



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P. O. Box 83720
Boise, Idaho 83720-0009
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February 6, 2020

Lisa Melchiorre, Administrator
St Luke's Elmore Long Term Care
PO Box 1270
Mountain Home, ID 83647-1270

Provider #: 135006

Dear Ms. Melchiorre:

On **January 24, 2020**, a survey was conducted at St Luke's Elmore Long Term Care by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 18, 2020**. Failure to submit an acceptable PoC by **February 18, 2020**, may result in the imposition of penalties by **March 10, 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,



Belinda Day, RN,, Supervisor
Long Term Care Program

BD/lj

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

PRINTED: 02/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2020
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S ELMORE LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 895 NORTH 6TH EAST MOUNTAIN HOME, ID 83647
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from January 21, 2020 through January 24, 2020.</p> <p>The surveyors conducting the survey were: Karen Gray, RD, Team Coordinator Michael Brunson, RN Jenny Walker, RN</p> <p>Survey Abbreviations: DNS = Director of Nursing MDS = Minimum Data Set</p>	F 000		
F 578 SS=E	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the</p>	F 578		2/17/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/14/2020
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	<p>Continued From page 1</p> <p>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' advance directive information was periodically reviewed with the residents and/or their representatives and was accurate. This was true for 3 of 3 residents (#3, #13, and #14) 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 incapacitated. Findings include:</p> <p>The State Operations Manual, Appendix PP, defines an Advance Directive as "...a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by</p>	F 578	<p>Resident # 3: Medical Director consulted on day of finding and changed Code order to reflect resident's wishes and Living Will.</p> <p>Resident #13: Medical Director consulted on day of finding and changed Code order to reflect resident's wishes and Durable Power of attorney for Health Care</p> <p>Resident #14: Resident Advocate contacted family of resident. A care conference was scheduled and Advanced Directives were discussed and signed on 1/28/2020.</p> <p>Resident's electronic records were reviewed for accuracy. Code status and</p>		

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F 578	<p>Continued From page 2</p> <p>the courts of the State), relating to the provision of health care when the individual is incapacitated." The State Operations Manual also states a Physician Orders for Life-Sustaining Treatment (POLST) is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an Advance Directive.</p> <p>The facility's Advance Directives policy, dated 8/31/19, documented the following:</p> <ul style="list-style-type: none"> * Staff will inquire and document whether there is an existing Advanced Directive. If one is provided it will be scanned into the medical record. * Copies of the Advanced Directive should be documented in the medical record and communicated clearly to staff involved with cares. <p>This policy was not followed.</p> <p>1. Resident #3 was admitted to the facility on 10/3/19, with multiple diagnoses which included pneumonia, heart failure and hypertension (high blood pressure).</p> <p>Resident #3's admission orders, dated 10/3/19, documented his status was full code (all interventions needed to restore breathing or heart function).</p> <p>Resident #3's admission orders, dated 10/3/19, documented his resuscitation status was to be a</p>	F 578	<p>Advanced directives were reviewed and verified.</p> <p>Policy and Procedure for obtaining, ordering and recording Advance Directives was reviewed with LTC Leadership. Pocket Care plan was reviewed with team members. Advance Directives will be reviewed for accuracy with resident/family wishes upon admission, transfer, discharge and any change of condition. Advance Directives will be reviewed by the Interdisciplinary Team on admission, during interdisciplinary conference (Resident at Risk) and quarterly at the residents care conference and/or change in condition. Order and appropriate documentation to support order will be reviewed for accuracy within the residents record at these times. A checklist has been implemented for Admission, Resident at Risk and Care Conference to ensure compliance. Frequency is with MDS quarterly review, Quarterly Resident Care Conference or if there is a change in condition.</p> <p>Advance Directive order accuracy will be reviewed by the MDS Coordinator and resident advocate quarterly and with any change of condition. Audits will be conducted weekly to ensure systems are working and sustained by Director of Nursing and MDS Coordinator. Director of Nursing will collect and review checklists weekly and is responsible for reporting compliance to QAPI Committee monthly.</p>		

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F 578	<p>Continued From page 3 full code.</p> <p>A care plan dated 1/10/20, documented Resident #3 did not want to prolong his life and requested comfort measures only.</p> <p>Resident #3's admission orders and care plan did not match his wishes documented in his Living Will.</p> <p>On 1/22/20 at 3:16 PM, the DNS stated there was a discrepancy in the documentation of Resident #3's code status and it should have been changed to reflect the residents wishes.</p> <p>2. Resident #13 was admitted to the facility on 11/30/18, with multiple diagnoses which included peripheral vascular disease (a common circulatory problem in which narrowed arteries reduce blood flow to the limbs), and chronic kidney disease.</p> <p>A Durable Power of Health Care dated 4/7/09, documented Resident #13 did not want efforts to prolong her life, and did not want life sustaining treatments or cardiopulmonary resuscitation.</p> <p>Resident #13's admission order, dated 11/30/18, documented her resuscitation status she was to be a full code.</p> <p>Resident #13's admission orders did not match her wishes documented in her Durable Power of Health Care.</p> <p>On 1/22/20 at 3:40 PM, the DNS stated Resident #13's code status was not documented to reflect her wishes and needed to be changed.</p>	F 578			

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F 578	Continued From page 4 3. Resident #14 was admitted to the facility on 12/4/19, with multiple diagnoses including metastatic colon cancer (cancer that originated in the colon and moves to other organs). Resident #14's record did not include documentation of an Advance Directive, or that it was offered or discussed with him. On 1/24/20 at 11:05 AM, the Resident Services Advocate stated Resident #14's record did not have documentation Advance Directives were offered or discussed with him or his representative.	F 578			
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and resident and staff interview, the facility failed to ensure MDS assessments accurately reflected the resident's status. This was true for 5 of 8 residents (#1, #5, #8, #11, and #12) whose MDS assessments were reviewed for accuracy. This failure created the potential for harm should residents receive inappropriate care related to discrepancies in the MDS assessment. Findings include: The facility's Restraint Policy, revised on 9/20/19, stated, "Physical Restraint/Hold: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the	F 641	MDS Coordinator re-educated on proper coding of restraints. Residents #1, #5, #8, #11 and #12 MDS were corrected to reflect the bedrails were not coded as being used as restraints. Residents current MDS reports were audited for restraint coding accuracy. No inaccuracies were noted. MDS Coordinator developed a live schedule of when tasks for each resident are due and a checklist of tasks when completed. MDS Coordinator will accurately capture and code residents	2/17/20	

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F 641	<p>Continued From page 5</p> <p>ability of a patient to move his arms, legs, body or head freely and/or a measure to prevent patient from exiting the bed/chair (e.g., mitts tied down, soft or leather wrist or ankle straps."</p> <p>The CMS Resident Assessment Instrument (RAI) Manual, Version 3.0, dated October 2019, which is used as an instruction manual for completing MDS assessments, defines physical restraints as "any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body."</p> <p>The use of bed rails in the facility did not meet the definition of a physical restraint as documented in residents' MDS assessments, as follows:</p> <p>a. Resident #1 was admitted to the facility on 11/19/18, with multiple diagnoses including chronic kidney disease and Type 2 diabetes mellitus.</p> <p>Resident #1's MDS assessments, dated 11/26/18, 2/19/19, 5/17/19, 8/17/19, and 11/15/19, documented bed rails were used daily as physical restraints.</p> <p>Resident #1's bed rail assessments, dated 2/19/19, 5/17/19, 8/16/19 and 11/15/19, documented bed rails were medically necessary and used for bed mobility, entering and exiting the bed safely, turning side to side, and positioning and moving up and down. The assessments did not include documentation the bed rails were used as a restraint.</p>	F 641	<p>information. Director of Nursing will review MDS documents on each patient for accuracy before submission. Director of Nursing reviews checklists weekly for completion and will follow up with MDS Coordinator for any identified gaps in practice. Frequency is with MDS quarterly review, Quarterly Resident Care Conference or if there is a change in condition.</p> <p>Director of Nursing will review MDS documents on each patient for accuracy before submission. Director of Nursing reviews checklists weekly for completion and will follow up with MDS Coordinator for any identified gaps in practice. Director of Nursing is responsible for reporting compliance to QAPI Committee monthly.</p>		

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F 641	<p>Continued From page 6</p> <p>On 1/22/20 at 5:00 PM, Resident #1 was observed laying in her bed with the left side against the wall and the bed rails were up. Resident #1 stated she used the bed rails to help her get in and out of bed.</p> <p>b. Resident #5 was admitted to the facility on 4/2/19, with diagnoses which included degenerative joint disease, osteoporosis of the right knee, and functional memory problem.</p> <p>A Risks and Benefits of Side Rails consent for use of bed rails for Resident #5 was signed by a family member on 4/2/19.</p> <p>Resident #5's MDS assessments, dated 4/9/19, 10/2/19, and 1/2/20, documented bed rails were used daily as a physical restraint.</p> <p>The initial bed rail assessment, dated 5/22/19, documented bed rails were medically necessary to assist Resident #5 for bed mobility, moving up and down in bed, and for transfer exiting and entering the bed more safely. The assessment documented the bed rails would not impede Resident #5's freedom of movement. The assessment did not include documentation the bed rails were used as a restraint.</p> <p>Resident #5's quarterly bed rail assessments dated 7/9/19, 10/2/19, and 1/2/20, documented the bed rails were used for supporting herself, improving balance, transferring more safely, turning side to side, and pulling herself from a laying to a sitting position. The assessments documented the bed rails would not impede Resident #5's freedom of movement. The</p>	F 641			

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F 641	<p>Continued From page 7</p> <p>assessments did not include documentation the bed rails were used as a restraint.</p> <p>During an interview with Resident #5 on 1/22/20 at 3:15 PM, she stated she used the bed rails when she was in bed, so she could reposition herself and the bed rails did not prevent her from getting out of the bed.</p> <p>c. Resident #8 was admitted to the facility on 12/3/18, with diagnoses which included restless leg syndrome, osteoporosis, diabetes mellitus, arthritis, tremor, and chronic obstructive pulmonary disease (progressive lung disease characterized by increasing breathlessness).</p> <p>A Risks and Benefits of Side Rails consent for use of bed rails was signed by Resident #8 on 12/3/18.</p> <p>Resident #8's MDS assessments, dated 12/10/18, 3/4/19, 6/4/19, 9/4/19, and 12/3/19, documented bed rails were used daily as a physical restraint.</p> <p>Resident #8's initial bed rail assessment, dated 12/3/18, and the subsequent quarterly assessments dated 3/4/19, 6/4/19, 9/6/19, and 12/3/19, documented the bed rails were recommended due to Resident #8's bladder incontinence, assistance of one person for toileting, diuretic use, and orthostatic medication use. The assessments documented the bed rails would not impede Resident #8's freedom of movement and the right upper bed rail had the bed controls imbedded in the rail. The assessments did not include documentation the bed rails were used as a restraint.</p>	F 641			

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F 641	<p>Continued From page 8</p> <p>During an interview with Resident #8 on 1/23/20 at 9:38 AM, she stated she had one bed rail on her bed that was used because it had the bed controls on the rail. She stated the rail did not keep her from getting out of bed.</p> <p>d. Resident #11 was admitted to the facility on 5/21/19, with diagnoses which included generalized weakness, seizure disorder, glaucoma (a disease that damages the eye's optic nerve), restless leg syndrome, osteoporosis, and insomnia.</p> <p>A Risks and Benefits of Side Rails consent for use of bed rails was signed by Resident #11 on 5/21/19.</p> <p>Resident #11's MDS assessments, dated 5/21/19, 8/21/19, and 11/21/19, documented bed rails were used daily as a physical restraint.</p> <p>Resident #11's initial bed rail assessment, dated 5/21/19, and the subsequent quarterly assessments for bed rails, dated 8/21/19, and 11/21/19, documented the bed rails were medically necessary to assist Resident #11 with bed mobility, for turning side to side, moving up and down in bed, pulling herself from a laying to a sitting position, and for transfer for improving balance and supporting herself. The assessments documented bed rails would not impede Resident #11's freedom of movement. The assessments did not include documentation the bed rails were used as a restraint.</p> <p>During an interview with Resident #11 on 1/23/20 at 3:15 PM, she stated she used the bed rails</p>	F 641			

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F 641	<p>Continued From page 9</p> <p>when she was in bed, so she could reposition herself and the bed rails did not prevent her from getting out of the bed.</p> <p>e. Resident #12 was admitted to the facility on 8/7/17, with diagnoses which included chronic musculoskeletal pain and transient ischemic attack (a brief episode of neurological dysfunction resulting from an interruption in the blood supply to the brain or the eye).</p> <p>Resident #12's MDS assessments, dated 11/17/18, 2/7/19, 5/7/19, 8/7/19, and 11/7/19, documented bed rails were used daily as a physical restraint.</p> <p>A Risks and Benefits of Side Rails consent for use of bed rails for Resident #12 was signed by a family member on 6/15/17.</p> <p>Resident #12's bed rail assessments, dated 2/7/19, 5/7/19, 8/6/19, and 11/7/19, documented the bed rails were medically necessary to assist Resident #12 with bed mobility, turning side to side, and pulling herself from a laying to sitting position. The bed rail was recommended due to conditions of dementia, bladder incontinence, assistance of two people for toileting, and orthostatic medications (blood pressure medications). The assessments stated the bed rails would not impede Resident #12's freedom of movement. The assessments did not include documentation the bed rails were used as a restraint.</p> <p>During an interview with Resident #12 on 1/21/20 at 9:45 AM, she stated she had one bed rail on her bed and used it to help pull herself up in bed.</p>	F 641			

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

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F 641	Continued From page 10 Resident #12 was observed on 1/22/20 at 9:48 AM, in bed with the upper bed rail on the right side of the bed in the raised position, with a pillow propped against it. Resident #12 stated it did not keep her from getting out of bed and she could not get out of bed without assistance from staff. On 1/22/20 at 9:02 AM, the MDS Coordinator stated bed rails are not used to restrict the residents but allowed them bed mobility. She stated the bed rails were coded as restraints because the residents could not lower the bed rails by themselves. She stated the bed rails in use did not prevent any of the residents using them from getting out of bed or restrict their movement. On 1/23/19 at 2:00 PM, the Administrator brought forward the CMS RAI Manual, dated October 2019, the reference used for coding bed rails as a positioning device. She referenced Section P: Physical Restraints, "Bed rails used as positioning devices: If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A." The surveyor explained to the Administrator the bed rails as used by the residents did not meet the definition of a physical restraint.	F 641			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		2/17/20	

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F 657	<p>Continued From page 11</p> <p>§483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents' care plans were regularly reviewed and revised for 1 of 16 residents (Resident #13) whose care plans were reviewed. This failure created the potential for harm if the resident was to receive inappropriate or inadequate care. Findings include:</p> <p>The facility's Resident Care Plan policy, dated</p>	F 657	<p>Resident #13 had care plan updated for the use of bed rails on 01/24/2020.</p> <p>Residents care plans were reviewed to confirm that accuracy of care provided was documented appropriately.</p> <p>Policy and Procedure for Admission Assessment was reviewed with LTC Leadership. Side rail assessment,</p>		

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F 657	<p>Continued From page 12</p> <p>6/30/18, documented a comprehensive person-centered care plan was developed by an interdisciplinary team for each resident, and upon a change in status of the resident, the care plan was modified.</p> <p>This policy was not followed.</p> <p>Resident #13 was admitted to the facility on 11/30/18, with multiple diagnoses which included peripheral vascular disease (a common circulatory problem in which narrowed arteries reduce blood flow to the limbs) and chronic kidney disease.</p> <p>On 1/21/20 at 3:31 PM, Resident #13 was observed in her room laying in bed with 2 bed rails up.</p> <p>A quarterly MDS assessment, dated 12/26/19, did not include documentation Resident #13 used bed rails.</p> <p>The next quarterly MDS assessments, dated 3/25/19, 6/25/19, and 9/25/19, documented Resident #13 used bed rails daily as a physical restraint.</p> <p>Resident #13's Care Plan did not include a revision for the use of bed rails or interventions why the resident needed them.</p> <p>On 1/23/20 at 5:15 PM, the DNS and MDS Coordinator were unable to locate a care plan for bed rails for Resident #13.</p> <p>On 1/24/20 at 10:45 AM, the Administrator stated Resident #13 did not have the use of bed rails</p>	F 657	<p>consent and FDA bed rail assessment for entrapment will be completed on admission. Residents care plans will reflect the utilization of bed rails. Need for bed rail(s) will be reviewed by the Interdisciplinary Team during interdisciplinary conference (Resident at Risk) and quarterly at the resident's care conference and/or change in condition. Physician orders will be verified. Frequency will be with MDS quarterly review, Quarterly Resident Care Conference or if there is a change in condition.</p> <p>Care Plan accuracy will be reviewed live during the Interdisciplinary Conference (Resident at Risk) and at the quarterly Resident Care Conference and modified as needed. Checklists used for the meetings will be collected and reviewed by the Director of Nursing weekly to ensure that solutions are sustained. Director of Nursing is responsible for reporting compliance to QAPI Committee monthly.</p>		

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F 657	Continued From page 13 documented on her care plan.	F 657			
F 700 SS=D	<p>Bedrails CFR(s): 483.25(n)(1)-(4)</p> <p>§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.</p> <p>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>§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.</p> <p>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>§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, record review, and staff interview, it was determined the facility failed to ensure a resident was appropriately assessed and a consent was obtained prior to installing bed rails. This was true for 1 of 8 residents (Resident #13) reviewed for bed rails. This failure created the potential for harm from entrapment or injury related to the use of bed rails. Findings include:</p>	F 700	<p>Resident #13 had assessment and consent for bed rail use completed on 01/24/2020.</p> <p>Residents that utilize bed rails charts were reviewed to ensure that appropriate assessments and consents were in place. No inaccuracies identified.</p> <p>Policy and Procedure for Bed Rail Use</p>	2/17/20	

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F 700	<p>Continued From page 14</p> <p>Resident #13 was admitted to the facility on 11/30/18, with multiple diagnoses which included peripheral vascular disease (circulatory problem in which narrowed arteries reduce blood flow to the limbs) and chronic kidney disease.</p> <p>On 1/21/20 at 3:31 PM, Resident #13 was observed in her room laying in bed with 2 bed rails up.</p> <p>Resident #13's MDS assessments, dated 3/25/19, 6/25/19, and 9/25/19, documented Resident #13 used bed rails daily as physical restraints.</p> <p>Resident #13's record included a bed rail assessment, dated 3/15/19, that was blank. Resident #13's chart did not include a current quarterly bed rail assessment.</p> <p>There was no risk versus benefit discussion documented in Resident #13's record or a consent for use of the bed rails by Resident #13.</p> <p>On 1/24/20 at 10:45 AM, the Administrator stated Resident #13 did not have a consent for the use of bed rails, the bed rails were not care planned, and her MDS assessment was inaccurate.</p>	F 700	<p>was reviewed with staff. Bed rail assessment, consent and FDA bed rail assessment for entrapment will be completed on admission. Need for side rail(s) will be reviewed by the Interdisciplinary Team during interdisciplinary conference (Resident at Risk) and quarterly at the residents care conference and/or change in condition. Physician orders will be verified. Frequency will be with MDS quarterly review, Quarterly Resident Care Conference or if there is a change in condition.</p> <p>Director of Nursing will review the MDS with sign off, and all checklist (Resident at Risk, Quarterly Care Conference) to ensure compliance. Director of Nursing is responsible for reporting compliance to QAPI Committee monthly.</p>		