact information of the practitioner responsible for the resident's care. * Contact information of the resident's representative. * Advance directive information. * Special instructions and/or precautions for ongoing care. * The resident's comprehensive care plan goals. * All information needed to meet the resident's needs, including but not limited to the resident's status, diagnoses and allergies, medications, and most recent relevant labs, other diagnostic tests, and recent immunizations. <p>This policy was not followed.</p> <p>Resident #36 was admitted to the facility on 12/7/18 and readmitted to the facility on 12/5/19, with multiple diagnoses including anemia (a low number of red blood cells), gastrointestinal hemorrhage (bleeding in the gastrointestinal tract), and GERD (a condition where acid from the stomach comes up into the esophagus).</p> <p>Resident #36's discharge MDS assessment, dated 11/29/19, documented she had an</p>	F 622	<p>Other Residents Residents discharged in the last 15 days were reviewed by the IDT to validate transfer/discharge policy was followed with no further findings.</p> <p>Facility Systems Licensed Nurses were educated on the facility transfer/discharge policy to include but not limited to, validation that transfer summary with required information was provided to the receiving provider/facility when a resident is transferred to the hospital to assist with timely treatment and provision of care and services. The system is amended to include review of residents who are transferred/discharged in clinical meeting to validate the required information was provided to the receiving facility and the discharge documentation is complete.</p> <p>Monitoring Medical Records and/or designee will audit all residents that have discharges/transfers to validate required documentation and required information was provided to the receiving provider/facility when a resident is transferred to the hospital to assist with timely treatment and provision of care and services was provided weekly for 4 weeks, then 3 residents that have discharged or transferred weekly for 8 weeks. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed</p>		

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F 622	Continued From page 10 unplanned discharge to the hospital. A Progress Note, dated 11/29/19 at 9:34 PM, documented Resident #36 had a large bowel movement that contained blood, and an order was received to send her to the Emergency Room for evaluation. Resident #36's record did not include documentation of the information provided to the receiving facility upon transfer to the hospital. On 1/24/20 at 8:21 AM, the DON said there was no other documentation of transfer paperwork for Resident #36's transfer to the hospital. The facility did not send information to the receiving provider regarding Resident #36 to ensure effective communication and transition of care.	F 622	with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.		
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.	F 623		2/24/20	

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F 623	Continued From page 11 §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 discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (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 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (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;	F 623			

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

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F 623	<p>Continued From page 12</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 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</p> <p>(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</p>	F 623			

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F 623	<p>Continued From page 13</p> <p>by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a written notice of transfer was provided to the resident and the State Long Term Care ombudsman when a resident was transferred to the hospital. This was true for 1 of 1 resident (Resident #36) who was reviewed for transfer to the hospital. This deficient practice had the potential to cause 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 facility provided a notice of transfer "as soon as practicable," and the written notice contained the following:</p> <ul style="list-style-type: none"> * The reason for the transfer/discharge. * The effective date of the transfer. * The location of where the resident was being transferred. * A statement that the resident had the right to appeal the transfer. * The contact information of the state long term care ombudsman. * If applicable, the contact information of the agency responsible for protection and advocacy of developmentally disabled or mentally ill individuals. * A copy was sent to the office of the state long term care ombudsman. <p>This policy was not followed.</p> <p>Resident #36 was admitted to the facility on 12/7/18 and readmitted to the facility on 12/5/19, with multiple diagnoses including anemia (a low</p>	F 623	<p>Resident Specific</p> <p>Resident #36 is currently a resident of the facility and need to send documentation to a receiving facility is no longer needed. Facility notified ombudsman of Resident #36 discharge to ER on 11/29/19.</p> <p>Other Residents</p> <p>Resident discharged in the last 15 days were reviewed by the IDT to validate transfer/ discharge policy was followed and that notification was provided to the state ombudsman. No further findings were noted.</p> <p>Facility Systems</p> <p>Licensed Nurses were educated on the facility transfer/discharge policy to include providing a written notice of transfer/discharge to resident or resident responsible party prior to transfer in order for resident to have an opportunity to exercise their rights. The system is amended to include review of residents who are transferred/discharged in clinical meeting to validate the required information was provided to the receiving facility and the discharge documentation is complete. Medical Records reviews monthly that transfer/discharge listing was provided to the state ombudsman. The process for notifying the state ombudsman has been amended to include Social Services will report through the new electronic notification portal and keep documentation to support transmission occurred. Social Services</p>		

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F 623	<p>Continued From page 14</p> <p>number of red blood cells), gastrointestinal hemorrhage (bleeding in the gastrointestinal tract), and GERD (a condition where acid from the stomach comes up into the esophagus).</p> <p>Resident #36's discharge MDS assessment, dated 11/29/19, documented she had an unplanned discharge to the hospital.</p> <p>A Progress Note, dated 11/29/19 at 9:34 PM, documented Resident #36 had a large bowel movement that contained blood, and an order was received to send her to the Emergency Room for evaluation. Resident #36's record did not include documentation a written notice of transfer was provided to her and her representative, or the State Long Term Care Ombudsman.</p> <p>On 1/24/20 at 11:10 AM, the SSD said she just started making a spreadsheet of notifications to the State Ombudsman, and prior to that the Administrator was completing notifications to the State Ombudsman and there was no system for tracking the notifications.</p> <p>On 1/24/20 at 11:20 AM, the Administrator said he could not remember if he reported Resident #36's transfer to the State Long Term Care Ombudsman, but when he reported resident transfers he completed it through the ombudsman's online portal. The Administrator said he did not keep track of the reported transfers.</p> <p>The facility did not provide a written notice of transfer to Resident #36, her representative, and the State Long Term Care Ombudsmen.</p>	F 623	<p>Director in serviced on the facility transfer/discharge policy and ombudsman notification.</p> <p>Monitoring The Medical Records Director and/or designee will audit 5 residents with discharges/transfers to validate written notice of transfer/discharge was provided weekly for 4 weeks, 3 residents with discharges/transfers weekly for 8 weeks. The review will be documented on the PI audit tool. The Medical Records Director and/or designee will audit discharges/transfers to validate transfer/discharge listing was provided to the state ombudsman monthly for 3 months. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.</p>		

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F 625 SS=D	<p>Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a bed hold notice was provided to the resident and/or their representative when a resident was transferred to the hospital. This was true for 1 of 1 resident (Resident #36) who was</p>	F 625	Resident Specific Resident #36 Resident #36 is currently a resident of the facility and need for bed hold for November 29th, 2019 is no longer needed.	2/24/20	

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F 625	<p>Continued From page 16</p> <p>reviewed for transfer to the hospital. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include:</p> <p>The facility's policy for Transfer and Discharge, dated 11/28/17, documented at the time of a resident's discharge, the facility provided a written notice of bed hold policy that specified the duration of the bed hold readmission criteria after the bed hold period ended.</p> <p>This policy was not followed.</p> <p>Resident #36 was admitted to the facility on 12/7/18 and readmitted to the facility on 12/5/19, with multiple diagnoses including anemia (a low number of red blood cells), gastrointestinal hemorrhage (bleeding in the gastrointestinal tract), and GERD (a condition where acid from the stomach comes up into the esophagus).</p> <p>Resident #36's discharge MDS assessment, dated 11/29/19, documented she had an unplanned discharge to the hospital.</p> <p>A Progress Note, dated 11/29/19 at 9:34 PM, documented Resident #36 had a large bowel movement that contained blood, and an order was received to send her to the Emergency Room for evaluation. Resident #36's record did not contain documentation a bed hold notice was provided to her or her representative.</p> <p>On 1/24/20 at 8:21 AM, the DON said there was no documentation a bed hold notice was provided to Resident #36 or her representative</p>	F 625	<p>Other Residents</p> <p>Resident discharged in the last 15 days were reviewed by the IDT to validate Bed-hold/readmission policy was followed to include providing a written notice of the bed-hold policy and their right to return to their former bed/room at the facility. No further findings were noted.</p> <p>Facility Systems</p> <p>Licensed Nurses, Social Services and Business Office Manager were educated on the facility Bed-Hold /Readmission policy to include providing a written notice of bed-hold to resident or resident responsible party prior to transfer in order for resident to have an opportunity to exercise their rights to return to their former bed/room at the facility. The system is amended to include review of residents who are transferred/discharged in clinical meeting to validate notice of bed-hold and discharge documentation is provided.</p> <p>Monitoring</p> <p>The Director of Medical Records and/or designee will audit 5 residents that have discharge/transfers per week for 4 weeks, then 3 residents that have discharged/transferred weekly for 8 weeks to validate notice of bed/hold was provided. The review will be documented on the PI audit tool. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit</p>		

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F 625	Continued From page 17 when she was transferred to the hospital.	F 625	and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.		
F 641 SS=D	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>§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 observation, staff and resident interview, and record review, it was determined the facility failed to ensure a resident's bed safety assessments were documented accurately. This was true for 1 of 1 resident (Resident #35) whose bed safety assessments were reviewed. This failure created the potential for harm if residents received an injury due to inaccurate resident assessments. Findings include:</p> <p>Resident #35 was admitted to the facility on 12/4/19, with multiple diagnoses including severe obesity, difficulty in walking, and muscle weakness.</p> <p>Resident #35's Bed Safety Evaluation, dated 12/4/19 at 11:26 AM, documented the recommendation for side rail use was "No Side Rails."</p> <p>Resident #35's Bed Safety Evaluation, dated 12/18/19 at 9:50 AM, documented "mobility bars to assist with independent bed mobility," and the recommendation for side rail use was "Side Rail Elimination." The assessment also documented a grab bar to allow improved bed mobility, and new</p>	F 641	<p>RESIDENT SPECIFIC On 1/23/2020 a new bed safety evaluation was completed for resident #35 and accurately reflects the ¼ side rails that are in place for bed mobility.</p> <p>OTHER RESIDENTS An audit was completed of all facility residents, and resident #35 is the only resident with side-rails in the facility.</p> <p>FACILITY SYSTEMS One-One training/education provided by CNO to nurse that inaccurately completed bed safety evaluation. Licensed Nurses were educated regarding bed safety evaluations. The system is amended to include completion of communication sheet for installation of side rails with the following components: evaluation from PT to determine need for use. PT will notify nursing if screen determines that resident would benefit from ¼ side rails for bed mobility. Nursing will complete evaluation, obtain consent and update care plan. Maintenance will install only after</p>	2/24/20	

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F 641	Continued From page 18 bed rail to allow for independent bed mobility. On 1/23/20 at 4:19 PM, bilateral padded side rails were in place to Resident #35's bed. Resident #35 said the side rails were put in place right after he was admitted to the facility, when the Administrator noticed he was "about to fall out of bed." Resident #35 said the first time he was asked for permission to have the side rails on his bed was "10 or 15 minutes ago." On 1/23/20 at 4:35 PM, the DON said Resident #35 had bilateral side rails on his bed. The DON said Resident #35's Bed Safety Assessment was incorrect. Resident #35's bed assessment was inaccurate.	F 641	receiving an Adaptive Equipment Communication sheet that confirms completion of all components. Chief Nursing Officer and/or Designee will audit all therapy referrals for ¼ side rails to ensure that all documentation is complete. MONITOR CNO and/or designee will audit a sample of 5 residents with side rails in use for accuracy of bed safety assessment weekly for 4 weeks, then three residents weekly for 8 weeks. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.		
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	F 657		2/24/20	

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F 657	<p>Continued From page 19</p> <p>the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure care conferences were held regularly and included the resident when possible. This was true for 2 of 14 residents (#9 and #35) whose care plans were reviewed. This failure created the potential for inappropriate care and services which did not meet the resident's current needs. 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 a change of condition. * The facility provided sufficient advanced notice of the meeting and scheduled the meetings to accommodate the resident's representative. * If the resident and/or their representative were not able to participate in the care conference meeting, an explanation was documented in the resident's record. 	F 657	<p>Resident Specific: Resident #9 had a care conference scheduled on 1/31/2019 to review plan of care and services. Resident #35 had a care conference scheduled on 2/14/2020 to review plan of care and services.</p> <p>Other Residents: Resident with Care Conferences in the last 30 days were reviewed by IDT to validate resident and responsible party as indicated were invited timely and given an opportunity to participate in resident care plan process.</p> <p>Facility Systems: Social Services and RCM were educated by CNO and/or designee to facility Care Plan Policy and requirement to ensure resident and/or responsible party are timely invited to care conferences to promote appropriate care and services the meet resident's individual needs. The</p>		

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F 657	<p>Continued From page 20</p> <p>This policy was not followed.</p> <p>1. Resident #9 was admitted to the facility on 7/18/19, with multiple diagnoses including hemiplegia and hemiparesis (weakness and paralysis) after a stroke, hypertension (high blood pressure), and Type 2 diabetes mellitus.</p> <p>A Care Conference Record, dated 7/22/19, documented an admission care conference was held for Resident #9. One staff signature was present, and it was documented a family member attended by phone. There was no documentation in Resident #9's record of a care conference after 7/22/19.</p> <p>Resident #9's quarterly MDS assessment, dated 10/25/19, documented he was cognitively intact.</p> <p>On 1/21/20 at 3:39 PM, Resident #9 said the facility had not talked with him about his care plan.</p> <p>On 1/23/20 at 11:17 AM, the DON said the SSD scheduled resident care conferences, and care conference meetings should be quarterly and as needed for changes in condition.</p> <p>On 1/23/20 at 3:00 PM, the SSD said Resident #9 was due for a care conference and she was working to catch up on care conference meetings.</p> <p>The facility did not conduct care conferences quarterly and did not include Resident #9 as part of the care conference.</p>	F 657	<p>system is amended to include review of care conferences scheduled during clinical morning meeting</p> <p>Monitoring: The Medical Records Director and/or designee will audit 5 residents per week based on MDS schedule to validate a care conference was conducted, residents and/or responsible party as indicated were invited to care conferences timely and were given the opportunity to participate for 4 weeks, then 3 residents weekly for 8 weeks. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.</p>		

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F 657	Continued From page 21 2. Resident #35 was admitted to the facility on 12/4/19, with multiple diagnoses including severe obesity, difficulty in walking, and muscle weakness. Resident #35's admission MDS assessment, dated 12/11/19, documented he was cognitively intact. On 1/22/20 at 1:08 PM, Resident #35 said he had not attended a care conference meeting in the facility. On 1/23/20 at 3:02 PM, the SSD said Resident #35 was scheduled for a care conference meeting the following week. The SSD said Resident #35 did not have a care conference, "at least not that he signed."	F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' hygiene and grooming were appropriately maintained. This was true for 1 of 14 residents (Resident #28) who were reviewed for ADLs. This failure had the potential to cause psychosocial distress if residents experienced	F 677	RESIDENT SPECIFIC Upon notification from surveyor that there was a concern for resident #28's hygiene, Director of Nursing of nursing immediately requested that CNA's re-approach resident and offer to shave and assist in changing clothing. Resident declined being shaved or changing clothing.	2/24/20	

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F 677	<p>Continued From page 22</p> <p>embarrassment, isolation, decreased sense of self-worth, and/or decreased sense of well-being. Findings include:</p> <p>The facility's policy for Activities of Daily Living, dated 2/28/19, documented assistance was provided to residents who required extensive or total assistance with nutrition, grooming, oral hygiene, toileting, and other personal cares.</p> <p>The facility's policy for Quality of Life, dated 11/28/19, documented the following:</p> <ul style="list-style-type: none"> * The facility provided appropriate treatment and services to maintain or improve residents' ADLs. * The facility provided the necessary services to maintain good nutrition, grooming, oral, and personal hygiene for residents who were unable to perform their ADLs. <p>These policies were not followed.</p> <p>Resident #28 was admitted to the facility on 11/10/17, with multiple diagnoses including dementia, weakness, unsteadiness on feet, repeated falls, and seizures.</p> <p>Resident #28's annual MDS assessment, dated 11/18/19, documented he required extensive assistance of 1 person with bed mobility, transfers, dressing, toileting, and personal hygiene, and he was totally dependent on 1 person for bathing.</p> <p>Resident # 28's care plan documented he required assistance with ADLs as follows:</p> <ul style="list-style-type: none"> * Extensive assistance of 1 staff for bathing. 	F 677	<p>Resident frequently refuses care, his behavior monitor, and care plan were updated to reflect this with instructions for CNA to re-approach following resident refusal of care.</p> <p>OTHER RESIDENTS Senior leaders completed a sampling of Resident Observation interviews in Abaqis to identify other residents with concerns related to ADLs and Hygiene. Facility IDT completed an audit to identify resident preference for facial hair and shaving. Care plan and Kardex were updated per preference.</p> <p>FACILITY SYSTEMS Review and education of the following facility policies was completed: ADLs- AM Cares and ADLS- PM/HS Cares. This review included education related to behaviors, resident refusals, re-approaching, notification and documentation. Facility will continue practice of Senior Leader rounds, which include resident observation related to ADLs and Hygiene. The system is amended to include Social Services review of ADL and Hygiene preferences and/or concerns with resident/representative during care conferences. Senior Leaders will continue to make twice a week rounds.</p> <p>MONITOR Administrator and Director of Nursing will review Senior Leader rounds weekly to identify issues and trends related to ADLs</p>		

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F 677	<p>Continued From page 23</p> <ul style="list-style-type: none"> * Limited assistance of 1 staff for dressing. * Limited assistance of 1 staff for personal hygiene. <p>On 1/23/20 at 3:39 PM, Resident #28 was unshaven with extensive stubble covering his lower face. Resident #28's hair was unkempt, and his pants were soiled on the left thigh area with an irregular approximately 2-inch diameter white, dried substance that resembled food or drink. Resident #28 said staff had not offered to shave him on that day and he would have to "get one of the girls to do it."</p> <p>On 1/23/20 at 3:40 PM, CNA #1 said she gave Resident #28 a shower on the previous night and it was late, so she did not offer to shave him.</p> <p>On 1/23/20 at 3:44 PM, CNA #2 said she noticed Resident #28 was unshaven, and if he asked to be shaved she shaved him. CNA #2 said normally when Resident #28 got a shower he was also shaved, or staff could shave him any time.</p> <p>There was no documentation in Resident #28's record he had refused assistance with personal hygiene.</p> <p>On 1/23/20 at 4:32 PM, the DON said she expected residents to be kept clean. The DON said Resident #28 could be "challenging," she expected staff to re-approach him if he refused cares, and staff were supposed to offer to shave him.</p> <p>The facility did not ensure Resident #28's personal hygiene was maintained.</p>	F 677	<p>and resident hygiene x 8 weeks. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.</p>		

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F 684 SS=E	<p>Quality of Care CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure blood pressure medications were held when the resident's pulse was outside of ordered parameters. This was true for 1 of 5 residents (Resident #9) reviewed for unnecessary medications. This failure created the potential for harm if residents experienced adverse effects from blood pressure medications. Findings include:</p> <p>Resident #9 was admitted to the facility on 7/18/19, with multiple diagnoses including hemiplegia and hemiparesis (weakness and paralysis) after a stroke, hypertension (high blood pressure), and Type 2 diabetes mellitus.</p> <p>Resident #9's physician orders documented the following:</p> <p>* Carvedilol (medication to lower blood pressure) 25 mg twice a day for hypertension. Hold if systolic blood pressure (top number of blood pressure reading) is less than 100 or if heart rate is less than 60, dated 10/29/19.</p>	F 684	<p>RESIDENT SPECIFIC Resident #9 was assessed by Physician Assistant on 1/22/20 for a follow-up regarding hypertension. Based on continued elevation of blood pressures changes were made to the resident's medication as well as the pulse parameters for holding hypertensive medications.</p> <p>OTHER RESIDENTS Medical Director and CNO reviewed residents on hypertensive medications. Based on this review MD chose to revise standing orders for when to hold medication. Pulse threshold is changed to hold medication below 50 bpm and/or systolic pressure of <100 mmHg.</p> <p>FACILITY SYSTEMS CNO completed 1:1 training with the agency nurse regarding errors related to resident #9. CNO completed training with all Licensed Nurses related to medication administration, notification of MD, and</p>	2/24/20	

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F 684	<p>Continued From page 25</p> <p>* Lisinopril (medication to lower blood pressure) 20 mg once a day for hypertension. Hold if systolic blood pressure is less than 100 or if heart rate is less than 60 unless otherwise directed, dated 11/15/19.</p> <p>* Norvasc (medication to lower blood pressure) 5 mg once a day for hypertension. Hold if systolic blood pressure is less than 100 or if heart rate is less than 60 unless otherwise directed, dated 11/15/19.</p> <p>The MAR documented Resident #9's pulse was less than 60 on 13 days between 1/1/20 and 1/23/20, as follows:</p> <ul style="list-style-type: none"> * January 1: pulse = 58 in the morning * January 2: pulse = 59 in the morning * January 5: pulse = 58 in the morning * January 6: pulse = 57 in the morning * January 7: pulse = 58 in the morning * January 13: pulse = 57 in the morning * January 16: pulse = 55 in the morning * January 17: pulse = 55 in the morning * January 19: pulse = 56 in the morning * January 20: pulse = 59 in the morning * January 21: pulse = 56 in the morning <p>Resident #9's January 2020 MAR documented the carvedilol, lisinopril, and Norvasc were administered each day from 1/1/20 through 1/23/20. Resident #9's physician orders were not followed.</p> <p>On 1/23/20 at 11:16 AM, the DON said she expected the nurse to follow the physician orders, hold the blood pressure medication, and notify the physician when Resident #9's pulse was outside of the ordered parameters. The DON</p>	F 684	<p>documentation. Consultant RN from the pharmacy will complete medication administration audit on 2/14/2020. MD will provide an in-service for licensed nurses on 2/24/2020 related to communication to medical provider for vitals outside parameters.</p> <p>MONITOR CNO and/or designee will audit 5 residents on blood pressure medications to validate that ordered parameters for med administration are followed as indicated by MD weekly for 4 weeks, then 3 residents weekly for 8 weeks. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.</p>		

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F 684	Continued From page 26 said she could not tell from the documentation on Resident #9's MAR if the blood pressure medications were held as ordered.	F 684			
F 692 SS=D	The facility did not follow Resident #9's physician ordered parameters when administering his blood pressure medications. Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents were consistently provided adequate nutritional interventions to prevent significant unplanned weight loss. This was true	F 692	RESIDENT SPECIFIC Resident #27 was reviewed and observed being weighed in wheelchair. Due to type and size of resident wheelchair it is impossible to accurately weigh using	2/24/20	

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F 692	<p>Continued From page 27</p> <p>for 1 of 1 resident (Resident #27) who was reviewed for weight loss. This failure created the potential for harm if residents experienced a loss in functional ADLs due to muscle loss and/or weakness. Findings include:</p> <p>The facility's Nutrition Care Policy - Identifying Nutrition Problems, Responding to Significant Change, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> * The registered dietitian (RD) identified residents needing further monitoring/evaluation, including those having a significant undesirable weight loss or gain. * Notify and consult with the physician regarding residents' current nutritional status or significant change in nutritional status. <p>This policy was not followed.</p> <p>Resident #27 was initially admitted to the facility on 11/9/17 and readmitted on 2/11/19, with multiple diagnoses including a stroke, weakness and paralysis on the right side of his face and limbs, contracture of the right hand (hardening of muscles), aphasia (loss of ability to understand or express speech), schizoaffective disorder (a condition where one feels detached from reality and affects mood), Type 2 diabetes mellitus, and dysphagia (swallowing difficulties).</p> <p>Resident #27's physician orders included a diet order, dated 2/16/19, for a regular diet of regular texture, and fluids of a thin consistency.</p> <p>Resident #27's care plan documented he had the potential for impaired nutrition, and staff were to</p>	F 692	<p>wheelchair scale. Resident Kardex updated to include weights with Hoyer only to ensure accuracy. Daily weights will continue to re-establish resident baseline and will be reviewed by RD and CNO to determine when weekly weights can resume. RD to re-assess dietary plan to fit the resident's specific situation.</p> <p>OTHER RESIDENTS Audit completed of current residents to ensure those using wheelchair scale for weights did not have similar issues. RD completed and audit of all residents who have experienced weight loss of 5%/10% in 30/180 days to ensure proper documentation, physician notification and nutrition interventions are in place when necessary. No further findings were noted.</p> <p>FACILITY SYSTEMS Education provided to nursing and dietary staff related to review of facility policies/procedures: Nutrition Care Process- Identifying Nutrition Problems Responding to Significant Change, Food and Fluid Intake, Weight Measurement, and Nutrition. The system is amended to include DON/RCM weekly review of RD recommendations to ensure proper documentation and notification has occurred. RD/DON/RCM will meet on a monthly basis to review all residents at risk and those on a routine schedule that have quarterly assessments due.</p> <p>MONITOR</p>		

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F 692	<p>Continued From page 28</p> <p>assist him with menu selections, provide a mechanical soft diet (foods that are easy to chew and swallow, such as ground or pureed), honor food preferences as applicable, and encourage healthy food choices. The care plan documented Resident #27 ate meals in the main dining room independently with set up.</p> <p>Resident #27's Nutrition Evaluation, dated 11/19/19, reviewed and approved by the RD, documented he understood and agreed with the current diet order of "regular," and his estimated calorie and protein needs were met.</p> <p>Resident #27's weight summary documented he weighed 225.5 pounds on 12/22/19, and he weighed 205.3 pounds on 1/19/20, resulting in a weight loss of 8.96% in one month. Resident #27 was weighed with a wheelchair on both dates.</p> <p>There was no documentation Resident #27's physician and the RD were notified he had significant weight loss in one month.</p> <p>On 1/24/20 at 3:16 PM, the DON stated the most recent nutritional evaluation was dated 11/19/19, and said she asked for a reweigh at one time to see if the wheelchair was part of the weight discrepancy.</p> <p>On 1/24/20 at 3:38 PM, the RD said Resident #27 needed to be seen, and the physician was notified of Resident #27's weight status. The RD said she observed Resident #27 eating in the dining room during the survey, and he did not seem to be having any difficulties and there was a lot going on that week so she "didn't push it."</p>	F 692	<p>CNO and/or Designee will audit 5 residents with weight changes to validate adequate nutritional interventions are in place to prevent significant unplanned weight loss, weekly for four weeks, then three residents weekly for eight weeks. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.</p>		

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F 692	Continued From page 29 The facility did not provide adequate nutritional interventions to prevent significant unintentional weight loss for Resident #27.	F 692			
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and record review, it was determined the facility failed to ensure a resident was appropriately assessed and a physician's order was obtained prior to installing side rails. This was true for 1 of 1 resident (Resident #35) who was reviewed for side rails. This created the potential for harm from entrapment or injury	F 700	RESIDENT SPECIFIC On 1/23/2020 a new bed safety evaluation was completed for resident #35 and accurately reflects the ¼ side rails that are in place for bed mobility. OTHER RESIDENTS An audit was completed of all facility	2/24/20	

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F 700	<p>Continued From page 30 related to the use of side rails. Findings include:</p> <p>The facility's policy for Restraints, dated 3/31/18, documented if a side rail was used, the facility ensured correct installation, use, and maintenance of the side rails, including a physician's order with rationale, and assessing the resident for risk of entrapment prior to installing the side rails.</p> <p>This policy was not followed.</p> <p>Resident #35 was admitted to the facility on 12/4/19, with multiple diagnoses including severe obesity, difficulty in walking, and muscle weakness.</p> <p>A Bed Safety Evaluation, dated 12/4/19 at 11:26 AM, documented Resident #35 was determined to be unsafe in bed and the recommendation for side rail use was "No Side Rails." The evaluation stated "will care plan appropriately."</p> <p>A Physical Therapy Note, dated 12/5/19, documented Resident #35 would benefit from side rails to decrease the burden on caregivers and increase his independence.</p> <p>A Bed Safety Evaluation, dated 12/18/19 at 9:50 AM, documented Resident #35's current treatment plan was for "mobility bars to assist with independent bed mobility," and the recommendation for side rail use was "Side Rail Elimination." The assessment also documented Resident #35 required a grab bar to allow improved bed mobility, and new bed rail to allow for independent bed mobility.</p>	F 700	<p>residents, and resident #35 is the only resident with side-rails in the facility.</p> <p>FACILITY SYSTEMS One-One training/education provided by CNO to nurse that inaccurately completed bed safety evaluation. Licensed Nurses were educated regarding bed safety evaluations. The system is amended to include completion of communication sheet for installation of side rails with the following components: evaluation from PT to determine need for use. PT will notify nursing if screen determines that resident would benefit from ¼ side rails for bed mobility. Nursing will complete evaluation, obtain consent and update care plan. Maintenance will install only after receiving an Adaptive Equipment Communication sheet that confirms completion of all components. Chief Nursing Officer and/or Designee will audit all therapy referrals for ¼ side rails to ensure that all documentation is complete.</p> <p>MONITOR CNO and/or designee will audit a sample of 5 residents with side rails in use for accuracy of bed safety assessment weekly for 4 weeks, then three residents weekly for 8 weeks. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until</p>		

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

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FORM APPROVED
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F 700	Continued From page 31 On 1/23/20 at 4:19 PM, Resident #35's bed had bilateral padded side rails. Resident #35 said the side rails were put in place right after he was admitted to the facility, when the Administrator noticed he was "about to fall out of bed." Resident #35 said the first time he was asked for permission to have the side rails on his bed was "10 or 15 minutes ago." Resident #35's record did not include a physician's order for the use of bilateral padded side rails. The Bed Safety Evaluations for Resident #35 did not include documentation or assessment for the use of bilateral padded side rails. On 1/23/20 at 4:35 PM, the DON said placement of side rails was driven by a therapy recommendation, who would notify the Resident Care Manager (RCM). The RCM then obtained consent and performed a bed safety evaluation, and maintenance was notified to place the side rails. The DON said side rails should be included in Resident #35's physician orders and it was not. Resident #35 did not have a physician order and was not properly assessed for padded bilateral bed rails.	F 700	substantial compliance maintained.		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).	F 730		2/24/20	

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F 730	<p>Continued From page 32</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review, and facility training documentation, it was determined the facility failed to ensure each CNA completed the required hours of yearly education. This was true for 3 of 3 CNAs (Staff A, B, and C), who worked at the facility for 1 year or longer. This failure created the potential for incompetent CNAs providing care and increased the risk for harm for 53 of 53 residents living in the facility. Findings include:</p> <p>The facility's policy for In-service Education/Training, dated 11/28/19, documented an employee performance review was completed, and regular in-service education was provided based on the outcome of the review. "In-service education maintains the continuing competence of the employee in their job performance." Procedures included the following:</p> <ul style="list-style-type: none"> * Education and in-service training were provided to assist in maintaining the continuing competence and knowledge of the staff, and education would meet the State/Federal mandatory 12-Hour continuing education requirements. * Ongoing education was provided at regular intervals on topics to maintain knowledge and standards of practice. * In-service education was logged with a history of the employee's education. * Documentation of the employee's training included the date of the training, a summary of the contents of the training session, the name and title of the individuals who received the training, and the name and qualifications of the 	F 730	<p>RESIDENT SPECIFIC Audit during survey identified staff A, B and C had completed the required 12hrs of training.</p> <p>OTHER RESIDENTS Staff A, B and C had completed the required 12hrs of training but was not documented in a spreadsheet. Currently Staff A, B, and C are the only CNAs employed for a year or greater. To ensure adequate training documentation all CNAs have been assigned training through Relias, in addition to all-staff in services and trainings. Completion of Relias Annual training is 2/23/2020.</p> <p>FACILITY SYSTEMS The system is amended to include the following education/training to be assigned upon hire and yearly at anniversary of hire through Relias: Annual/New hire and BCU trainings. These will ensure that all CNAs meet the 12hr a year training requirement and allow for better tracking and documentation of trainings. CNO will maintain a binder with sign-in sheets, training material presented and signature of person presenting material for all in person trainings/education/all staff-meetings.</p> <p>MONITOR CEO and/or designee will run report 2/24/2020 to ensure completion of</p>		

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F 730	<p>Continued From page 33 person who provided the training.</p> <p>On 1/23/20, the Administrator provided copies of individual training documentation for Staff A, B, and C. The documentation included a facility Skills Fair 2020, which did not include the training content summary, the date of training, or the names, qualifications, and signatures of the educators.</p> <p>Other training documentation provided by the facility included abuse reporting and prevention, infection control, transfers, safety and falls, perineal care, catheter care, and ADL coding. The training documents did not include the number of hours each training fulfilled, the date of the training, or the qualified educator's signature and date.</p> <p>On 1/24/20 at 9:28 AM, the SDC said staff education consisted of dementia and abuse training in the first 90 days of hire through an on-line training program. The SDC said additional education was obtained through support provided from staff and the skills fair. The SDC said she did not have an employee education tracking record, only the documentation in each employee's file.</p> <p>On 1/24/20 at 10:42 AM, the DON said keeping track of staff training hours was shared with the SDC. The DON said the facility did not use a spreadsheet to track employees' education.</p> <p>The facility failed to ensure CNAs completed 12 hours of education annually, based on their performance evaluation.</p>	F 730	<p>training for CNA staff. Going forward this report will be run monthly to audit new employees and those whose annual training is due for completion. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.</p>		
F 757	Drug Regimen is Free from Unnecessary Drugs	F 757		2/24/20	

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F 757	<p>Continued From page 35</p> <p>diabetes mellitus with diabetic neuropathy (nerve damage).</p> <p>Resident #101's physician orders documented the following:</p> <ul style="list-style-type: none"> * Blood sugar checks as needed (PRN) to rule out hyper or hypoglycemia, dated 1/19/20. * Hypoglycemia protocol: if able to take by mouth, follow the 15/15 rule- administer 15 grams of fast acting carbohydrate and recheck BG in 15 minutes. If still less than 70, administer another 15 grams of fast acting carbohydrate and recheck second BG in 15 minutes. If not above 70, administer another 15 grams of fast acting carbohydrate and notify the physician for further orders. Once BG is above 70, provide a protein snack "or assist to next meal," dated 1/19/20. * Glucagon emergency kit 1 mg: inject 1 unit as needed for BG less than 70 and unable to swallow. If no improvement, notify the physician immediately. If improving, may repeat and recheck BG in 15 minutes, dated 1/19/20. * Insulin glargine (a long-acting insulin) inject 20 units once a day at bedtime, dated 1/17/20. * Januvia (an oral anti-diabetic medication) 100 mg by mouth once a day, dated 1/17/20. * Metformin (an oral anti-diabetic medication) 1000 mg by mouth once a day, dated 1/17/20. <p>Resident #101's record did not document her BG was checked since her admission.</p> <p>On 1/22/20 at 5:41 PM, the DON said there should have been orders to do BG monitoring for Resident #101, they should have been doing it, and it was not being done.</p>	F 757	<p>also provided for all licensed nurses related to need for blood glucose monitoring upon admit, and requirement for a second nurse to review and verify orders. The system has been amended to include Medical Director standing order to institute three times a day blood glucose monitoring for new admits that are on diabetic medications that arrive without blood glucose monitoring orders.</p> <p>MONITOR CNO and/or designee will audit 5 residents newly admitted or new diabetic medication to ensure that blood glucose monitoring is weekly for four weeks, and then three residents weekly for eight weeks. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.</p>		

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F 757	Continued From page 36 On 1/23/20 at 4:47 PM, the Medical Director said the facility missed getting orders for Resident #101's BG monitoring. The Medical Director said the BG checks should be more often than PRN. The Medical Director said he would expect BG checks to be done routinely until it was shown a resident was stable.	F 757			
F 804 SS=F	The facility did not appropriately monitor Resident #101's BG levels for her diabetes. Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, resident interview, food test tray evaluation, and staff interview, it was determined the facility failed to ensure palatable food was served. This was true for 4 of 4 residents (#1, #9, #19 and #35) reviewed for food concerns, and had the potential to affect all residents in the facility who ate food from the kitchen. This failed practice had the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include: The facility's policy for Food: Quality and Palatability, dated 9/2017, documented:	F 804	Resident Specific Resident's #1, #9, #19, #35 were interviewed on 2/17/2020 regarding concerns with temperature and palatability of food. Other Residents Dietary manager and/or designee will interview all other residents in facility by 2/24/2020 regarding any concerns with temperature and palatability of food. Facility Systems All dietary staff educated by facility DON	2/24/20	

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F 804	<p>Continued From page 37</p> <ul style="list-style-type: none"> * Food was prepared by methods that conserve nutritive value, flavor, and appearance. * Food was palatable, attractive, and served at a safe and appetizing temperature. * Food and liquids/beverages were prepared in a manner, form, and texture that met the needs of the residents. <p>The facility's policy for Food Preparation, dated 11/28/17, documented food was prepared by methods that conserve nutritive value, flavor and appearance. The documented procedures included:</p> <ul style="list-style-type: none"> * Food was stored, prepared, and held by methods that preserved the nutritive value of the food to the extent possible. * Food was prepared according to standardized, yield adjusted recipes by trained staff to produce a palatable and attractive meal. * Food temperatures were kept at the appropriate levels to maintain flavor and palatability. <p>These policies were not followed.</p> <p>On 1/22/20 at 10:37 AM, during the Resident Group interview, Resident #4 said "yuck" when asked about the food. Resident #4 said the facility served too much starch, bread, and noodles, the food was not always hot, and the facility needed to redo their menus and "get some new stuff on there." Resident #9 said the facility served cold eggs and rotten milk, and the residents needed more fresh fruit.</p> <p>Residents were interviewed individually regarding the food served at the facility, and they</p>	F 804	<p>and/or designee, this review included education related to food temperatures, palatability and appearance of food. The system has been amended to include bi-weekly test-trays and three resident interviews to validate palatability and appropriate serving temperatures of food. Facility has implemented dining committee in conjunction with resident council monthly as well as randomized resident satisfaction interviews through ABAQIS.</p> <p>Monitor Dietary manager and/or designee will ensure bi-weekly test trays are completed, that resident satisfaction interviews are completed, and monthly dining committee meetings occur. The review will be documented on the PI audit tool, any concerns will be addressed immediately and will be discussed with QAPI committee. The QAPI committee may continue audits and adjust the frequency of the monitoring of these audits until substantial compliance is maintained.</p>		

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F 804	<p>Continued From page 38 responded as follows:</p> <ul style="list-style-type: none"> * On 1/21/20 at 3:41 PM, Resident #9 said the food was usually cold. * On 1/22/20 at 1:11 PM, Resident #35 said the food was often not hot. * On 1/22/20 at 1:49 PM, Resident #1 said he did not like the food, he "would not serve it to my cat," and it did not taste good. * On 1/22/20 at 2:51 PM, Resident #19 said she did not like the food and the flavor was bad. <p>On 1/23/20 at 12:44 PM, a test tray was evaluated during the lunch meal at the end of the 400 hall, which was the farthest from the kitchen. Dietary Supervisor #2 (DS #2) took the meal tray out of the insulated food cart, and it was evaluated by two surveyors along with DS #2. The meal included sweet potatoes which had a temperature of 128 degrees F (Fahrenheit), the chicken was 133 degrees F, brussel sprouts were 113 degrees F, and a glass of red juice was 50 degrees F.</p> <p>DS #2 said the sweet potatoes tasted good and could be warmer; the brussel sprouts could use some butter or salt and could be hotter; and the chicken was good, but it had cooled down and could use more seasoning. A surveyor said the brussel sprouts were overcooked and had lost their bright green color, and DS #2 agreed. DS #2 said the cake was good and it could use a little more powdered sugar. DS #2 said perhaps the facility should switch to 2 carts for 300 and 400 halls instead of 1 cart for both.</p> <p>The facility did not ensure food served to the residents was palatable in regards to</p>	F 804			

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F 804	Continued From page 39	F 804			
F 838	temperature and flavors.				
SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.	F 838	2/24/20		

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F 838	<p>Continued From page 40</p> <p>§483.70(e)(2) The facility's resources, including but not limited to,</p> <p>(i) All buildings and/or other physical structures and vehicles;</p> <p>(ii) Equipment (medical and non- medical);</p> <p>(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;</p> <p>(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;</p> <p>(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and</p> <p>(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.</p> <p>§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, review of the Facility Assessment, and staff interview, it was determined the facility failed to ensure the Facility Assessment identified how staffing levels and competencies met resident needs. This had the potential to affect all residents residing in the facility, and created the potential for harm if the facility did not have sufficient and competent staff to provide the necessary care and services for the residents. Findings include:</p> <p>1. The facility's policy for Facility Assessment,</p>	F 838	<p>RESIDENT SPECIFIC CEO and CNO, with input from Senior Leaders updated the Facility Assessment.</p> <p>OTHER RESIDENTS CEO and CNO, with input from Senior Leaders updated the Facility Assessment.</p> <p>FACILITY SYSTEMS CNO completed Abaqis Reports Training Sessions on 2/11/2020, that included the Facility Assessment. Facility system</p>		

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F 838	<p>Continued From page 41</p> <p>dated 11/28/17, documented the facility evaluated its resident population and identified the resources needed to provide the necessary care for its residents competently during both day-to-day operations and emergencies. The procedure components included an assessment that addressed or included the following:</p> <ul style="list-style-type: none"> * The staff competencies that were necessary to provide the level and types of care needed for the resident population. * All personnel, including managers, staff (both employees and those who provided services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care. <p>The Facility Assessment, dated "November 2019 - 2019," did not provide documentation under "Section II. Staffing, Training, Services and Personnel," the types of staff employed by the facility to provide services and care (e.g. RNs, LPNs, CNAs, NAs, Therapies, etc.), the numbers of staff available to provide services or care (average or range), or a general staffing plan to ensure there were sufficient staff to meet the needs of the residents at a given time.</p> <p>The Facility Assessment, under Section II, included four subsections: A. Function, Mobility and Physical Disabilities, B. Acuity-Diseases, Conditions, and Treatments, C. Cognitive, Mental, and Behavioral Status, and D. Cultural, Ethnic, and Religious Factors. Each subsection included "Sufficiency Analysis Categories." For each category listed there were corresponding columns titled Overall Staffing, Staff Competencies, and Services, and under each</p>	F 838	<p>includes IDT review of diagnosis and acuity levels of our residents and based on findings the team assigns training through Relias, and in person trainings to validate competency of staff to meet resident needs. Staffing levels are reviewed daily in the clinical meeting and adjusted as needed for new admissions, changes in conditions, resident behaviors and vacancies in current schedule. This allows the facility to ensure adequate, competent staffing in day-to-day operations as well as in emergent situations.</p> <p>MONITOR CEO and/or designee will audit the facility assessment to determine if adjustments are indicated monthly for three months. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.</p>		

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F 838	<p>Continued From page 42</p> <p>column it was documented "Sufficient" or "Not Applicable." The Facility Assessment documented for their Resident Profile there was a high number of residents who required assistance from two or more staff with ADLs. The staffing section of the assessment did not provide documentation how they had sufficient staffing to meet the needs of those residents who required assistance from two or more staff.</p> <p>The Facility Assessment did not document a description of the staff competencies that were necessary to provide the level and types of care needed for the resident population described, and it did not document all personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, and their education, training, and/or competencies related to resident care.</p> <p>On 1/24/20 at 9:28 AM, the SDC said she provided input for the Facility Assessment, and she utilized the acuity and number of residents for her staff training plans.</p> <p>On 1/24/20 at 10:42 AM, the DON said staffing was reviewed and coordinated by her and the staffing coordinator. The DON said resident needs were reviewed and staffing was adjusted every morning at the 9:00 AM stand-up meeting. The DON said she looked at the residents, and if they had increased behaviors or required heavy care such as a Hoyer (mechanical) lift, they had more CNA staff present and reviewed how many Nursing Assistants were present.</p> <p>2. Refer to F730 as it relates to the facility's failure to ensure each CNA completed the</p>	F 838			

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F 838	Continued From page 43 required hours of yearly education.	F 838			
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care.	F 849		2/24/20	

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F 849	Continued From page 44 (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.	F 849			

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F 849	<p>Continued From page 45</p> <p>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.</p> <p>The designated interdisciplinary team member is responsible for the following:</p> <p>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those</p>	F 849			

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F 849	<p>Continued From page 46</p> <p>residents receiving these services.</p> <p>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.</p> <p>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.</p> <p>(iv) Obtaining the following information from the hospice:</p> <p>(A) The most recent hospice plan of care specific to each patient.</p> <p>(B) Hospice election form.</p> <p>(C) Physician certification and recertification of the terminal illness specific to each patient.</p> <p>(D) Names and contact information for hospice personnel involved in hospice care of each patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a</p>	F 849			

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F 849	<p>Continued From page 47</p> <p>description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.</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 hospice documentation included a physician statement of terminal illness. This was true for 1 of 1 resident (Resident #7) reviewed for hospice care. This failure created the potential for harm if residents received inappropriate hospice care. Findings include:</p> <p>The facility's policy for Hospice, dated 1/28/17, documented a written physician certification the individual was terminally ill must be completed.</p> <p>Resident #7 was admitted to the facility on 3/10/08, and readmitted on 6/11/19, with multiple diagnoses including schizophrenia (a mental disorder involving a breakdown in the relation between thought, emotion, and behavior), dysphagia (swallowing difficulties), and history of stroke.</p> <p>A Hospice Referral Order, dated 3/5/19 and signed by the physician, documented that in the event Resident #7 had an event of acute decline, staff were to make an emergent admission referral for hospice services. No physician statement of terminal illness was found in Resident #7's record.</p> <p>A health status note, dated 1/9/20 at 3:03 PM, documented the DON spoke with Resident #7's guardian regarding resident change in condition</p>	F 849	<p>RESIDENT SPECIFIC Resident #7 is no longer at the facility.</p> <p>OTHER RESIDENTS Currently there are no other residents on Hospice Services.</p> <p>FACILITY SYSTEMS The Facility IDT has amended the system to include obtaining a new Physician's Statement of Terminal Illness when a resident transition from Palliative Care Services to Hospice Care Services, even if that transition is within the same company and same physician.</p> <p>MONITOR CNO and/or designee will audit every Hospice referral to ensure that a physician statement of terminal illness is present prior to admission to Hospice services. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.</p>		

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F 849	Continued From page 48 and transitioning from palliative care to hospice. The note documented the palliative nurse would complete the hospice admissions paper work the next day. A hospice agency plan of care form, dated 1/10/20, documented Resident #7 was admitted to hospice and her diagnosis was senile degeneration of the brain. A significant change MDS assessment, dated 1/13/20, documented Resident #7 received hospice services. A hospice nursing visit record, dated 1/14/20 at 9:53 AM, documented Resident #7 was referred to hospice on 1/9/20 and admitted to hospice on 1/10/20. On 1/24/20 at 12:51 PM, when asked to provide the physician's statement of terminal illness for Resident #7, the DON referred to the Hospice Referral Order, dated 3/5/19. The facility did not have documentation of a physician's statement of terminal illness for Resident #7.	F 849			
F 880 SS=F	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.	F 880		2/24/20	

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F 880	<p>Continued From page 49</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:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility</p>	F 880			

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F 880	<p>Continued From page 50</p> <p>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 (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: a) clean laundry was covered appropriately when transported throughout the facility which had the potential to affect all residents in the facility b) Staff performed hand hygiene in between contact with residents in the dining room which was true for 4 residents (#31, #32, #36, and #42) who were observed in the main dining room and required assistance with their meals. These deficient practices created the potential for harm if residents experienced infections from cross contamination. Findings include:</p> <p>1. The facility's policy for Work Practices - Linen and Laundry, dated 11/28/17, documented that</p>	F 880	<p>RESIDENT SPECIFIC Upon notification from surveyor that staff NA#1 and CNA#3 were feeding resident's #32, #42, #36, and #31 without performing hand hygiene, the Director of Nursing provided immediate education to staff members assisting residents during that meal.</p> <p>OTHER RESIDENTS The same day the surveyor identified hand hygiene issue in dining room, the RN Resource provided 1:1 education to all staff members, that assist residents with food, related to performing hand hygiene when feeding more than one resident in the dining room, as well as</p>		

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F 880	<p>Continued From page 51</p> <p>clean linen was to be delivered on a covered cart to resident areas.</p> <p>This policy was not followed.</p> <p>On 1/22/20 at 8:36 AM, a laundry cart with residents' personal laundry was observed being rolled down a unit corridor, and it was partially covered as clothing was delivered to residents' rooms. A sheet was resting on top of the hangers along the length of the cart, and it was hanging down the sides of the cart approximately 4-6 inches. The sheet was covering the shoulders of the clothes, and the remainder of the clothes were exposed.</p> <p>On 1/23/20 at 9:09 AM, a laundry cart with residents' personal laundry was observed being rolled down a unit corridor to residents' rooms with a plastic bag covering all but 3-4 inches at the bottom. The plastic bag was pulled up at one end to allow the clothing on hangers to be removed and delivered to a resident. The bag was not pulled back down when it was rolled down the corridor to the next resident's room.</p> <p>On 1/24/20 at 8:51 AM, the SDC said if a sheet was not pulled down over personal laundry when it was delivered, then it was not protected. The Infection Preventionist said if personal laundry was not covered to include the bottom 3 to 4 inches, then it was exposed. The Infection Preventionist said the cover must come down to the bottom of the cart, and the plastic bag must be pulled down over personal laundry between deliveries.</p> <p>2. The facility's policy for Hand</p>	F 880	<p>review of facility hand hygiene policy. When surveyor reported that laundry was not being completely covered when being transported down hall and delivered to resident rooms, Maintenance Director provided large bags that completely covered linen from top to bottom.</p> <p>FACILITY SYSTEMS Central Supply Clerk purchased individual sized hand sanitizer that can be kept by each CNA in the dining room to be used in-between feeding residents and if hand hygiene is necessary. The system has been amended to include that dietary staff will place an extra set of silverware for residents that require assistance with feeding. This will allow staff to perform hand hygiene and only touch silverware used by them. Residents that can partially feed themselves will use a separate set of silverware. Facility IDT will continue to provide hand hygiene training upon hire and annually. Regarding Linen and laundry, Maintenance Director purchased laundry covers from Medline that will ensure that items are fully covered. Maintenance Director will provide education to laundry staff</p> <p>MONITOR Dietary Manager and/or designee will complete meal observations in the dining room to validate appropriate hand hygiene is conducted preventing cross contamination 5 times weekly for four weeks, then 3 times weekly for eight weeks. Maintenance Director and/or</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135052	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/24/2020
NAME OF PROVIDER OR SUPPLIER COEUR D'ALENE HEALTH & REHABILITATION OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2514 NORTH SEVENTH STREET COEUR D'ALENE, ID 83814		
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F 880	<p>Continued From page 52</p> <p>Hygiene/Handwashing, dated 11/28/17, documented hand hygiene was to be performed in clinical situations, including:</p> <ul style="list-style-type: none"> * Between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. * After contact with a patient's intact skin. <p>This policy was not followed.</p> <p>On 1/21/20 at 12:48 PM, NA #1 was observed feeding Resident #32 and #42 in the main dining room. NA #1 alternated between feeding Resident #32 and #42, and at multiple times she touched each resident and/or their utensils without performing hand hygiene before touching or feeding the other resident.</p> <p>On 1/21/20 at 12:57 PM, NA #1 said she washed her hands before entering the dining room, before sitting down to feed residents, and if her hands got dirty. NA #1 said she was unaware of a policy regarding hand hygiene while feeding residents.</p> <p>On 1/21/20 at 12:51 PM, CNA #3 was observed feeding Resident #36 and Resident #31 in the main dining room. CNA #3 alternated between feeding Resident #36 and Resident #31, and at multiple times she touched each resident and/or their utensils without performing hand hygiene before touching or feeding the other resident.</p> <p>On 1/21/20 at 2:00 PM, CNA #3 said she washed her hands when entering the dining room, when first touching a resident, and when adjusting a resident's clothes or chair. CNA #3 said if she</p>	F 880	<p>designee will audit to include rounds made during transport and delivery of resident laundry to validate fully covered with no areas of exposure 5 times weekly for four weeks, then 3 times weekly for eight weeks. The reviews will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.</p>		

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

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F 880	<p>Continued From page 53</p> <p>was feeding two residents, she switched hands between each resident. CNA #3 said she was told it was acceptable if one hand touched one resident and the other hand was used for the other resident, and that was the facility's policy.</p> <p>On 1/21/20 at 2:49 PM, the DON said staff should perform hand hygiene in the dining room before starting to feed a resident, if they got up to help another resident, if their hands were visibly soiled, and if passing several meal trays. The DON said the facility taught the CNAs not to use the same hand for feeding another resident, and they could use one hand for feeding each resident. The DON said it did not meet her expectation for a CNA to touch a resident with both hands then touch or feed another resident.</p> <p>The facility failed to ensure infection prevention practices were followed by staff to prevent potential cross-contamination.</p>	F 880			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001600	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2020
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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiency was cited during the State licensure survey conducted at the facility from January 21, 2020 through January 24, 2020.</p> <p>The surveyors conducting the survey were:</p> <p>Cecilia Stockdill, RN, Team Coordinator Sallie Schwartzkopf, LCSW</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection Control attendance records, it was determined the facility failed to ensure the Dietary Services Supervisor attended the Infection Control meetings on a regular basis. This had the potential to affect all residents, staff, and visitors in the facility. Findings include:</p> <p>On 1/23/20 at 4:00 PM, the attendance sheets were reviewed for the facility's 2019 Quality Assurance and Performance Improvement/Infection Control meetings. There was no documentation the dietary/nutrition manager attended the Infection Control meetings on 4/24/19, 5/22/19, 7/17/19, 8/28/19, 10/2/19, 11/6/19, or 12/4/19.</p> <p>On 1/23/20 at 6:04 PM, the Administrator said there was no documentation the dietary/nutrition</p>	C 664	<p>RESIDENT SPECIFIC CEO and CNO evaluated the QAPI/Infection Control meeting attendance.</p> <p>OTHER RESIDENTS CEO and CNO evaluated the QAPI/Infection Control meeting attendance.</p> <p>FACILITY SYSTEMS Monthly QAPI/Infection control meeting dates will be determined at the beginning of each month. The facility dietary manager or representative will attend the facility's monthly QAPI/Infection Control meeting. 1:1 education provided to dietary manager regarding required attendance and participation in all</p>	2/24/20

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

TITLE

(X6) DATE
02/17/20

Bureau of Facility Standards

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C 664	Continued From page 1 manager attended the Infection Control meetings during the second and fourth quarters of 2019, and it was likely due to the meeting occurring at noon and the dietary manger was cooking at that time.	C 664	QAPI/Infection Control meetings. MONITOR CEO and/designee will audit QAPI/Infection Control attendance sheets every month for three months to ensure appropriate personnel are attending required meetings. The review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may continue audit and adjust the frequency of the monitoring after 12 weeks, until substantial compliance maintained.	
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