



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE- Governor
DAVE JEPPESEN- Director

TAMARA PRISOCK—ADMINISTRATOR
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March 8, 2019

Brantley Shattuck, Administrator
Cascadia of Nampa
900 N. Happy Valley Rd.
Nampa, ID 83687

Provider #: 135144

Dear Mr. Shattuck:

On **February 1, 2019**, a survey was conducted at Cascadia of Nampa 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 an isolated deficiency that constitutes actual 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.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 18, 2019**. Failure to submit an acceptable PoC by **March 18, 2019**, may result in the imposition of civil monetary penalties by **April 10, 2019**.

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

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

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

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

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy(ies):

- **Denial of payment for new admissions effective May 1, 2019**
- **A civil money penalty**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 1, 2019**, if substantial compliance is not achieved by that time.

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

Brantley Shattuck, Administrator
March 8, 2019
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If you believe these deficiencies have been corrected, you may contact Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

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

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

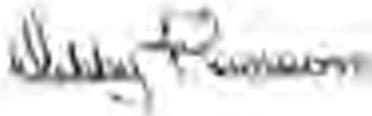
- BFS Letters (06/30/11)

[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **March 18, 2019**. If your request for informal dispute resolution is received after **March 18, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



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

DR/lj

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

PRINTED: 04/18/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2019
NAME OF PROVIDER OR SUPPLIER CASCADIA OF NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N HAPPY VALLEY RD NAMPA, ID 83687		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint investigation survey conducted at the facility from 1/28/19 to 2/1/19.</p> <p>The surveyors conducting the survey were:</p> <p>Cecilia Stockdill, RN, Team Coordinator Brad Perry, LSW Presie Billington, RN Wendi Gonzales, RN Kate Johnsrud, RN Kristy Flodquist, RN Sharon Dunn, RD</p> <p>Survey Abbreviations: 1:1 = One-to-one ADL = Activities of Daily Living appts = appointments cm = Centimeter CNA = Certified Nursing Assistant DNR = Do Not Resuscitate DNS = Director of Nursing Services IDT = Interdisciplinary Team LPN = Licensed Practical Nurse LTC = Long Term Care MAR = Medication Administration Record MDS = Minimum Data Set assessment meds = medications PRN = As Needed QAPI = Quality Assurance and Performance Improvement RCM = Resident Care Manager RD = Registered Dietitian RN = Registered Nurse</p>	F 000			
F 554	Resident Self-Admin Meds-Clinically Approp	F 554		4/2/19	

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

TITLE

(X6) DATE

Electronically Signed

03/18/2019

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

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F 554 SS=D	Continued From page 1 CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure 2 of 2 residents (#15 and #168) reviewed for self-administration of medications were clinically appropriate to do so prior to allowing them to self-administer medications. This had the potential for harm should the residents administer medications contrary to physician orders. Findings include: 1. Resident #15 was admitted to the facility on 5/7/18 with multiple diagnoses, including major depressive disorder, insomnia, anxiety disorder, and bipolar disorder. Resident #15's quarterly MDS assessment, dated 12/4/18, documented he was cognitively intact, did not exhibit behaviors, and required supervision for bed mobility, transfers, walking in his room and the corridor, locomotion, dressing, and eating, and required limited assistance with toilet use. On 1/30/19 at 2:25 PM, Resident #15 had a baggie with a prescription cream inside the bag on his overbed table. The pharmacy label on the cream documented it was ordered on 9/22/18 and read, "Mupirocin 2% and Bactroban 2% ointment [an antibiotic ointment combination] apply to the affected area two times a day as	F 554	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cascadia of Nampa does not admit that the deficiencies listed on the cms form 2567 exist, nor does the Facility admit to any statement, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, finds, facts and conclusions that form the basis for the deficiency. F 554 Resident Specific The clinical management team reviewed resident #15 and #168. Resident #168 discharged from facility. Resident #15 has a Self-Medication Assessment completed and order in place. Other Residents The clinical management team reviewed other residents to ensure if indicated have a self-medication assessment and order in place.		

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F 554	<p>Continued From page 2</p> <p>needed." Resident #15 stated the nurse let him keep the ointment and put it on his toe as needed. He stated currently he was not using it because he wanted his toenail to harden up and he believed it was keeping his toenail soft.</p> <p>On 1/30/19 at 2:35 PM, RN #3 said Resident #15 had the prescription ointment in his room and could self-administer it. Resident #15's medical record did not include a self-administration of medication order and self-administration assessment.</p> <p>On 1/31/19 at 5:44 PM, RCM #2 stated Resident #15 should have had an assessment for self-administration and an order to self-administer the ointment prior to being allowed to keep it in his room.</p> <p>2. Resident #168 was admitted to the facility on 1/21/19 with a diagnosis of kidney failure.</p> <p>Resident #168's current physician orders documented an order for "Sevelamer HCl Tablet 800 MG [milligrams] - Give 1 tablet by mouth with meals for kidney failure - May leave medication with patient in room so that it can be taken just prior to first bite of food."</p> <p>On 1/31/19 at 12:03 PM, RN #4 said Resident #168 had an order for Sevelamer HCL tablet 800 mg and to give 1 tablet by mouth with meals for kidney failure. RN #4 said Resident #168's order included, "May leave medication with patient in room so that it can be taken just prior to first bite of food." RN #4 delivered the medication to Resident #168 and left the room before she took the medication. RN #4 said she would check with</p>	F 554	<p>Facility Systems</p> <p>Licensed Nurses are educated to the process for self-medication. The CNO, SDC, and/or designee re-trained licensed nurses on how to determine if a resident meets criteria of administering medications independently, completion of a self-medication assessment, receiving an order, care planning, and monitoring for safety of medications in resident rooms who are on self-medication programs. CNAs and other staff are educated to notify the licensed nurse if medications are not safely monitored by the resident. The system is amended to evaluate residents in clinical meeting upon admission, upon request, and/or with new orders for completion of the the self-medication administration process. And to include monitoring for prescription and OTC medications accessible during leadership and nursing rounds.</p> <p>Monitor</p> <p>The CNO and/or designee will audit 5 random residents to determine if self-medication assessment and orders in place weekly x3 and then monthly x2. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/02/19</p>		

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F 554	Continued From page 3 her RCM to find out if an assessment was completed.	F 554			
F 565 SS=E	On 1/31/19 at 7:05 PM, RCM #1 said she could not find evidence of an assessment for self-administration of medications for Resident #168, and she completed one on that day. Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565		4/2/19	

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F 565	Continued From page 4 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, policy review, review of meeting minutes, and record review, it was determined the facility failed to provide guidance to assist the Resident Council group with agenda items to address and discuss facility policies/rules, concerns and grievances, and requests that resulted from the group meetings, and failed to act promptly to resolve and respond to requests from the group meetings. This was true for 13 of 13 (#3, #4, #7, #15, #16, #19, #28, #32, #36, #38, #41, #50, and #53) residents who attended the Resident Group Meeting. These negative practices placed residents at risk of ongoing frustration and decreased sense of self-worth, as well as, unmet care needs, when issues of concern to them were not promptly addressed by the facility. Findings include: Review of the facility's 11/28/17 policy, Resident & Family Group Meetings, indicated the facility was to, "Respect their residents' right to organize and participate in resident/family groups in the facility. . . Definition . . . Resident's Group . . . A group that meets regularly to: Discuss and offer suggestions about the facility policies and procedures affecting residents' care, treatment, and quality of life; Support each other; Plan resident activities; Participate in educational activities; or for any other purpose.	F 565	F565 Resident Specific LSW and/or designee of residents choice, met with residents #3, 4, 7, 15, 16, 19, 28, 32, 36, 38, 41, 50, 53 on or before 4/2/2019 to discuss and document possible concerns and grievances regarding cares. Concerns are documented on facility grievance form; follow up is provided per facility policy. Other Residents Resident council will be held on or before 4/2/2019 with LSW and/or designee of residents choice to provide guidance with agenda items, to educate on resident rights, explanation regarding facility rules, to review concerns/grievances and to address desires for programing changes and/or enhancements for the facility. . Concerns noted will be addressed and follow-up provided in the next resident council. Facility Systems Department managers educated by CEO and/or designee on or before 4/2/2019 to include but not limited to guidance with		

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F 565	Continued From page 5 [The] Facility procedure provides a resident group, if one exists, and takes reasonable steps, with the approval of the group, to make resident members aware of upcoming meetings in a timely manner . . . Educate the Resident Group President on protocols for presiding over the meetings . . . Assist residents with the structure of the group (i.e., election of officers, etc.) . . . Establish an agenda the residents and [the] Facility administration mutually agreed upon . . . A Resident Group appointee presides (usually the Resident Group President) over the meeting. [The] Facility representative does not conduct the meeting . . . [The] Facility provides a designated staff person who is approved by the resident group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings . . . [and to] Communicate results of the meeting to facility administration . . . The facility considers the views of a resident or family group and acts promptly upon grievances and recommendations of such groups concerning issues of resident care and life in the facility . . . The facility documents their response and rationale for the response to the residents or family recommendations and/or concerns . . . This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. Documentation Guidelines . . . Document communication of the meeting results to the facility's administration in the Performance Improvement minutes . . . Document actions taken to address needs or concerns expressed by the Resident Group/Family Group members."	F 565	agenda items required to support resident council, facility rules, process for completion of grievance concerns, , and timely follow up for individual resident and group grievances. The system is amended to trend/review grievance log concerns/resolutions and resident council minutes in monthly QAPI. Monitor The CEO and/or designee will audit resident council meeting notes for education on resident rights, resident directives to address community process, and timely follow up of concerns. Results will be documented on the QAPI audit tool monthly for 3 months. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.		

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F 565	Continued From page 6 The Resident Council Meeting minutes for the past six months were requested in the afternoon on 1/28/19. The facility provided the Resident Community Meeting minutes for five of the past six months in the morning on 1/29/19. Review of the Resident Community Meeting minutes for 8/7/18, 9/4/18, 10/3/18, 11/6/18, and 1/8/19 (the December 2018 minutes were not provided) documented the group reviewed activities topics only; it did not address or discuss facility policies/rules, rights, concerns and grievances, or other topics. These meetings were attended by 19 different residents. A Resident Group Interview was held on 1/29/19 at 10:30 AM, with Residents #3, #4, #7, #15, #16, #19, #28, #32, #36, #38, #41, #50, and #53, in attendance. Eleven of the 13 residents in attendance stated their cares were not being met and voiced concerns of possible retaliation, such as cares not being provided, if they voiced or filed grievances. The group said they met monthly, did not have a president, and no one was in charge. They said the meeting was on the activities calendar. They said there was a box outside the social services office with grievance forms to fill out, or staff could fill out the grievance forms as needed. Residents said the facility did not consistently respond to concerns/grievances, especially verbal concerns. Residents said call light response times were a problem last month, with 30 to 90 minutes elapsing before the lights were answered - with the worst response times being before breakfast, bed time, shift change, and weekends. The residents said the nurses did not answer lights and would not help residents	F 565			

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F 565	<p>Continued From page 7</p> <p>near change of shift, so the next shift would have to take care of the residents' needs. They said the nurses worked 12 hours shifts from 6:00 AM to 6:00 PM and some of the CNAs (Certified Nurse Aides) worked eight hours shifts, when other CNAs worked 12 hours shifts. The residents said the night shift had the best call light response times with about a five-minute response time.</p> <p>During an interview on 1/30/19 at 5:17 PM, the Activities Director and the Administrator stated the Resident Community Meetings were about activities, and confirmed they did not address resident rights, concerns/grievances, or follow-up from previous meetings. They confirmed this meeting was the Resident Council Meeting. They said none of the residents wanted to be the President, Vice President, or Secretary. Instead of officers, they had a Board of Directors, which was whomever attended each meeting. They said the attendees were cognitively intact and were usually the residents who were the most active in activities. The Activities Director said the calendar showed monthly menu reviews with the chef every second Tuesday, followed by a group discussion with the Administrator to go over concerns or recommendations. They said they would provide the meeting minutes and follow-up for the additional group meetings.</p> <p>During an interview on 1/31/19 at 9:30 AM, the Administrator provided minutes for the monthly group meetings with the chef, and for the monthly group meetings with the Administrator. None of the minutes provided included evidence of meeting the requirements for Resident Council. The grievances were not all resolved. The</p>	F 565			

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F 565	<p>Continued From page 8</p> <p>Administrator provided the Performance Improvement Plan (PIP) for call light response times. When asked about a lack of grievances, which reported concerns about call light responses, he agreed there was only one grievance form filled out for call lights, and said the Ombudsman told him there were call light response concerns. The Administrator then said he had not interviewed the residents to find out when the problems with call lights were happening. The Administrator confirmed the minutes should reflect a logical flow to the Resident Council concerns that detailed the process of forwarding concerns to the department heads, the actions taken by the department heads to resolve the concerns or provide resolutions to the residents, and whether or not the residents confirmed resolution of the concerns. The Administrator confirmed he did not interview residents about call light response times and did not have documented evidence of resident interviews.</p> <p>Review of the 1/17/19 PIP call light audits showed several random call light audits were performed. The Administrator acknowledged the call light audits may not necessarily be for the times the residents complained about because the residents were not interviewed about call lights. The Administrator confirmed he worked on resolving concerns/grievances. He said he was doing work "right away" to resolve concerns; however, he was not taking credit for his actions by documenting those actions. He said only one of the three group meetings reviewed had evidence of reviewing the grievances.</p> <p>Review of the first Group Discussion with the</p>	F 565			

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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	
F 565	<p>Continued From page 9</p> <p>Administrator minutes for 10/3/18, showed seven residents attended. Documented concerns included:</p> <p>"My room is hot and the hallway is cool."</p> <p>"O2 [oxygen] cannula tubing not changed regularly."</p> <p>"CNAs [Certified Nurse Aides] not returning to give showers."</p> <p>Review of the 11/6/18 Group Discussion with the Administrator minutes showed seven residents attended. There was no documented evidence the concerns/grievances voiced at the October 2018 group meeting were addressed or resolved for the residents. New documented concerns included:</p> <p>"Can we have nursing taught how to program with the remotes so when we have an issue we don't have to track down maintenance."</p> <p>"Why do I have to constantly ask for towels, they take my towels instead of getting more towels."</p> <p>"Couple of times my room mates [sic] bed pan has been left in the bathroom sink."</p> <p>Review of the 12/11/18 Group Discussion with the Administrator minutes showed 10 residents attended. There was no documented evidence the concerns/grievances voiced at the November 2018 group meeting were addressed or resolved for the residents. New documented concerns included:</p>	F 565			

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F 565	<p>Continued From page 10</p> <p>"Shower towels are not always collected and or new ones provided."</p> <p>"Our towel racks should be closer to the sink not across the bathroom."</p> <p>"Shower aide pulled to floor."</p> <p>"New staff need to be better informed on how to do their job."</p> <p>"I feel I need to be checked on more often, I feel like they forget about me because my room is in the corner."</p> <p>Review of the 1/8/19 Group Discussion with the Administrator minutes showed 10 residents and one family member attended. There was no documented evidence the concerns/grievances voiced at the December 2018 group meeting were addressed or resolved for the residents. New documented concerns included:</p> <p>"She continually get [sic] carrots, broccoli and chicken breast when she doesn't like them and it is on her ticket." "Assured daughter that this will be communicated to the dietary staff. All staff members are to work together to read the meal ticket to assure that what is placed on the plate is correct. Chef [name] will also be informed."</p> <p>"Executive Director reminded all residents/family present to not hesitate to use the green grievance cards to voice any [of] their concerns. We try very hard to resolve any issues/problems. Address it to the appropriate [department] manager if its [sic] regarding meds, appts [sic] direct to nursing. If you find that your concerns</p>	F 565			

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F 565	<p>Continued From page 11 are not being addressed, then bring it to the attention of the executive director."</p> <p>Review of the 10/3/18 Menu Review with the Chef minutes showed seven residents and one family member attended. Documented concerns included:</p> <p>"Can we have more grain wheat bread and english [sic] muffins."</p> <p>"Also croissants would be nice."</p> <p>"Sliders on a roll for a snack would be nice."</p> <p>"Salad bowls are to [sic] small, difficult to stir up the dressing."</p> <p>"There's no staff to help on the opposite side of the dining room sometimes."</p> <p>Review of the 11/3/18 Menu Review with the Chef minutes showed seven residents attended. There was no documented evidence the concerns/grievances voiced at the October 2018 group meeting were addressed or resolved for the residents. New documented concerns included:</p> <p>"Can't we have a different type of lettuce for our salads." "Chef suggested Spring Mix, group agreed."</p> <p>"I don't like to [sic] much pepper or spicy foods, please put that on my ticket."</p> <p>"Yeah, no spicy for me or no tomatoes, no acidic type foods for me."</p>	F 565			

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F 565	<p>Continued From page 12</p> <p>"Can I get my food chopped up for me."</p> <p>"I don't care for ground beef or bread."</p> <p>Review of the 12/11/18 Menu Review with the Chef minutes showed 10 residents attended. There was no documented evidence the concerns/grievances voiced at the November 2018 group meeting were addressed or resolved for the residents. New documented concerns included:</p> <p>"Food isn't hot."</p> <p>"They don't serve fast enough."</p> <p>"Salt & pepper shakers missing from the tables."</p> <p>"Can the gravy be put on the side as not everyone likes lots of gravy on their food."</p> <p>"Can we have beans and cornbread sometimes . . . fresh fruit, apples, oranges sometimes too."</p> <p>Review of the 1/8/19 Menu Review with the Chef minutes showed 10 residents and one family member attended. There was no documented evidence the concerns/grievances voiced at the December 2018 group meeting were addressed or resolved for the residents. New documented concerns included:</p> <p>"My mom continues to receive carrots and broccoli, [and] chicken breast and she dislikes these items." The Chef responded, "I will remind my staff to look more closely at the tickets."</p>	F 565			

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F 565	Continued From page 13 "I would like to see more meat at breakfast." The Chef responded, "I can look at that, we don't have a second option for breakfast, but I will look at that." "It seems like breakfast is always late getting to the dining room." A functional, organized Resident Council had not been developed at the facility to promote resident rights and address residents' concerns and preferences.	F 565			
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, 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 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		4/2/19	

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F 578	<p>Continued From page 14</p> <p>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 resident, family, and staff interview, it was determined the facility failed to ensure a) residents were provided information regarding Advance Directives upon admission, b) assisted to formulate Advance Directives if necessary, c) residents' records included documentation of this process, and d) a copy of the residents' Advance Directives or documentation of their decision not to formulate Advance Directives were included in residents' records. This was true for 6 of 13 residents (#32, #37, #38, #43, #54 and #267) whose records were reviewed for Advance Directives. These failures increased the risk of residents not having their decisions documented, honored, and respected when they were unable to make or communicate health care preferences. Findings include:</p> <p>The facility's Advance Directives policy and</p>	F 578	<p>F578 Resident Specific The Clinical Management Team reviewed resident #32. Resident #32 has a DPOA for healthcare, son to provide. Resident #37 has discharged from the facility. Resident #38, Advance directives education was provided to the resident DPOA-HC. LSW will continue to support the DPOA-HC for return of documents and place them in the medical record. Resident #237 has discharged from the facility. Resident #54 has discharged from the facility. Resident #43 has discharged from the facility.</p>		

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F 578	<p>Continued From page 15</p> <p>procedure, dated 10/2017, documented residents had the right to accept or refuse medical or surgical treatment and to formulate Advance Directives. During the admission process the facility determined whether the resident had an Advance Directive. If the resident or the resident's legal representative had executed an Advance Directive, a copy was requested and maintained in the resident's record. If the resident did not have an Advance Directive, the facility provided assistance to the resident and their family to establish an Advance Directive. The facility documented in the resident's record the discussions regarding Advance Directives and any healthcare decisions the resident made. If the resident decided to change their Advance Directive, it was documented in their record.</p> <p>1. Resident #37 was admitted to the on 8/4/18, with multiple diagnoses which included muscle weakness and diabetes mellitus.</p> <p>A Multidisciplinary Care Conference report, dated 11/5/18, documented Resident #37's Advance Directive was reviewed and to continue her Advance Directive.</p> <p>Resident #37's care plan, revised on 12/14/18, documented she had a POST and her Advance Directives was reviewed on admission, quarterly and with a change of condition.</p> <p>Resident #37's POST signed by her representative on 8/4/18, documented her code status was DNR.</p> <p>Resident #37's clinical record did not include an Advance Directive or documentation she had</p>	F 578	<p>Other Residents The Clinical Management Team reviewed other residents for advanced directives to validate they are located in the medical record and/or to determine whether the facility had provided information regarding formulation of an advanced directive. Adjustments were made as needed.</p> <p>Facility Systems licensed nursing and Social Services staff are educated to assist residents and families with advanced directives upon resident admission to facility. . Re-education was provided by CNO and/or designee to include but not limited to obtaining copies of advanced directives upon admission, offering information/education regarding advanced directives with residents and/or responsible parties, and including the advanced directive documents into the medical record upon admission and quarterly. The system is amended to include advanced directives education with residents and/or responsible parties on admission. In addition, the advanced directive review will be completed as indicated, or at least quarterly and with significant change and documented in the medical record.</p> <p>Monitor The CNO and/or designee will audit new admissions and quarterly care plan</p>		

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F 578	<p>Continued From page 16</p> <p>been provided information regarding formulating an Advanced Directive and offered assistance to do so, and declined the offer.</p> <p>On 1/31/19 at 1:35 PM, the Social Worker said the facility did not have a copy of Resident #37's Advance Directive. The Social Worker said when Resident #37 Multidisciplinary Care Conference report documented the Advance Directive was reviewed, it was referring to the POST that was reviewed with the residents and/or their families during the care conferences.</p> <p>2. Resident #38 was admitted to the facility on 3/19/18 and was readmitted on 7/18/18, with multiple diagnoses which included diabetes mellitus, muscle weakness, and difficulty walking.</p> <p>A Multidisciplinary Care Conference report, dated 10/25/18, documented Resident #38's Advance Directive was reviewed and to continue her Advance Directive.</p> <p>Resident #38's care plan, revised on 12/14/18, documented she had a POST and her Advance Directive was reviewed on admission, quarterly and with a change of condition.</p> <p>A POST signed by Resident #38 documented her code status was DNR.</p> <p>Resident #38's clinical record did not include an Advance Directive or documentation she had been provided information regarding formulating an Advanced Directive and offered assistance to do so, and declined the offer.</p> <p>On 1/31/19 at 1:35 PM, the Social Worker said</p>	F 578	<p>conferences for advanced directives weekly for 3 weeks, then monthly for 2 months. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p>		

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F 578	<p>Continued From page 17</p> <p>the facility did not have a copy of Resident #38's Advance Directive. The Social Worker said when Resident #38 Multidisciplinary Care Conference report documented the Advance Directive was reviewed, it was referring to the POST that was reviewed with the residents and/or their families during the care conference.</p> <p>3. Resident #267 was admitted to the facility on 12/26/18, with multiple diagnoses which included depression and hypertension.</p> <p>Resident #267's care plan, revised on 12/28/18, documented she had a POST and her code status was DNR.</p> <p>A POST signed by Resident #267's representative on 12/26/18, documented her code status was DNR.</p> <p>Resident #267's clinical record did not include an Advance Directive or documentation she had been provided information regarding formulating an Advanced Directive and offered assistance to do so, and declined the offer.</p> <p>On 1/31/19 at 1:35 PM, the Social Worker said Resident #267's POST was reviewed to establish the care plan, not information regarding an Advance Directive.</p> <p>4. Resident #54 was admitted to the facility on 11/29/18 with multiple diagnoses, including hemiplegia and hemiparesis (weakness and paralysis on one side) following cerebral infarction (stroke) affecting the right side, and aphasia (loss of ability to understand or express speech).</p>	F 578			

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F 578	<p>Continued From page 18</p> <p>A Multidisciplinary Care Conference note, dated 12/4/18 at 12:20 PM, documented Resident #54's Advance Directive was reviewed and to continue the Advance Directive.</p> <p>Resident #54's admission MDS assessment, dated 12/6/18, documented he had severely impaired cognitive skills for daily decision making.</p> <p>Resident #54's physician orders, dated 1/30/19, documented his code status was Full Code (initiate all life-saving measures).</p> <p>Resident #54's care plan documented he had a POST in place, initiated on 11/30/18 and revised on 12/14/18. The care plan documented his code status was Full Code.</p> <p>Resident #54's POST documented his code status as Full Code, and was signed by his representative on 11/29/18.</p> <p>Resident #54's clinical record did not include an Advance Directive or documentation he had been provided information regarding formulating an Advanced Directive and offered assistance to do so, and declined the offer.</p> <p>On 1/31/19 at 10:04 AM, the Social Worker said when a resident came in for admission to the facility, the Admission Coordinator asked for a copy of the Advanced Directive. If the resident did not have an Advanced Directive, it would be discussed in the initial care conference and documented in the admission care conference note. The Social Worker said the Advance</p>	F 578			

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F 578	<p>Continued From page 19</p> <p>Directive might not be in the chart of some residents who had been in the facility for awhile and before she became aware an Advance Directive was to be discussed.</p> <p>On 1/31/19 at 10:26 AM, the Social Worker and Clinical Resource Nurse said they did not find anything other than a POST form in Resident #54's clinical record.</p> <p>5. Resident #43 was admitted to the facility on 12/17/18, with multiple diagnosis including type II diabetes and cerebrovascular (related to blood vessels of the brain) disease.</p> <p>Resident #43's POST, dated 12/18/18, documented a code status of Full Code. The POST section for Advance Directives to identify a Living Will was blank.</p> <p>Resident #43's care conference note, dated 12/27/18, documented the Advance Directive was reviewed and continued.</p> <p>On 1/30/19 at 10:41 AM, Resident #43 said he had a living will.</p> <p>On 1/30/19 at 4:12 PM, Resident #43's spouse said she was unsure if a copy of the living had been provided to the facility, and said she had a copy of the living will in the car, if the facility needed it.</p> <p>On 1/31/19 at 10:04 AM, the Social Worker said she knew Resident #43 had a living will, and did not see a copy of it in his chart.</p> <p>6. Resident #32 was admitted to the facility on</p>	F 578			

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F 578	Continued From page 20 7/22/18 with multiple diagnoses, including multiple sclerosis (degenerative neurological disorder). Resident #32's Physician's Orders documented her Advance Directive was listed as, "Do Not Resuscitate, Physician Order for Scope of Treatment (DNR, POST)." Resident #32's current care plan documented her code status as DNR. Resident #32's POST, dated 7/23/18, signed by her, documented her code status was DNR. Resident #38's clinical record did not include an Advance Directive or documentation she had been provided information regarding formulating an Advanced Directive and offered assistance to do so, and declined the offer. On 1/31/19 at 10:33 AM, the Social Worker and the Clinical Resource Nurse said they did not have a copy of a Living Will, an Advance Directive, or a Durable Power of Attorney, or information related to Advanced Directives documented for Resident #32.	F 578			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		4/2/19	

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F 580	<p>Continued From page 21</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations</p>	F 580			

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F 580	<p>Continued From page 22 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and resident and staff interviews, it was determined the facility failed to ensure a resident's physician and representative were notified of significant changes in the resident's clinical condition in a timely manner. This was true for 1 of 3 residents (Resident #319) reviewed for notification of changes. This failure created the potential for harm when the facility failed to immediately notify Resident #319's physician and family member of his decreased level of consciousness. Findings include:</p> <p>The facility's policy for Resident Change of Condition, dated 11/28/17, documented the following:</p> <p>* When a potentially life-threatening condition is recognized, the nurse should relay the information to the health care provider. * Changes of condition may include a change in functional status, new or increased confusion, deteriorating mobility, falls, changes in behavior, and potentially life threatening conditions related to a change in the resident's chronic disease state and medical condition. * The physician should be notified as close to the time of the event as possible, and should be notified immediately if any sign or symptom is sudden in onset, a marked change compared to the resident's usual signs and symptoms, or not improved with previously prescribed measures. * Significant change is a decline or improvement in a resident's condition that would not normally improve without staff intervention, affects more</p>	F 580	<p>F580</p> <p>Based on record review, policy review, and resident and staff interviews, it was determined the facility failed to ensure a resident's physician and representative were notified of significant changes in the resident's clinical condition in a timely manner. This was true for 1 of 3 residents (Resident #319) reviewed for notification of changes. This failure created the potential for harm when the facility failed to immediately notify Resident #319's physician and family member of his decreased level of consciousness.</p> <p>Resident Specific Resident #319 is discharged from facility.</p> <p>Other Residents The clinical management team reviewed other residents for documentation of timely notifying resident's physician and representative of falls and/or significant changes in the resident's clinical condition. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses are educated to timely notify resident's physician and representative of significant changes in the resident's clinical condition.</p>		

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F 580	<p>Continued From page 23</p> <p>than one area of the resident's health status, and requires review or revision of the care plan by the interdisciplinary team.</p> <p>* The facility is to immediately inform the resident, seek advice from the physician, and notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status, or a need to significantly change treatment.</p> <p>1. Resident #319 was admitted to the facility on 8/23/18 with multiple diagnoses, including Amyotrophic Lateral Sclerosis (a degenerative neurological disease), altered mental status, Type 2 diabetes mellitus, schizophrenia, major depressive disorder, chronic kidney disease, after effects of cerebral infarction (stroke), history of pulmonary embolism (blood clot), and hepatic (liver) failure.</p> <p>Resident #319's Progress Notes documented the following:</p> <p>* On 8/23/18 at 9:25 PM, he was admitted to the facility and was able to communicate his needs.</p> <p>* On 8/26/18 at 3:14 AM, he was alert and oriented with slight confusion at times, he was able to verbalize his needs, and was "pleasantly happy."</p> <p>* On 8/26/18 at 8:00 AM, he had two witnessed falls within 30 minutes.</p> <p>* On 8/26/18 at 1:25 PM, there was increased confusion, he was impulsive and "having a difficult time complaining." He was having difficulty with mobility due to increased confusion.</p> <p>* On 8/27/18 at 12:31 AM, Resident #319 had been unresponsive that morning. The physician was making rounds in the facility, evaluated</p>	F 580	<p>Re-education was provided by CNO and/or designee to include but not limited to, notifying resident's physician and representative of falls, significant changes in the resident's clinical condition. The system is amended to include review of the falls documentation or resident significant changes for timely notification of resident's physician and representative by clinical management team in clinical meeting.</p> <p>Monitor The CNO and/or designee will audit 5 residents for timely notification of fall and/or significant change in resident's clinical condition to the resident's physician and representative weekly for 3 weeks, then monthly for 2 months. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p>		

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F 580	Continued From page 24 Resident #319, and was unable to waken him. Resident #319's wife was visiting, and the physician ordered immediate transport to the emergency room. An IDT Review of Falls that occurred on 8/26/18 documented Resident #319 was admitted to the facility after being hospitalized for liver failure and cirrhosis (degenerative disease of the liver). He was alert and oriented with some confusion at 3:14 AM, and had a fall at 6:00 AM. Resident #319 fell again at 8:00 AM and 8:30 AM. When the physician was making rounds on Monday morning (8/27/18), Resident #319 was "difficult to arouse" and was sent to the emergency room. There was no documentation in Resident #319's clinical record regarding when he became unresponsive and when his physician and wife were notified of his change in condition. On 1/31/19 at 5:27 PM, LPN #5 said she did not recall when Resident #319's level of consciousness changed or when his physician and wife were made aware of his change in condition. On 2/1/19 at 10:27 AM, the Clinical Resource Nurse said she could not tell from the documentation when Resident #319's condition changed or when his physician and wife were notified of his change in condition. The Clinical Resource Nurse said she would expect Resident #319's physician and wife to be notified when his condition changed.	F 580			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		4/2/19	

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F 584	<p>Continued From page 25</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable</p>	F 584			

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F 584	<p>Continued From page 26</p> <p>sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, and resident and staff interview, it was determined the facility failed to ensure the residents' living environment was homelike. This was true for 4 of 22 residents (#16, #24, #29, and #41) reviewed for homelike environment. This failure created the potential for diminished quality of life and psychosocial harm for those residents with room wall damage. Findings include:</p> <p>The facility's General Environmental Condition policy and procedure, dated 11/28/17, documented a comfortable environment was provided for residents, staff and the public. Plant operation and maintenance services were provided to maintain the inside and outside of the building, as necessary (e.g., painting, building repair such as handrails, flooring, plumbing, electrical, yard work, etc.).</p> <p>On 1/28/19 at 10:55 AM, Resident #16's room was observed with 4 inch by 4 inch wall damage above the baseboard on the west wall, and 12 inch by 12 inch wall damage on the south wall. Resident #16 stated he could not avoid hitting the wall with his wheelchair and the other wall damage was done by the back of a stationary chair. Resident #16 stated the holes on the west wall were fixed months ago, and the painting needed to be done. Resident #16 stated he knew the staff were busy and doing other things that were more important, and he would really like the wall to be fixed.</p> <p>On 1/28/19 at 11:19 AM, Resident #29's room</p>	F 584	<p>F584</p> <p>Resident Specific: Resident #16, 24, 29, and 41 have had the walls and/or paint repaired in their rooms.</p> <p>Other Residents: The maintenance team completed room rounds to identify areas of wall damage and/or missing paint. Areas identified have been repaired.</p> <p>Facility System: The CEO and/or designee re-educated on the inclusion of wall damage and paint damage to the preventative maintenance log. In addition, staff were re-educated to assist with the completion of work orders when areas are identified that are in need of repair and/or areas that have not been completed. The system is amended by including wall damage and paint damage review to the monthly preventative maintenance log, and validation by the CEO that projects are completed.</p> <p>Monitoring: The CEO and/or designee will audit resident areas and review the work order reports weekly for 3 weeks to validate timely repair of identified areas. Documentation will start the week of March 31 and be documented on the work order report. Any concerns will be addressed immediately and discussed</p>		

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F 584	Continued From page 27 had a 2 inch circle of missing paint, and 2 inch by 2 inch area of paint bubbling up on the east wall. Resident #29 stated he could avoid hitting the wall with his wheelchair and he would like the damage to the wall fixed. On 1/28/19 at 3:24 PM, Resident #24's and #41's room was observed with 6 inch by 12 inch significant wall damage on the left side of Resident #41's bed, and two 3 inch by 2 inch places of wall damage on the north side of the room. Resident #24 and Resident #41 stated the wall damage had been there since the side rails were put in place. On 1/29/19 at 3:00 PM, the Maintenance Director stated he was aware of the wall damage in the rooms of Residents #16, #24, #29 and #41. The Maintenance Director stated the wall damage was on his list to be repaired and he tried to touch up walls after residents were discharged.	F 584	with the QAPI committee. The QAPI committee may adjust the frequency of monitoring after 3 months, as it deems necessary.		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the	F 585		4/2/19	

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F 585	Continued From page 28 facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the	F 585			

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F 585	Continued From page 29 identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.	F 585			

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F 585	<p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, review of meeting minutes, and resident, family member, and staff interview, it was determined the facility failed to ensure grievances were responded to, investigated, and prompt corrective action taken to resolve the grievances. This was true for 4 of 21 residents (#1, #24, #41, and #64) reviewed for grievances and 13 of 13 residents (#3, #4, #7, #15, #16, #19, #28, #32, #36, #38, #41, #50, and #53) who participated in the Resident Group Interview. This failure created the potential for harm if residents' grievances, both verbal and written, were not acted upon and residents did not receive appropriate care or were at risk for abuse or neglect. Findings include:</p> <p>The facility's Complaints and Grievances policy and procedure, dated 11/28/17, documented an individual had the right to voice grievances to the facility or other agency or entity that hears grievances without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which had been furnished as well as that which had not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. The facility should make prompt efforts to resolve grievances the resident may have. Complaint/grievances may be verbal or written including social media. Complaints/grievances were acknowledged, investigated, and the complainant apprised of progress toward a resolution and takes appropriate corrective action if the alleged violation was confirmed by the facility.</p>	F 585	<p>F585</p> <p>Resident Specific Resident #24 discharged from the facility. LSW and/or designee met with residents #1, 3, 4, 7, 15, 16, 19, 24, 28, 32, 36, 38, 41, 50, 53, and 64 on or before 4/2/2019 to discuss and document possible concerns and grievances on facility grievance form and provide individualized investigation and follow up per facility policy.</p> <p>Other Residents Facility residents have been interviewed by LSW or designee on or before 4/2/2019 to address any grievances or concerns and validate they were documented, reviewed, and responded to per facility policy. The CEO has reviewed and validated the grievance log is complete and resolution has occurred.</p> <p>Facility Systems Facility staff have been educated by CEO and/or designee on or before 4/2/2019 to include but not limited to grievance policy, documentation of grievances/concerns on grievance tools, appropriate response and investigation process for grievances, and timely follow up of grievances. The system is amended to include review of grievances in morning meeting for timely management and trending of</p>		

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F 585	<p>Continued From page 31</p> <p>1. The Resident Council Meeting minutes for the past six months were requested in the afternoon on 1/28/19. The facility provided the Resident Community Meeting minutes for five of the past six months in the morning on 1/29/19.</p> <p>Review of the Resident Community Meeting minutes for 8/7/18, 9/4/18, 10/3/18, 11/6/18, and 1/8/19 (the December 2018 minutes were not provided) documented the group reviewed activities topics only; it did not address or discuss resident concerns and grievances.</p> <p>A Resident Group Interview was held on 1/29/19 at 10:30 AM, with Residents #3, #4, #7, #15, #16, #19, #28, #32, #36, #38, #41, #50, and #53, in attendance. The group said they met monthly, did not have a president, and no one was in charge. They said the meeting was on the activities calendar. They said there was a box outside the social services office with grievance forms to fill out, or staff could fill out the grievance forms as needed. Residents said the facility did not consistently respond concerns/grievances, especially verbal concerns. Resident #38 said there were not enough staff in the facility. She said her call light sometimes took an hour or more to be answered, and another 10 out of 13 residents in the Resident Group Interview said their call lights were not answered in timely manner. Residents said call light response times were a problem last month, with 30 to 90 minutes elapsing before the lights were answered - with the worst response times being before breakfast, bed time, shift change, and weekends. The residents said the nurses did not answer lights and would not help residents near change of shift, so the next shift would have to take care of</p>	F 585	<p>grievances/responses for review in monthly QAPI.</p> <p>Monitor The CEO and/or designee will audit facility grievance forms to validate grievance policy is followed including timely follow up weekly x 3 weeks and then monthly x 2. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p>		

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F 585	<p>Continued From page 32</p> <p>the residents' needs. They said the nurses worked 12 hours shifts from 6:00 AM to 6:00 PM and some of the CNAs (Certified Nurse Aides) worked eight hours shifts, when other CNAs worked 12 hours shifts. The residents said the night shift had the best call light response times with about a five-minute response time.</p> <p>During an interview on 1/30/19 at 5:17 PM, the Activities Director and the Administrator stated the Resident Community Meetings were about activities, and confirmed they did not address residents' concerns/grievances, or follow-up from previous meetings. They confirmed this meeting was the Resident Council Meeting. They said the attendees were cognitively intact and were usually the residents who were the most active in activities. The Activities Director said the calendar showed monthly menu reviews with the chef every second Tuesday, followed by a group discussion with the Administrator to go over concerns or recommendations. They said they would provide the meeting minutes and follow-up for the additional group meetings.</p> <p>During an interview on 1/31/19 at 9:30 AM, the Administrator provided minutes for the monthly group meetings with the chef, and for the monthly group meetings with the Administrator. The minutes provided did not consistently included evidence of the facility's response to the concerns/grievances shared at the Resident Council meetings. The grievances were not all resolved. The Administrator provided the Performance Improvement Plan (PIP) for call light response times. When asked about a lack of grievances, which reported concerns about call light responses, he agreed there was only one</p>	F 585			

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F 585	<p>Continued From page 33</p> <p>grievance form filled out for call lights, and said the Ombudsman told him there were call light response concerns. The Administrator then said he had not interviewed the residents to find out when the problems with call lights were happening. The Administrator confirmed the minutes should reflect a logical flow to the Resident Council concerns that detailed the process of forwarding concerns to the department heads, the actions taken by the department heads to resolve the concerns or provide resolutions to the residents, and whether or not the residents confirmed resolution of the concerns. The Administrator confirmed he did not interview residents about call light response times and did not have documented evidence of resident interviews.</p> <p>Review of the 1/17/19 PIP call light audits showed several random call light audits were performed. The Administrator acknowledged the call light audits may not necessarily be for the times the residents complained about because the residents were not interviewed about call lights. The Administrator confirmed he worked on resolving concerns/grievances. He said he was doing work "right away" to resolve concerns; however, he was not taking credit for his actions by documenting those actions. He said only one of the three group meetings reviewed had evidence of reviewing the grievances.</p> <p>Review of the first Group Discussion with the Administrator minutes for 10/3/18, showed seven residents attended. Documented concerns included:</p> <p>"My room is hot and the hallway is cool."</p>	F 585			

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F 585	<p>Continued From page 34</p> <p>"O2 [oxygen] cannula tubing not changed regularly."</p> <p>"CNAs [Certified Nurse Aides] not returning to give showers."</p> <p>Review of the 11/6/18 Group Discussion with the Administrator minutes showed seven residents attended. There was no documented evidence that the concerns/grievances voiced at the October 2018 group meeting were addressed or resolved for the residents. New documented concerns included:</p> <p>"Can we have nursing taught how to program with the remotes so when we have an issue we don't have to track down maintenance."</p> <p>"Why do I have to constantly ask for towels, they take my towels instead of getting more towels."</p> <p>"Couple of times my room mates [sic] bed pan has been left in the bathroom sink."</p> <p>Review of the 12/11/18 Group Discussion with the Administrator minutes showed 10 residents attended. There was no documented evidence the concerns/grievances voiced at the November 2018 group meeting were addressed or resolved for the residents. New documented concerns included:</p> <p>"Shower towels are not always collected and or new ones provided."</p> <p>"Our towel racks should be closer to the sink not across the bathroom."</p>	F 585			

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F 585	<p>Continued From page 35</p> <p>"Shower aide pulled to floor."</p> <p>"New staff need to be better informed on how to do their job."</p> <p>"I feel I need to be checked on more often, I feel like they forget about me because my room is in the corner."</p> <p>Review of the 1/8/19 Group Discussion with the Administrator minutes showed 10 residents and one family member attended. There was no documented evidence the concerns/grievances voiced at the December 2018 group meeting were addressed or resolved for the residents. New documented concerns included:</p> <p>"She continually get [sic] carrots, broccoli and chicken breast when she doesn't like them and it is on her ticket." "Assured daughter that this will be communicated to the dietary staff. All staff members are to work together to read the meal ticket to assure that what is placed on the plate is correct. Chef [name] will also be informed."</p> <p>"Executive Director reminded all residents/family present to not hesitate to use the green grievance cards to voice any [of] their concerns. We try very hard to resolve any issues/problems. Address it to the appropriate [department] manager if its [sic] regarding meds, appts [sic] direct to nursing. If you find that your concerns are not being addressed, then bring it to the attention of the executive director."</p> <p>Review of the 10/3/18 Menu Review with the Chef minutes showed seven residents and one</p>	F 585			

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F 585	<p>Continued From page 36</p> <p>family member attended. Documented concerns included:</p> <p>"Can we have more grain wheat bread and english [sic] muffins."</p> <p>"Also croissants would be nice."</p> <p>"Sliders on a roll for a snack would be nice."</p> <p>"Salad bowls are to [sic] small, difficult to stir up the dressing."</p> <p>"There's no staff to help on the opposite side of the dining room sometimes."</p> <p>Review of the 11/3/18 Menu Review with the Chef minutes showed seven residents attended. There was no documented evidence the concerns/grievances voiced at the October 2018 group meeting were addressed or resolved for the residents. New documented concerns included:</p> <p>"Can't we have a different type of lettuce for our salads." "Chef suggested Spring Mix, group agreed."</p> <p>"I don't like to [sic] much pepper or spicy foods, please put that on my ticket."</p> <p>"Yeah, no spicy for me or no tomatoes, no acidic type foods for me."</p> <p>"Can I get my food chopped up for me."</p> <p>"I don't care for ground beef or bread."</p>	F 585			

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F 585	<p>Continued From page 37</p> <p>Review of the 12/11/18 Menu Review with the Chef minutes showed 10 residents attended. There was no documented evidence the concerns/grievances voiced at the November 2018 group meeting were addressed or resolved for the residents. New documented concerns included:</p> <p>"Food isn't hot."</p> <p>"They don't serve fast enough."</p> <p>"Salt & pepper shakers missing from the tables."</p> <p>"Can the gravy be put on the side as not everyone likes lots of gravy on their food."</p> <p>"Can we have beans and cornbread sometimes . . . fresh fruit, apples, oranges sometimes too."</p> <p>Review of the 1/8/19 Menu Review with the Chef minutes showed 10 residents and one family member attended. There was no documented evidence the concerns/grievances voiced at the December 2018 group meeting were addressed or resolved for the residents. New documented concerns included:</p> <p>"My mom continues to receive carrots and broccoli, [and] chicken breast and she dislikes these items." The Chef responded, "I will remind my staff to look more closely at the tickets."</p> <p>"I would like to see more meat at breakfast." The Chef responded, "I can look at that, we don't have a second option for breakfast, but I will look at that."</p>	F 585			

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F 585	<p>Continued From page 38</p> <p>"It seems like breakfast is always late getting to the dining room."</p> <p>The facility failed to address residents' concerns/grievances.</p> <p>2. On 1/28/19 at 3:27 PM, Resident #1's responsible party stated Resident #1 was missing clothes, especially pajama pants. She stated at times she would see other residents wearing clothes that looked like his missing pajama pants. She also stated she brought in eight cloth pads, that cost \$30.00 each, to cover and protect the seat of his recliner. She stated now all eight pads were missing and she did his laundry; the pads did not show up in the laundry. Signs were posted on his closet and wall, informing staff that the family did Resident #1's laundry. Resident #1's responsible party stated she told RCM #2 many times about the missing items; however, they did not find them, did not replace them, and she had not heard anything back.</p> <p>On 1/31/19 at 5:44 PM, RCM #2 said, with the Clinical Resource Nurse present, Resident #1's responsible party did report the missing clothes and pads to him. He could not remember the date, but he stated it was sometime in the past month. He stated he took her to the laundry and they located a couple pairs of pajama pants, but did not locate any of the cloth pads and did not locate all the clothes she reported as missing. He stated he did not follow up or complete an investigation. The Clinical Resource Nurse said RCM #2 should have filled out a grievance form and a further investigation should have been completed.</p>	F 585			

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F 585	<p>Continued From page 39</p> <p>3. Resident #64 was admitted to the facility on 9/22/18 with multiple diagnoses, including muscle weakness.</p> <p>On 2/1/19 at 9:30 AM, Resident #64 said he told housekeeping and laundry staff at the end of December that he was missing a pair of blue Nike shorts, a pair of Nike sweats, and a blue Boise State shirt. He said laundry staff kept losing his clothes despite having his name put on them. Resident #64 said no one had filled out a grievance or offered to fill out a grievance for him.</p> <p>On 2/1/19 at 9:36 AM, the Director of Hospitality Services said Resident #64 told her about some missing clothes about a week ago, and she did not fill out a grievance for him. She said she should have filled out a grievance and given it to the Social Worker. The Director of Hospitality Services said she posted the missing clothes on an undated list and hung it on the wall in the laundry room and had been looking for the clothes. The undated list documented missing clothes, including a pair of blue shorts, a pair of black sweats, and a blue Boise State shirt.</p> <p>On 2/1/19 at 9:44 AM, the Social Worker said she did not have a grievance for Resident #64's missing clothes. She said staff were to fill out a grievance and/or let residents know they can complete one when issues came up. The Social Worker said if the clothes were not found, then the facility would replace them.</p> <p>4. Resident #24 was admitted to the facility on 11/21/18 with multiple diagnoses, including history of falls, cognitive communication deficit,</p>	F 585			

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F 585	<p>Continued From page 40 and depression.</p> <p>Resident #41 was admitted to the facility on 11/17/18 with multiple diagnoses, including history of falls, cognitive communication deficit, difficulty walking, and generalized muscle weakness.</p> <p>Resident #24 and Resident #41 were roommates. On 1/28/19 at 3:24 PM, Resident #24 and Resident #41, stated they made several complaints to staff since admission regarding cares and treatment, and the facility ignored their concerns. Resident #24 stated he did not know what a grievance was, how to complete a grievance or to whom to submit the grievance, and staff did not provide information regarding grievances at any time when he voiced a concern. Resident #24 and Resident #41 stated the complaints included concerns such as missing clothing and call lights taking 30 minutes up to 2 hours to be answered.</p> <p>Resident Grievances, dated 4/11/18 through 1/22/19, were reviewed and did not document grievances for Resident #24 and Resident #41.</p> <p>On 1/31/19 at 4:52 PM, the Social Worker stated residents or staff would complete a grievance form and place it in the box outside her office, which was checked once or twice a day. The Social Worker stated she resolved any issues that she was able to, signed and dated the form after completion and placed it in the grievance binder. The Social Worker stated any unresolved issues or problems that had many of the same items were directed to the specific departments. The Social Worker stated call lights were a</p>	F 585			

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F 585	Continued From page 41 concern for every facility and she was unsure why there were not more call light grievances in the binder. The Social Worker stated she was unsure of who educated the residents or staff on grievances and did not know about the resident council meetings. On 2/1/19 at 9:22 AM, the Director of Community Relations stated he reviewed the facility tour and admission packet information with each resident and their representative on admission. The Director of Community Relations stated he provided an Admission Packet, which included a summary of the facility's grievance policy and a copy of a grievance form. The Director of Community Relations stated he explained the grievance information and resident rights, and he provided a description of grievance examples and to whom to submit the grievance after the grievance was completed. The Director of Community Relations stated the Administrator was the first person to submit grievances to and the Social Worker was the second person to submit the grievance to once the grievance form was completed, and it could be completed by a charge nurse or department head. The Director of Community Relations stated he was unsure if there was a process for educating staff, a follow up process for educating residents, whether grievances were discussed in resident group meetings, or if verbal grievances were completed and submitted by staff.	F 585			
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	F 622			4/2/19

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F 622	Continued From page 42 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; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (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; or (F) The facility ceases to operate. (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.	F 622			

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F 622	Continued From page 43 §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. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c) (1)(i) of this section. (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). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary,	F 622			

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F 622	<p>Continued From page 44</p> <p>consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. 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 the required documentation was completed when a resident was transferred to the hospital. This was true for 1 of 3 residents (#318) reviewed for transfer or discharge, and had the potential for harm if the required documentation was not obtained from the physician and the pertinent information made available to the receiving facility. Findings include:</p> <p>The facility's policy for Transfer and Discharge, dated 11/28/17, documented the following: Information provided to the receiving facility should include, at a minimum, contact information of the responsible medical practitioner and the resident's representative, Advance Directive information, special instructions and/or precautions for ongoing care, the resident's care plan goals, and "all information necessary to meet the resident's needs..."</p> <p>A Progress Note, dated 1/27/19 at 3:11 AM, documented Resident #318 was transferred to the emergency room "per MD verbal order" at 1:30 AM due to increased blood in her Foley catheter, worsening flank pain, and headache. There was no documentation in Resident #318's clinical record of the physician's name or a physician's order to transfer her to the emergency room.</p>	F 622	<p>F622</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure the required documentation was completed when a resident was transferred to the hospital. This was true for 1 of 3 residents (#318) reviewed for transfer or discharge, and had the potential for harm if the required documentation was not obtained from the physician and the pertinent information made available to the receiving facility.</p> <p>Resident Specific Resident #318 is discharged from facility.</p> <p>Other Residents The clinical management team reviewed other residents for completion of required documentation when resident was transferred or discharged. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses are educated to complete transfer and/or discharge documentation when a resident is transferred or discharged. Re-education was provided by CNO and/or designee to include but not limited to, providing evidence that the information to the</p>		

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F 622	Continued From page 45 An Emergency Room physician note, dated 1/27/19 at 3:21 AM, documented Resident #318 was evaluated in the emergency room and was diagnosed with a urinary tract infection. A Progress note, dated 1/27/19 at 8:12 AM, documented Resident #318 returned to the facility from the hospital at 5:00 AM. Resident #318's clinical record did not contain documentation regarding her transfer summary or what information was provided to the receiving facility at the time of her transfer. On 1/30/19 at 11:49 AM, RCM #1 said she did not see a physician's order in Resident #318's clinical record for her to be transferred to the emergency room. RCM #1 said a transfer evaluation was usually completed when a resident was transferred, but she did not see it documented for Resident #318. On 1/31/19 at 9:46 AM, the DNS said an evaluation for transfers and a physician's order should have been completed for Resident #318 when she was transferred to the hospital.	F 622	receiving provider is listed in the resident medical record to ensure a safe and effective transition of care. The system is amended to include review of the required documentation as scanned into the resident medical record for residents who are transferred or discharged from facility during clinical meeting. Monitor The CNO and/or designee will audit 3 residents for completion of required documentation who are transferred or discharged weekly for 3 weeks, then monthly for 2 months. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.		
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	F 623		4/2/19	

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F 623	<p>Continued From page 46 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.</p> <p>§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.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (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;</p>	F 623			

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F 623	<p>Continued From page 47</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual 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</p>	F 623			

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F 623	<p>Continued From page 48</p> <p>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).</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 a notice of transfer was provided in writing to a resident and/or her representative when she was transferred to the hospital. This was true for 1 of 3 residents (#318) reviewed for transfer or discharge, and had the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's policy for Transfer and Discharge, dated 11/28/17, documented the following: Contents of the written notice would include the reason for transfer/discharge, the effective date, the location of where the resident is being transferred/discharged, the contact information for the state ombudsman, and the contact information for the agency responsible for protection and advocacy of those who are developmentally disabled or mentally ill.</p> <p>A Progress Note, dated 1/27/19 at 3:11 AM, documented Resident #318 was transferred to the emergency room at 1:30 AM due to increased blood in her Foley catheter, worsening flank pain, and headache.</p> <p>An Emergency Room physician note, dated 1/27/19 at 3:21 AM, documented Resident #318</p>	F 623	<p>F623</p> <p>Resident Specific Resident #318 is discharged from facility.</p> <p>Other Residents The clinical management team reviewed other residents transferred after March 1, 2019 for providing notice of transfer in writing to resident and/or their representative when the resident is transferred to the hospital. Adjustments have been made as indicated for residents still residing in the facility.</p> <p>Facility Systems Licensed nurses, Social Workers, and admission/discharge staff are educated to provide notice of transfer in writing to a resident and/or their representative when the resident is transferred to the hospital without an appointment. Re-education was provided by CNO and/or designee to include but not limited to, providing a notice of transfer in writing to a resident and/or their representative when the resident is transferred to the hospital for</p>		

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F 623	Continued From page 49 was seen in the emergency room, was diagnosed with a urinary tract infection. A Progress note, dated 1/27/19 at 8:12 AM, documented Resident #318 returned to the facility from the hospital at 5:00 AM. On 1/30/19 at 11:49 AM, RCM #1 said Resident #318's family was not notified in writing of her transfer to the emergency room. On 1/30/19 at 4:31 PM, RCM #1 said she did not follow up on notifying Resident #318 and her family regarding her transfer to the hospital. On 1/30/19 at 5:02 PM, the Medical Records Coordinator said Resident #318 did not receive a notice of transfer when she was transferred to the emergency room because she had arrived at the facility so recently.	F 623	emergent or non-emergent issues if there is no appointment established. The system is amended to include review in clinical meeting of the required notice of transfer documentation in the clinical record when there is evidence that the resident was transferred to the hospital even if returned and not admitted. Monitor The CNO and/or designee will audit 3 residents for completion of required notice of transfer in writing to a resident and/or their representative when the resident is transferred to the hospital weekly for 3 weeks, then monthly for 2 months. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 weeks, as it deems appropriate.		
F 637 SS=D	Comprehensive Assessment After Significant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced	F 637		4/2/19	

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F 637	<p>Continued From page 50</p> <p>by: Based on record review, policy review, and staff interview, it was determined the facility failed to complete a comprehensive assessment when a resident experienced a significant change in health and functional status. This was true for 1 of 1 resident (#65) reviewed for hospice. This had the potential for harm if facility staff did not recognize changes in the resident's health status and needs. Findings include:</p> <p>The facility's Resident Assessment policy, dated 11/28/17, documented a significant change assessment should be completed within 14 days after the facility determines or should have determined there has been a significant change in the resident's physical or mental condition.</p> <p>Resident #65 was admitted to the facility on 10/26/18 with multiple diagnoses, including dementia.</p> <p>Resident #65's admission MDS assessment, dated 11/2/18, documented he did not have hospice services. There were no other comprehensive MDS assessments found in Resident #65's clinical record.</p> <p>Resident #65's progress note, dated 11/21/18, documented a discussion regarding hospice services.</p> <p>Resident #65's hospice election form, dated 11/23/18, documented he was to receive hospice services.</p> <p>Resident #65's physician orders, dated 11/26/18, documented an order for hospice.</p>	F 637	<p>F637</p> <p>Resident Specific Resident #65 discharged from the facility.</p> <p>Other Residents Residents on hospice services were reviewed by CNO and/or designee on or before 4/2/2019 to ensure appropriate comprehensive assessment after significant change was completed.</p> <p>Facility Systems MDS nurse was educated by the CNO on or before 4/2/2019 regarding RAI requirements for hospice patients and facility policy for comprehensive assessments after significant change. The system is amended to review residents with new hospice orders in clinical meeting and validate the significant change MDS was completed.</p> <p>Monitor The CNO and/or designee will audit patients newly admitted to hospice services weekly x 3 weeks and then twice monthly x 2 to validate that a significant change MDS was completed timely. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p>		

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F 637	Continued From page 51 Resident #65's physician hospice justification and hospice plan of care, dated 11/28/18, documented he was to receive hospice services. On 1/31/19 at 11:33 AM, the MDS Nurse said there should have been a significant change MDS assessment completed when Resident #65 was placed on hospice, and it was missed.	F 637			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		4/2/19	

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F 656	<p>Continued From page 52</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans to include code status and assistance with eating. This was true for 2 of 21 residents (#40 and #43) who were reviewed for care plans. This failure created the potential for harm if residents received inappropriate or inadequate care, and if their resuscitation code status wishes were not honored. Findings include:</p> <p>The facility's care plan policy, dated 11/28/17, documented comprehensive person-centered care plans would be developed for each resident to attain or maintain residents highest practicable physical, mental, and psychosocial well-being.</p> <p>1. Resident #40 was admitted to the facility on 12/21/18 with multiple diagnoses, including aphasia (loss of ability to understand or express speech, caused by brain damage), muscle</p>	F 656	<p>F656</p> <p>Resident Specific Resident #43 discharged from the facility. Resident #40 was reviewed by the clinical team CNO on or before 4/2/2019 to validate care plan was updated for assistance with eating.</p> <p>Other Residents Residents care plans were reviewed by the clinical team on or before 4/2/2019 to validate care plans include code status and level of assistance needed for eating.</p> <p>Facility Systems Licensed nurses were educated by CNO and/or designee regarding comprehensive care plans on or before 4/2/2019. Re-education includes updating with appropriate code status and level of assistance needed for eating. The system</p>		

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F 656	<p>Continued From page 53</p> <p>weakness, dysphagia (difficulty swallowing), and dementia.</p> <p>Resident #40's admission MDS assessment, dated 12/29/18, documented he required the assistance of one staff for eating.</p> <p>Resident #40's care plan did not document the need for staff to assist him with eating.</p> <p>Resident #40's History and Physical, dated 12/28/18, documented, "I met with [Resident #40] today to admit him to our facility. Due to his dementia and schizophrenia he is non-verbal and requires assistance with all ADLs . . . He is sitting up in his chair and appears to be comfortable."</p> <p>On 1/30/19 at 12:50 PM, CNA #1 fed Resident #40 and she confirmed Resident #40 could not feed himself.</p> <p>During an interview with RCM #2 on 1/30/19 at 6:32 PM, RCM #2 confirmed Resident #40 needed feeding assistance. RCM #2 looked through the care plan and confirmed Resident #40's need for assistance with eating was not on the care plan.</p> <p>2. Resident #43 was admitted to the facility on 12/17/18 with multiple diagnosis, including Type 2 diabetes mellitus and cerebrovascular (related to blood vessels of the brain) disease.</p> <p>Resident #43's POST, dated 12/18/18, documented a code status of Full Code (initiate life-saving measures).</p> <p>Resident #43's current comprehensive care plan</p>	F 656	<p>is amended to include review upon completion of the comprehensive care plan and during quarterly care conferences. In addition, during clinical meeting new orders and resident changes will be reviewed with validation the care plan is updated.</p> <p>Monitor The CNO and/or designee will audit 5 random care plans weekly x 3 weeks and then 5 random care plans monthly x 2. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p>		

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F 656	Continued From page 54 did not include documentation of his code status.	F 656			
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident, family, and staff interview	F 657		4/2/19	
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F 657	<p>Continued From page 55</p> <p>and record review, it was determined the facility failed to ensure care plans were reviewed and/or revised, and failed to ensure residents and/or resident representatives were involved in the development of the care plan for 9 of 22 residents (Residents #1, #7, #14, #15, #32, #54, #64, #267, and #318) whose care plans were reviewed. This failure created the potential for harm should residents receive inappropriate care due to inaccurate information on their care plan and should residents' input not be considered on the care plan. Findings include:</p> <p>1. Resident #32 was admitted to the facility on 7/22/18, with multiple diagnoses including muscle weakness, abnormal posture, multiple sclerosis (degenerative neurological disorder), and hereditary spastic paraplegia (progressive weakness and stiffness of the legs).</p> <p>Resident #32's quarterly MDS assessment, dated 10/29/18, documented she was cognitively intact. She required extensive assistance from staff for bed mobility, dressing, toilet use, and personal hygiene.</p> <p>Resident #32's Care Conference Notes documented she was admitted on 7/22/18. The one Care Conference documented in her record was dated 11/28/18 at 2:00 PM. The attendance list on the 11/28/18 care conference documented Resident #32 and the social worker were present and no other members of the interdisciplinary team were present for the conference.</p> <p>On 1/28/19 at 9:25 AM, Resident #32 stated she was not invited to participate in planning her care related to medicine, therapy, and other</p>	F 657	<p>Resident Specific Resident #267, #54, and #318 discharged from the facility. Resident #1, 15, 32, and 64 have had a care plan conference completed with required IDT members, as well as with resident/resident representative. Resident #7, and 14's care plans were reviewed by the clinical team CNO to validate it currently reflects the residents needs. Other Residents Resident care plans and care conferences were reviewed by the clinical team for timeliness, appropriate participation of IDT and resident/resident representative, and accuracy.</p> <p>Facility Systems IDT members were educated by CNO and/or designee regarding requirements for care plan revisions and care conferences. Re-education included but was not limited to, family invitation to the care conference, timely scheduling of the care conference, an interdisciplinary team attendance as directed. The system is amended to review careplans in resident meeting on a quarterly basis and with any significant changes.</p> <p>Monitor The CNO and/or designee will audit 3 random care plan conference notes for</p>		

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F 657	<p>Continued From page 56</p> <p>treatments. Resident #32 stated she had not been to a care conference since she was admitted to the facility in July 2018.</p> <p>On 1/31/19 at 10:30 AM, the Care Conference information was reviewed with the Social Worker and the Clinical Resource Nurse. They both stated the meeting on 11/28/18 was the only care plan meeting documented for Resident #32. They stated a meeting was not completed upon admission, the first meeting was completed four months after admission, and only involved the resident and the Social Worker, and the meeting did not include applicable members of the interdisciplinary team.</p> <p>2. Resident #1 was admitted to the facility on 9/13/18, with multiple diagnoses including difficulty walking, generalized muscle weakness, history of falls, and dementia without behavioral disturbances.</p> <p>Resident #1's admission MDS, dated 9/20/18, and quarterly MDS, dated 12/20/18, documented he had severe cognitive impairment. He required extensive assistance from staff for bed mobility, transfers, dressing, personal hygiene, and toileting, was totally dependent on staff for bathing, and required limited assistance to walk in his room and to eat. He was not steady or able to balance with transfers.</p> <p>Resident #1's Care Conference notes documented the last conference was held on 10/2/18 at 1:00 PM, and his responsible party attended the conference. No additional care conferences were held after 10/2/18.</p>	F 657	<p>individualized care weekly x 3 weeks and then 3 random care plan conferences monthly x 2. Any concerns will be addressed and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p>		

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F 657	<p>Continued From page 57</p> <p>On 1/28/19 at 3:32 PM, Resident #1's representative stated she had not been invited to care conferences and asked whether the facility had them.</p> <p>On 1/31/19 at 10:30 AM, the Care Conference information was reviewed with the Social Worker and the Clinical Resource Nurse, and they stated a care plan meeting was not held for Resident #1 since 10/2/18.</p> <p>3. Resident #15 was admitted to the facility on 5/7/18 with multiple diagnoses, including major depressive disorder, insomnia, gastrointestinal hemorrhage (bleeding), acute and chronic respiratory failure, diverticulosis (when pockets develop in the intestines and become inflamed or infected) of the large intestine with bleeding, acute respiratory failure with hypoxia (low oxygen level), dependence on supplemental oxygen, bipolar disorder, ileostomy (surgically created opening in the abdominal wall through which digested food passes), and colostomy.</p> <p>Resident #15's quarterly MDS assessment, dated 12/4/18, documented he was cognitively intact and did not exhibit behaviors. He required supervision for bed mobility, transfers, walking in his room and in a corridor, locomotion, dressing, and eating, and required limited assistance with toilet use.</p> <p>Resident #15's Care Conference notes documented he attended a care conference on 5/9/18, 5/24/18, and 8/28/18. Resident #15's record did not include documentation of a Care Conference being completed since 8/28/18.</p>	F 657			

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F 657	<p>Continued From page 58</p> <p>On 1/28/19 at 11:21 AM, Resident #15 stated he did not feel like he was given the opportunity to participate in making decisions related to his care, medications, and treatment, and he was not informed of his plan of care or invited to care conferences.</p> <p>On 1/31/19 at 10:30 AM, the Care Conference information was reviewed with the Social Worker and the Clinical Research Nurse, and they stated a care conference meeting was not held for Resident #15 since 8/28/18.</p> <p>4. Resident #14 was admitted to the facility on 6/1/18 with multiple diagnoses, including dementia, abnormalities of gait and mobility, Parkinson's disease (degenerative neurological disorder), and repeated falls.</p> <p>Resident #14's quarterly MDS assessment, dated 12/9/18, documented he required extensive assistance of two staff persons for bed mobility and transfers, and was frequently incontinent.</p> <p>Resident #14's physician orders, dated 11/20/18, documented he was to be toileted every two hours while awake, every shift.</p> <p>Resident #14's care plan, dated 7/1/18, documented he had occasional episodes of bladder incontinence. The interventions included:</p> <ul style="list-style-type: none"> * Check for incontinence before and after meals, at bedtime, and as required during the night. * Offer toileting to Resident #14 before and after meals, at bedtime, and as needed. <p>Resident #14's care plan did not document</p>	F 657			

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F 657	<p>Continued From page 59</p> <p>toileting every 2 hours as ordered by the physician.</p> <p>On 2/1/19 at 10:54 AM, the Clinical Resource Nurse stated Resident #14 had an order for toileting every two hours while awake, and the intervention was not on the current care plan.</p> <p>5. Resident #64 was admitted to the facility on 9/22/18, with multiple diagnoses including muscle weakness.</p> <p>A Care Conference note, dated 9/24/18, documented a care conference was conducted with Resident #64, social services, nursing, the Administrator, and therapy. The note documented he was on a regular diet with regular texture and consistency. There was no documentation that a member of food and nutrition services attended the care conference.</p> <p>A Care Conference note, dated 12/28/18, documented a care conference was conducted with Resident #64, social services, and nursing. The note documented his diet was reviewed with no changes. There was no documentation that a member of food and nutrition services attended the care conference.</p> <p>Resident #64's current care plan documented he was on a regular diet.</p> <p>On 1/28/19 at 10:15 AM, Resident #64 said he knew what care conferences were and said he had not been to one since he was admitted to the facility. He said food was important to him, he did not like the food, and he generally ate from the alternate menu.</p>	F 657			

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F 657	<p>Continued From page 60</p> <p>On 1/31/19 at 10:33 AM, the Social Worker said there were no staff from the dietary department at Resident #64's care conferences, and she was unaware that dietary staff needed to be at the care conferences.</p> <p>On 2/1/19 at 10:04 AM, the Dietary Manager said he had not attended a care conference for Resident #64. The Dietary Manager said that he was aware of Resident #64's dietary needs.</p> <p>6. Resident #267 was admitted to the facility on 12/26/18, with multiple diagnoses which included major depressive disorder.</p> <p>An admission MDS assessment, dated 1/2/19, documented Resident #267 was severely cognitively impaired.</p> <p>Resident #267's Care Conference form, dated 12/28/18, was blank.</p> <p>Resident #267's clinical record did not include documentation a care conference was held with her or with her family.</p> <p>On 2/1/19 at 11:04 AM, the Social Worker said a care conference was held with Resident #267's representative over the phone, but she failed to complete the care conference form.</p> <p>7. Resident #54 was admitted to the facility on 11/29/18 with multiple diagnoses, including hemiplegia and hemiparesis (weakness and paralysis on one side) following cerebral infarction (stroke) affecting the right side, and aphasia (loss of ability to understand or express</p>	F 657			

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F 657	<p>Continued From page 61 speech).</p> <p>On 1/28/19 at 3:47 PM and 1/30/19 at 2:36 PM, Resident #54 had bilateral bed canes (handle or grab bar type device attached to a bed) present on his bed. Resident #54's care plan did not document the use of bed canes.</p> <p>On 1/30/19 at 4:40 PM, RCM #1 said she did not see bed canes documented on Resident #54's care plan.</p> <p>8. Resident #318 was admitted to the facility on 1/26/19 with multiple diagnoses, including polyneuropathy (degeneration of nerves), chronic heart disease, and severe chronic kidney disease.</p> <p>Resident #318's physician orders, dated 1/30/19, documented Trazadone (antidepressant medication) 50 mg tablet at bedtime for insomnia was ordered on 1/25/19.</p> <p>Resident #318's MAR documented the Trazadone was administered each day on 1/26/19 to 1/29/19 and the hours of sleep were documented each day and night shift.</p> <p>Resident #318's care plan did not document insomnia or medication for insomnia.</p> <p>On 2/1/19 at 9:41 AM, RCM #1 said she would expect to see Trazadone for insomnia on the care plan and she did not see it documented on Resident #318's care plan. RCM #1 said any nurse could add Trazadone for insomnia to the care plan.</p>	F 657			

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F 657	<p>Continued From page 62</p> <p>9. Resident #7 was admitted to the facility on 6/28/18, with multiple diagnoses including history of falls, cognitive communication deficit, difficulty walking, and generalized muscle weakness.</p> <p>Resident #7's admission MDS assessment, dated 6/28/18, documented she was cognitively intact, having her family involved in discussions about her care was very important, and she required the assistance of one person for bathing.</p> <p>Resident #7's care plan, dated 1/6/19, directed staff to provide Resident #7 with one shower a week.</p> <p>Resident #7's bathing/shower flowsheets, dated 10/1/18 through 1/26/19, documented if the resident refused to please call her daughter and notify social services.</p> <p>On 1/29/19 at 8:50 AM, Resident #7's daughter stated she was adamant that Resident #7 be provided with two showers a week and had requested the facility to contact her if she was not provided the showers.</p> <p>On 1/31/19 at 12:13 PM, Resident #7 stated she should have been provided with two showers a week.</p> <p>On 1/31/19 at 4:08 PM, the DNS, with the Clinical Resource Nurse present, reviewed Resident #7's care plan which directed staff to provide Resident #7 with one shower a week, and stated she would update Resident #7's care plan to provide Resident #7 with two showers a week and would call Resident #7's daughter when she refused.</p>	F 657			

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F 677 SS=E	<p>ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)</p> <p>§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:</p> <p>Based on observation, resident, resident representative, and staff interviews and record review, the facility failed to ensure residents were provided assistance with bathing and eating consistent with their needs. This was true for 5 of 6 residents (#1, #7, #15, #37, and #41) reviewed for activities of daily living. This failure created the potential for residents to experience embarrassment, isolation, decreased sense of self-worth, skin impairment, and compromised physical and psychosocial well-being. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 9/13/18 with multiple diagnoses, which included difficulty in walking and generalized muscle weakness.</p> <p>A quarterly MDS assessment, dated 9/20/18, documented he had severe cognitive impairment and he required extensive assistance of 1 to 2 staff member for activities of daily living.</p> <p>On 1/28/19 at 3:38 PM, Resident #1's representative stated she did not know how often Resident #1 got bathed. She stated she had asked the staff about how often they bathed or showered him and no one had provided her with an answer.</p>	F 677	<p>F677</p> <p>Resident Specific The clinical management team reviewed residents #1, #7, #15, and #41 and validated that currently they are getting their showers per schedule. Resident #37 discharged from facility.</p> <p>Other Residents The clinical management team reviewed other resident's to validate they were provided assistance with bathing and eating consistent with their needs.</p> <p>Facility Systems Nursing Staff have been educated by the CNO and/or desigee on ensuring ADL care for dependent residents is being provided to include but not limited to, showers, feeding, licensed nurse notification if unable to complete, and documentation to include refusals. The system is amended to include clinical management team to review shower documentation in clinical meeting. Rounds validate the adl assistance being provided while eating.</p> <p>Monitor</p>	4/2/19	

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F 677	<p>Continued From page 64</p> <p>Resident #1's care plan for ADLs, revised 12/17/18, documented he was totally dependent on staff and the staff were to provide him a bath or shower two times a week.</p> <p>Resident #1's bathing/shower flowsheet, dated 12/26/18 through 1/30/19, documented he did not receive a bath/shower as follows:</p> <p>* Documentation from 12/26/18 - 1/30/19 included:</p> <ul style="list-style-type: none"> - On 12/26/18 shower - On 1/7/19 shower - On 1/9/19 shower - On 1/14/19 resident refused - On 1/16/19 resident refused - On 1/21/19 shower - On 1/23/19 shower - On 1/30/19 shower <p>Resident #1 did not receive a shower for 11 days (12/27/18 - 1/6/19), did not receive a shower for 11 days (1/10/19 - 1/20/19), and did not receive a shower for 6 days (1/24/19 to 1/29/19).</p> <p>On 1/31/19 at 12:55 PM, CNA #4 stated she was the shower aide and responsible for providing showers to the residents on the B unit. She stated she was scheduled to work Sunday through Thursday and the aides who worked on the floor were to complete the Friday and Saturday showers. CNA #4 stated Resident #1 did not receive showers during the timeframes noted above. CNA #4 stated she could not see Resident #1 refusing two showers in a row, unless he was the last person on her list and she did not have time to go back and encourage him to take a shower a second time.</p>	F 677	<p>The CNO and/or designee will audit 5 random residents to validate showers are completed as per schedule and 3 assisted residents receiving feeding assistance as indicated weekly for 3 weeks and monthly x2. CNO. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p>		

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F 677	<p>Continued From page 65</p> <p>2. Resident #15 was admitted to the facility on 5/24/18, with multiple diagnoses which included major depressive disorder, and chronic obstructive pulmonary disease (lung disease that makes it hard to breathe).</p> <p>Resident #15's quarterly MDS assessment, dated 12/4/18, documented he was cognitively intact and required assistance of 1 staff member for activities of daily living. The MDS assessment documented Resident #15 had not bathed during the 7 days prior to the assessment.</p> <p>Resident #15 ADL care plan, revised on 1/2/19, documented he required assistance of 1 staff member with bathing and personal hygiene related to his weakness and shortness of breath.</p> <p>On 1/28/19 at 10:57 AM, Resident #15 stated he was to have a shower twice a week and said he received a shower "about every 11 days." He stated he wanted to have his showers twice weekly.</p> <p>Resident #15's bathing/shower flowsheet, dated 1/1/19 through 1/31/19, documented he did not receive baths/showers as follows:</p> <p>* Documentation from 1/1/19 - 1/28/19 included:</p> <ul style="list-style-type: none"> - On 1/1/19 shower - On 1/5/19 not applicable - On 1/12/19 supervision (with shower) - On 1/15/19 resident refused - On 1/16/19 resident refused - On 1/19/19 not applicable - On 1/21/19 shower - On 1/26/19 not applicable 	F 677			

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F 677	<p>Continued From page 66</p> <p>- On 1/28/19 physical help (with shower)</p> <p>Resident #15 did not receive a bath/shower for 10 days (1/2/19 - 1/11/19), for 8 days (1/13/19 - 1/20/19), and for 6 days (1/22/19 - 1/27/19).</p> <p>Resident #15's Nurse's Progress Notes did not include documentation to explain why he did not receive his showers as care planned.</p> <p>On 1/31/19 at 1:10 PM, CNA #4 stated she was the shower aide on the unit where Resident #15 resided and she worked Sunday through Thursday. Resident #15's bathing/shower flowsheet documented his shower schedule was Tuesdays and Saturdays. CNA #4 said the CNAs working on the floor were responsible to provide Resident #15 his shower on Saturdays. CNA #4 stated when the shower was marked not applicable it indicated the shower was not given. CNA #4 stated she was scheduled to shower up to 20 residents a day, and if she was unable to complete them, or if the resident refused or asked for a shower at a different time, she told the next shift. She said the next shift did not complete the showers she was unable to give. CNA #4 stated the showers scheduled for Saturdays were not being completed by the CNAs. She stated Resident #15's shower was not completed on 1/16/19 and he had refused that day because he had a therapy appointment. She said the only showers Resident #15 received in January were on 1/12/19, 1/21/19, and 1/28/19.</p> <p>3. Resident #37 was admitted on 8/4/18, with multiple diagnoses which included muscle weakness and diabetes mellitus.</p>	F 677			

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F 677	<p>Continued From page 67</p> <p>a. A quarterly MDS assessment, dated 8/10/18, documented Resident #37 was moderately cognitively impaired and required the assistance of two staff for bathing.</p> <p>The Activities of Daily Living care plan, dated 8/5/18, documented Resident #37 was totally dependent on staff for bathing.</p> <p>Resident #37's January 2019 bathing/shower flowsheet documented her bathing schedule was every Tuesday and Friday. Resident #37 did not receive a bath/shower as follows:</p> <p>* Documentation from 1/1/19 - 1/29/19 included:</p> <ul style="list-style-type: none"> - On 1/1/19 not applicable - On 1/4/19 not applicable - On 1/8/19 resident refused - On 1/11/19 not applicable - On 1/15/19 resident refused - On 1/18/19 not applicable - On 1/21/19 shower - On 1/22/19 resident refused - On 1/25/19 not applicable - On 1/29/19 not applicable <p>Resident #37 did not receive a shower for 20 days (from 1/1/19 - 1/20/19) and did not receive a shower for 8 days (from 1/22/19 - 1/29/19).</p> <p>On 1/29/19 at 2:27 PM, RCM #2 reviewed Resident #37's bathing/shower flowsheet and said Resident #37 had one shower from 1/1/19 through 1/29/19. RCM #2 said when a resident refused the bath/shower the Shower Aide should reapproach the resident at least 3 times and if the resident continued to refuse it was to be</p>	F 677			

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F 677	<p>Continued From page 68</p> <p>reported to the nurse. RCM #2 said the nurse should document the resident's refusals. RCM #2 said he did not find documentation as to why Resident #37 refused her bath/shower or if the nurse reapproached her.</p> <p>On 1/31/19 at 1:02 PM, CNA #4, who was the Shower Aide, said it was difficult for her to complete the bath/shower of the residents. She said her busiest day was Monday with 17 residents scheduled to receive their baths/showers. CNA #4 said the only time she could complete all of baths/showers was when some of the resident refused their showers. CNA #4 said there was a time when she was pulled to the floor because somebody called in sick and she was unable to complete any of the baths/showers. CNA #4 said she always documented "refused" when the resident refused a bath/shower.</p> <p>b. A quarterly MDS assessment, dated 11/10/18, documented Resident #37 was moderately cognitively impaired and she required the assistance of one staff member with eating. The assessment also documented Resident #37 required the assistance of two or more staff for bed mobility.</p> <p>Resident #37's care plan area addressing her food and fluid intake, documented she had inadequate oral food and beverage intake related to a variety of diagnoses including protein calorie malnutrition, anemia related to chronic kidney disease, and a left hip fracture. The care plan documented staff were to assist Resident #37 with eating and drinking.</p>	F 677			

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F 677	<p>Continued From page 69</p> <p>On 1/28/19 the following were observed for Resident #37:</p> <p>* 10:28 AM: Resident #37 was observed lying flat in bed watching television on her roommate's television. An over-the-bed table was approximately two feet away from her bed. On top of the over-the-bed table was a tray of food, which consisted of one-half banana, a full glass of apple juice, a small bowl of oatmeal with plastic cover, a plate with a cover, a bowl of fruit with plastic cover, and utensils that were wrapped together with a brown cloth.</p> <p>*10:51 AM: Same as above.</p> <p>*11:02 AM: CNA #11 and CNA #8 entered Resident #37's room. CNA# 8 left Resident #37's room. CNA #11 assisted Resident #37's to the bathroom.</p> <p>*11:11 AM: RCM #2 asked Resident #37 what she would like to eat for lunch and if she wanted a menu. RCM #2 left the room without asking Resident #37 if she wanted to eat her breakfast.</p> <p>*11:13 AM: CNA #11 left Resident #37's room.</p> <p>*11:30 AM: Same as at 10:28 AM above.</p> <p>*12:07 PM: Same as at 10:28 AM above.</p> <p>*12:13 PM: CNA #11 brought Resident #37's breakfast food tray out of her room. CNA #11 said Resident #37 was a picky eater, and staff usually left Resident #37's tray on the over-the-bed table and she would just pick whatever she wanted to eat.</p>	F 677			

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F 677	<p>Continued From page 70</p> <p>On 1/30/19 at 12:15, the DNS said Resident #37 was able to feed herself. The DNS said the CNAs should have repositioned Resident #37 to eat, set-up her meal, removed the plate cover, and ensured the food was within her reach.</p> <p>Resident #37 was not provided with staff assistance for the breakfast meal.</p> <p>4. Resident #7 was admitted to the facility on 6/28/18, with multiple diagnoses including history of falls, cognitive communication deficit, difficulty walking, and generalized muscle weakness.</p> <p>Resident #7's admission MDS assessment, dated 6/28/18, documented she was cognitively intact, family involvement in discussions about her care was very important, and she required the assistance of one person for bathing.</p> <p>Resident #7's care plan, dated 1/6/19, directed staff to provide Resident #7 with one shower a week.</p> <p>Resident #7's bathing/shower flowsheets and nurses' progress notes, dated 10/1/18 through 1/26/19, documented missing shower entries. The flowsheets documented if Resident #7 refused, to please call her daughter and notify social services. Showers should have been provided for Resident #7 on Sundays and Thursdays. Resident #7 did not receive baths/showers as follows:</p> <p>* Documentation from 10/6/18 - 10/14/18 included: - On 10/6/18 shower</p>	F 677			

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F 677	<p>Continued From page 71</p> <ul style="list-style-type: none"> - On 10/10/18 not applicable - On 10/14/18 shower <p>Resident #7 did not receive a shower for 7 days (10/7/18 - 10/13/18)</p> <p>* Documentation from 10/28/18 - 11/8/18 included:</p> <ul style="list-style-type: none"> - On 10/28/18 shower - On 10/31/18 not applicable - On 11/3/18 resident not available - On 11/8/18 shower <p>Resident #7 did not receive a shower for 10 days (10/29/18 - 11/7/18)</p> <p>Documentation from 11/22/18 - 11/29/18 included:</p> <ul style="list-style-type: none"> - On 11/22/18 shower - On 11/24/18 not applicable - On 11/28/18 not applicable - On 11/29/18 shower <p>Resident #7 did not receive a shower for 6 days (11/23/18 - 11/28/18)</p> <p>* Documentation from 12/3/18 - 12/9/18 included:</p> <ul style="list-style-type: none"> - On 12/3/18 shower - On 12/5/18 not applicable - On 12/6/18 resident refused - On 12/8/18 not applicable - On 12/9/18 shower <p>Resident #7 did not receive a shower for 5 days (12/4/18 - 12/8/18)</p> <p>Documentation from 1/3/19 - 1/9/19 included:</p> <ul style="list-style-type: none"> - On 1/3/19 shower - On 1/5/19 not applicable - On 1/6/19 resident refused - On 1/9/19 shower <p>Resident #7 did not receive a shower for 5 days</p>	F 677			

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F 677	<p>Continued From page 72 (1/4/19 - 1/8/19)</p> <p>* Documentation from 1/20/19 - 1/27/19 included: - On 1/20/19 shower - On 1/23/19 not applicable - On 1/26/19 not applicable - On 1/27/19 shower Resident #7 did not receive a shower for 6 days (1/21/19 - 1/26/19)</p> <p>On 1/29/19 at 8:50 AM, Resident #7's daughter stated she was adamant that Resident #7 be provided with two showers a week and requested the facility to contact her if she were not provided showers.</p> <p>On 1/31/19 at 12:13 PM, Resident #7 stated she should have been provided with two showers a week.</p> <p>On 1/30/19 at 3:15 PM, the RCM #2 stated there was not a follow up or documentation system in place to make sure the residents were getting their showers. RCM #2 stated there were missing showers for Resident #7.</p> <p>On 1/31/19 at 4:08 PM, the DNS, with the Clinical Resource Nurse present, reviewed Resident #7's care plan which directed staff to provide Resident #7 with one shower a week, and stated she would update Resident #7's care plan to provide Resident #7 with two showers a week and would call Resident #7's daughter when she refused.</p> <p>5. Resident #41 was admitted to the facility on 11/17/18, with multiple diagnoses including history of falls, cognitive communication deficit, difficulty walking, and generalized muscle</p>	F 677			

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F 677	<p>Continued From page 73 weakness.</p> <p>Resident #41's care plan, dated 11/20/18, directed staff to provide 2-person assist with hoyer (mechanical) lifts for toileting and transfers.</p> <p>Resident #41's admission MDS assessment, dated 12/15/18, documented her cognition was moderately impaired, and she required 2-person assistance with ADLs.</p> <p>Resident #41's bathing/shower flowsheets and nurses' progress notes, dated 11/18/18 through 1/29/19, documented missing shower entries and progress notes did not document the reason for the missing showers. Showers were to be provided for Resident #41 on Tuesdays and Saturdays. Resident #7 did not receive baths/showers as follows:</p> <p>* Documentation from 12/11/18 - 12/18/18 included: - On 12/11/18 shower - On 12/15/18 resident refused - On 12/18/18 shower Resident #41 did not receive a shower for 6 days (12/12/18 - 12/17/18).</p> <p>* Documentation from 12/25/18 - 1/3/19 included: - On 12/25/18 shower - On 1/1/19 not applicable - On 1/3/19 shower Resident #41 did not receive a shower for 7 days (12/26/18 - 1/2/19).</p> <p>* Documentation from 1/3/19 - 1/15/19 included: - On 1/3/19 shower - On 1/5/19 not applicable</p>	F 677			

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F 677	<p>Continued From page 74</p> <ul style="list-style-type: none"> - On 1/12/19 resident refused - On 1/15/19 shower <p>Resident #41 did not receive a shower for 11 days (1/4/19 - 1/14/19).</p> <p>* Documentation from 1/22/19 - 1/29/19 included:</p> <ul style="list-style-type: none"> - On 1/22/19 shower - On 1/23/19 not applicable - On 1/24/19 not applicable - On 1/26/19 not applicable - On 1/29/19 not applicable <p>Resident #41 did not receive a shower for 7 days (1/23/19 - 1/29/19).</p> <p>On 1/28/19 at 3:24 PM, Resident #41 stated she should have been provided with two showers a week.</p> <p>On 1/30/19 at 11:00 AM, CNA #2 stated the facility had a shower aide, but the CNAs helped with showers when the aide was not there or if the shower aide needed help. CNA #2 said if a resident got a shower, it would be documented 'shower', if the resident refused, it would be documented 'resident refused', and if the resident did not receive a shower, it would be documented 'not applicable'.</p> <p>On 1/30/19 at 3:15 PM, RCM #2 stated there were missing showers for Resident #41.</p> <p>On 1/31/19 at 12:54 PM, CNA #4 stated she provided resident showers on the B side for the long term care residents and worked Sunday through Thursday. CNA #4 stated she tried hard to get the showers done, but it was impossible to complete all the showers in one day and it helped</p>	F 677			

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F 677	Continued From page 75 when some of the residents refused to take their showers. CNA #4 said there was a time when she was pulled to the floor once or twice last month because somebody called in sick and she was unable to complete baths/showers. CNA #4 said the facility needed more aides to help with the showers, especially on Mondays and Wednesdays. CNA #4 stated she documented when the resident was given a shower or if the resident refused. If the resident refused a shower, she came back later and offered the resident a shower on at least three separate occasions, and notified the nurse if the resident was not provided a shower. CNA #4 stated there was no documentation of when the nurses were notified of missed showers. On 1/31/19 at 4:08 PM, the DNS, with the Clinical Resource Nurse present, reviewed Resident #7's and #41's ADL bathing/shower flowsheets and nurses' progress notes from October 1, 2018 through January 26, 2019. The DNS stated Resident #7 and #41 had missing shower days, progress notes did not document Resident #7's daughter was called when she refused, and a process was not in place for follow up and documentation for aides providing showers and nurses being notified when residents were not provided showers.	F 677			
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684			4/2/19

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F 684	<p>Continued From page 76</p> <p>accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, resident and staff interview, and policy review, it was determined the facility failed to ensure professional standards of practice were maintained related to neurological checks being completed following unwitnessed falls, pressure reduction interventions initiated as stated on the care plan, and medication availability. This was true for 7 of 9 residents (#1, #43, #54, #65, & #319) reviewed for falls and 2 of 22 residents (#15 and #32) whose medication regimes were reviewed. These failures created the potential for harm if changes in residents' neurological status went undetected and untreated after falls, if medications were not given in a timely manner, and/or residents developed skin impairments. Findings include:</p> <p>The facility's Fall Response and Management Policy, dated 11/28/17, documented that after a fall the resident's condition was to be evaluated for injuries, soreness, weakness, pain, and psychosocial adverse affects, for at least 72 hours following the fall.</p> <p>The facility's Neurological Evaluation policy and procedure, dated 11/28/17, documented:</p> <p>* Neurological vital signs supplement the routine measurement of temperature, pulse rate, and respirations "when a resident is suspected to have hit their head (e.g., a fall)" or had hit his/her head.</p>	F 684	<p>F684</p> <p>Resident Specific A neurological assessment was completed and a pressure reducing cushion was provided for resident #1. Residents #43, #65, #54, and #319 have discharged from facility. The medication regimes for residents #15 and #32 were reviewed for medication availability.</p> <p>Other Residents The clinical management team reviewed other residents for completed neurological checks following unwitnessed falls, pressure reduction interventions initiated as stated on the care plan, and medication availability. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses are educated to complete neurological checks following unwitnessed falls, pressure reduction interventions initiated as stated on the care plan, and medication availability. Re-education was provided by CNO and/or designee to include but not limited to, completing neurological checks following unwitnessed falls, initiating pressure reduction interventions as stated</p>		

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F 684	<p>Continued From page 77</p> <p>* The physician's order dictates the frequency of neurological evaluations.</p> <p>* The neurological evaluation consists of assessing the resident's level of consciousness, pupils and eye movement, and motor function response.</p> <p>* In the absence of physician orders, neurological evaluations should be assessed every 15 minutes for an hour, then; every 30 minutes for an hour, then; every hour for 2 hours, then every 4 hours until the physician stated it was no longer necessary or in the 72 hours if the resident's condition is stable and showing no signs and symptoms of neurological injury.</p> <p>The facility's Fall Response and Management Policy, dated 11/28/17, documented that after a fall the resident's condition was to be evaluated for injuries, soreness, weakness, pain, and psychosocial adverse affects, for at least 72 hours following the fall.</p> <p>1. Resident #65 was admitted to the facility on 10/26/18 with multiple diagnoses, including repeated falls, dementia, and disorientation.</p> <p>a. Resident #65's Incident Report, dated 10/27/18, documented he had an unwitnessed fall in his room at 3:45 AM that day, and was found on the floor in a fetal position.</p> <p>Resident #65's Neurological Assessment Flow Sheet documented neurological assessments were started on 10/27/18 at 4:30 AM and were stopped on 10/28/18 at 6:30 AM. There were no more neurological checks completed to meet the</p>	F 684	<p>on the care plan, reviewing medication availability for resident's medication regimes, if physician orders are not able to be carried out then physician notification and receipt of directives is documented in the record. The system is amended to include review completion of neurological checks following unwitnessed falls in clinical meeting, pressure reduction interventions for residents, is initiated as stated on the care plan, validated on rounds,, and medications not available report is reviewed and compared to physician notification directives in clinical meeting.</p> <p>Monitor The CNO and/or designee will audit 3 residents with unwitnessed falls for completion of neurological checks, 5 residents on rounds for pressure reduction interventions initiated as stated on the care plan, and the medications not available physician notification directives weekly for 3 weeks, then monthly for 2 months Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p>		

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F 684	<p>Continued From page 78 policy requirement of 72 hours.</p> <p>b. Resident #65's Incident Report, dated 10/28/18, documented he had an unwitnessed fall that day and was found on the floor of the bathroom at 10:00 AM.</p> <p>There were no neurological assessments found in Resident #65's clinical record after the fall.</p> <p>c. Resident #65's Incident Report, dated 11/3/18, documented he had an unwitnessed fall in his room at 10:45 AM, and was found on the floor in a fetal position.</p> <p>Resident #65's Neurological Assessment Flow Sheet documented neurological assessments were started on 11/3/18 at 10:45 AM and were stopped on 11/3/18 at 12:45 PM. There were no more neurological checks completed to meet the policy requirement of 72 hours.</p> <p>d. Resident #65's Incident Report, dated 11/15/18, documented he had an unwitnessed fall in his room at 5:42 PM and sustained a skin tear to his right elbow. The report documented Resident #65 appeared very tired at the time of the fall, did not open his eyes, and had slow movements.</p> <p>There were no neurological assessments found in Resident #65's clinical record after the fall.</p> <p>e. Resident #65's Incident Report, dated 11/18/18 at 3:00 PM, documented Resident #65 was found on the floor in another resident's room.</p> <p>There were no neurological assessments found</p>	F 684			

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F 684	<p>Continued From page 79 in Resident #65's clinical record after the fall.</p> <p>f. Resident #65's Incident Report, dated 11/19/18 at 5:00 AM and 11:00 AM, documented he was found on the floor in his room. Resident #65's Neurological Assessment Flow Sheet documented neurological assessments were started on 11/19/18 at 5:00 AM and were stopped on 11/19/18 at 6:00 PM.</p> <p>There were no more neurological checks completed to meet the policy requirement of 72 hours.</p> <p>g. Resident #65's Incident Report, dated 11/21/18 at 11:00 AM, documented he had unwitnessed falls and was found on the floor in his bathroom. The report documented he sustained a small bump to his forehead.</p> <p>A neurological check was documented in nursing progress notes on 11/21/18 at 1:00 PM. Further neurological checks were not found in Resident #65's clinical record until 11/21/18 at 7:30 PM. The neurological assessments were stopped on 11/22/18 at 4:00 PM. There were no more neurological checks completed to meet the policy requirement of 72 hours.</p> <p>h. Resident #65's Incident Report, dated 1/23/19, documented he had an unwitnessed fall in his bathroom at 10:00 AM on that day.</p> <p>There were no neurological assessments found in Resident #65's clinical record after the fall.</p> <p>On 1/30/19 at 3:55 PM, RN #4 said neurological assessments were to be completed for 72 hours</p>	F 684			

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F 684	<p>Continued From page 80 at the time points identified in the facility's Neurological Evaluation policy.</p> <p>On 1/31/19 at 12:06 PM, the DNS said she expected staff to follow the facility's policy and complete neurological checks for 72 hours after a fall or an unwitnessed fall. The DNS said Resident #65's neurological checks were either not done or they were not completed correctly.</p> <p>2. Resident #1 was admitted to the facility on 9/13/18 with multiple diagnoses, including difficulty in walking, generalized muscle weakness, history of falls, and unspecified dementia without behavioral disturbances.</p> <p>Resident #1's admission MDS, dated 9/20/18, and quarterly MDS, dated 12/20/18, documented he had severe cognitive impairment. He required extensive assistance of staff for bed mobility, transfers, dressing, personal hygiene, and toileting, was totally dependent on staff for bathing, and required limited assistance to walk in room and eat. He was not steady or able to balance with transfers.</p> <p>Resident #1's care plan for falls, revised on 12/24/18, documented he was at risk for falls due to having actual falls with no injuries and due to having dementia with poor safety awareness, poor balance, confusion, vision/hearing problems, and having an unsteady gait. The interventions on the plan of care included neurological assessment checks per policy and procedure.</p> <p>Resident #1's Post Fall Investigation report, Incident Follow-Up Documentation Form, nursing</p>	F 684			

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F 684	<p>Continued From page 81 notes, and Neurological Assessment Flow sheets were reviewed for each of the falls since his admission in September 2018. The falls and fall documentation were reviewed with the Clinical Resource Nurse on 2/1/19 at 9:30 AM.</p> <p>Review of the documentation with the Clinical Resource Nurse was as follows:</p> <p>* On 9/16/18 at 6:30 AM, Resident #1 had an unwitnessed fall when he was found on the floor in his room with his back against the bed and his legs straight out in front of him. Documentation of his neurological checks was requested. The Clinical Resource Nurse stated they were not able to locate documentation to show neurological checks were completed after this fall.</p> <p>* On 9/29/18 at 12:40 PM, Resident #1 was found in his room lying on the floor next to the bed on his left side. The Post Fall Investigation document it was an unwitnessed fall. There was no documented evidence of neurological checks related to this fall. The Clinical Resource Nurse verified neurological checks were not completed after this fall.</p> <p>* On 11/26/18 at 11:25 PM, Resident #1 was found with his knees on the floor and his torso on the bed. The Post Fall Investigation report and the Incident Follow-Up and Recommendation form documented the fall was not witnessed.</p> <p>Resident #1's Neurological Assessment Flow Sheet documented neurological checks were completed on 11/26/18 from 11:45 PM through 11/27/18 at 2:00 AM. The Clinical Resource</p>	F 684			

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F 684	<p>Continued From page 82</p> <p>Nurse verified the neurological checks were not completed as expected because they were not completed for 72 hours after the unwitnessed fall occurred.</p> <p>* On 12/8/18 at 3:00 AM, Resident #1 was found on the floor in his room. The incident follow up report documented he crawled out of bed and was noted to have increased restlessness. Resident #1's Neurological Assessment Flow Sheet documented neurological checks were completed on 12/8/18; however, only one neurological check was documented on 12/9/18 at 2:00 PM. The Clinical Resource Nurse verified the neurological checks were not completed as expected for 72 hours after the fall.</p> <p>* On 12/21/18 at 11:40 PM, Resident #1 was found on the floor with a skin tear to his left arm. The Post Fall Investigation, dated 12/22/18, documented the fall was unwitnessed. Review of neurological checks documented they were completed on 12/21/18 from 11:45 PM through 4:45 PM. The Clinical Resource Nurse verified the neurological checks were not completed as expected for 72 hours after the fall.</p> <p>On 2/1/19 at 9:30 AM, the Clinical Resource Nurse stated the facility did not follow the facility policy regarding neurological assessments.</p> <p>b. Resident #1's Admission MDS assessment, dated 9/20/18, and quarterly MDS assessment, dated 12/20/18, documented he was severely cognitively impaired. The assessment documented he required extensive assistance of staff for bed mobility, transfers, dressing, and toileting, and required limited assistance to walk</p>	F 684			

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F 684	<p>Continued From page 83</p> <p>in his room and to eat. The assessment stated Resident #1 was not steady or able to balance with transfers.</p> <p>Resident #1's care plan, revised on 12/17/18, documented he had moderate skin/tissue integrity risk due to diagnoses of immobility, deconditioning, sepsis, dementia, and incontinence. The goal was for the resident to have intact skin. The interventions included using a pressure relieving device while in a chair.</p> <p>Resident #1 was observed sitting in his wheelchair on 1/28/19 at 2:14 PM, 1/29/19 at 8:18 AM, 1/30/19 at 12:00 PM, 12:27 PM, 5:31 PM, and 6:16 PM, 1/31/19 at 12:00 PM, 2:07 PM, 3:26 PM, 3:34 PM, and 4:30 PM. He sat in his wheelchair directly on the seat portion of the wheelchair and had no pressure relieving device in place.</p> <p>On 1/31/19 at 3:26 PM, Resident #1 sat in his wheelchair in the activity room next to the activity director. He did not have a pressure relieving device in place. The Activity Director verified Resident #1 did not have a cushion or pressure relieving device in the seat of his wheelchair.</p> <p>On 1/31/19 at 3:34 PM, CNA #1 verified Resident #1 did not have a pressure relieving device in the seat of his wheelchair. She stated she routinely cared for him on the 2:00 PM to 10:00 PM shift and he generally did not have a cushion or pressure relieving device in the seat of his wheelchair. She stated Resident #1 sat directly on the seat of the wheelchair when he was in the wheelchair.</p>	F 684			

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F 684	<p>Continued From page 84</p> <p>3. Resident #54 was admitted to the facility on 11/29/18 with multiple diagnoses, including hemiplegia and hemiparesis (weakness and paralysis on one side) following cerebral infarction (stroke) affecting the right side, difficulty walking, facial weakness following cerebral infarction, and aphasia (loss of ability to understand or express speech).</p> <p>Resident #54's admission MDS assessment, dated 12/6/18, documented he had severe cognitive impairment for daily decision making and one fall with injury since admission.</p> <p>Resident #54's current care plan documented he was at high risk for falls related to confusion, deconditioning, and lack of awareness of safety needs, initiated on 12/3/18. The care plan directed staff to follow the facility's fall protocol.</p> <p>Resident #54's Fall Risk Assessment Tool, dated 11/29/18 at 3:56 PM, documented he was at risk for falls.</p> <p>An Incident Follow-Up and Recommendation Form, dated 12/1/18 documented Resident #54 was found on the floor face down at 4:15 AM with injury/swelling to the right side of his forehead and neurological checks were started. Resident #54's Neurological Assessment Flow Sheet documented neurological checks on 12/1/18 at 3:15 AM through 12/2/18 at 2:00 PM. The level of consciousness was not documented on 16 out of 21 opportunities. The pupil response was not documented on 19 out of 21 opportunities. Hand grasps were not documented on 20 out of 21 opportunities. Motor function of extremities was not documented on 16 out of 21 opportunities.</p>	F 684			

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F 684	<p>Continued From page 85</p> <p>Pain response was not documented on 17 out of 21 opportunities. Vital signs were not documented on 2 out of 21 opportunities. The staff signature was not documented on 9 out of 21 opportunities. Additionally, the neurological checks were not completed for 72 hours following the fall, as required by the facility's Neurological Evaluation Policy.</p> <p>Resident #54's Post Fall Investigation Assessment Tool, dated 1/13/19 at 10:43 PM, documented he was found lying on his back with his legs straight and arms by his side. Immediate interventions included nursing assessment, neurological checks, vital signs, and pain assessment. Further neurological checks were not found documented in Resident #54's clinical record following this fall.</p> <p>Resident #54's Post Fall Investigation Assessment Tool, dated 1/26/19 at 8:09 PM, documented he was found sitting on his buttocks with his legs straight out in front of him and his head against the bed mattress. The immediate interventions included initiation of neurological checks and a pain assessment. Further neurological checks were not found documented in Resident #54's clinical record.</p> <p>On 1/31/19 at 7:06 PM, the DON said she would check to see if neurological checks were documented somewhere for Resident #54.</p> <p>On 2/1/19 at 9:39 AM, RCM #1 said if a resident had an unwitnessed fall, she would expect neurological checks to be completed. RCM #1 said she did not see any neurological checks documented for Resident #54 after the falls on</p>	F 684			

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F 684	<p>Continued From page 86 1/13/19 and 1/26/19.</p> <p>On 2/1/19 at 10:18 AM, the Clinical Resource Nurse said neurological checks were not completed for Resident #54 and they should be completed for 72 hours unless the physician said to stop neurological checks sooner.</p> <p>4. Resident #319 was admitted to the facility on 8/23/18 with multiple diagnoses, including Amyotrophic Lateral Sclerosis (a degenerative neurological disease), altered mental status, Type 2 diabetes mellitus, schizophrenia, major depressive disorder, chronic kidney disease, and unspecified sequelae (after effects) of cerebral infarction (stroke).</p> <p>A Post Fall Investigation, dated 8/26/18 at 1:00 AM, documented Resident #319 was found sitting on his buttocks with both legs straight out in front of him. Resident #319's Neurological Assessment Flow Sheet documented neurological checks were performed on 8/26/18 though 8/27/19 at 4:00 AM. The level of consciousness was not documented on 3 of 14 opportunities. Pupil response was not documented on 3 of 14 opportunities. Hand grasps and motor function of extremities was not documented on 3 of 14 opportunities. Pain response was not documented on was not documented on 3 of 14 opportunities. The staff signature was not documented on 10 of 14 opportunities. Additionally, the neurological checks were not completed for 72 hours following the fall, as required by the facility's Neurological Evaluation Policy.</p> <p>On 1/31/19 at 7:03 PM, the DNS said it looked</p>	F 684			

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F 684	<p>Continued From page 87</p> <p>like there were a few areas of missing information on Resident #319's Neurological Assessment Flow Sheet. The DNS said she was not aware of any reason for the missing information, and she would expect all of the areas to be completed on the Neurological Assessment Flow Sheet.</p> <p>5. Resident #43 was admitted to the facility on 12/17/18 with multiple diagnosis, including unspecified fall, hip fracture, and general muscle weakness.</p> <p>Resident #43's Incident Report, dated 1/20/19 at 11:45 PM, documented Resident #43 found on the floor in his room while attempting to get up to go to the bathroom, and sustained a bump on the head.</p> <p>A Neurological Assessment Flow Sheet was initiated on 1/20/19 at 11:45 PM and were stopped on 1/21/19 at 8:45 PM. There were no more neurological checks documented to complete the 72 hour policy requirement.</p> <p>On 1/30/19 at 12:20 PM, RCM #1 stated neurological checks were part of the facility's protocol if a resident fell with a bump to the head.</p> <p>On 1/30/19 at 3:55 PM, RN #4 said neurological assessments were to be completed consistent with the facility's Neurological Evaluation Policy.</p> <p>6. Resident #32 was admitted to the facility on 7/22/18 with multiple diagnoses, including muscle weakness, abnormal posture, multiple sclerosis (degenerative neurological disorder), and hereditary spastic paraplegia (an inherited</p>	F 684			

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F 684	<p>Continued From page 88</p> <p>disorder that results in progressive weakness and stiffness of the legs).</p> <p>Resident #32's quarterly MDS assessment, dated 10/29/18, documented she was cognitively intact. She required extensive assistance from staff for bed mobility, dressing, toilet use, and personal hygiene.</p> <p>Resident #32's physician orders documented a handwritten order, dated 12/27/18, for terbinafine (antifungal medication) 1% to be applied to the sole/sides of her feet twice daily for two weeks for probable tinea pedis (athlete's foot).</p> <p>Resident #32's MAR documented the first time the terbinafine 1% was applied to her feet was on 1/6/19, ten days after the order was documented.</p> <p>On 1/28/19 at 9:25 AM, Resident #32 stated the facility was two weeks late obtaining a foot medication because they lost the prescription.</p> <p>On 1/31/19 at 6:26 PM, the DNS stated the terbinafine prescription was ordered from the pharmacy on 1/3/19. She stated on 1/3/19 Resident #32 gave her the prescription. She stated Resident #32 went out of the facility to her private physician and did not give the prescription to the facility until that date. The DNS stated the prescription was entered into the computer and transmitted to the pharmacy on 1/3/19, and it took the pharmacy three days to get the medication to the facility.</p> <p>On 2/10/19 at 9:56 AM, the Clinical Resource Nurse stated the pharmacy was late delivering the terbinafine due to insurance issues, and she</p>	F 684			

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F 684	<p>Continued From page 89</p> <p>verified the terbinafine 1% foot cream was started on 1/6/19. The Clinical Resource Nurse confirmed Resident #32's physician was not notified that the medication was not ordered until 1/3/19 or that the medication was not started until 1/6/19.</p> <p>7. Resident #15 was readmitted to the facility on 5/24/18 with multiple diagnoses including gastrointestinal hemorrhage (bleeding), diverticulosis (when pockets develop in the intestines and become inflamed or infected) of large intestine without perforation or abscess with bleeding, ileostomy (surgically created opening in the abdominal wall through which digested food passes), and colostomy.</p> <p>Resident #15's quarterly MDS assessment, dated 12/4/18, documented he was cognitively intact and he did not exhibit behaviors. He required supervision for bed mobility, transfers, walking in room/corridor, locomotion, dressing, and eating, and required limited assistance with toilet use.</p> <p>Resident #15's clinical record documented he had an appointment with a gastroenterologist on 12/28/18, and the gastroenterologist ordered Anusol HC 25 mg rectal suppositories twice a day for 10 days.</p> <p>Resident #15's MAR documented the Anusol suppositories were started on 1/7/19, 10 days after the gastroenterologist's order.</p> <p>On 1/28/19 at 11:08 AM, Resident #15 stated he had to wait for a suppository ordered by the physician. He stated it took 11 days for the facility to receive the suppository from the pharmacy.</p>	F 684			

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F 684	Continued From page 90 On 1/30/19 at 3:16 PM, RN #3 verified the Anusol suppositories were not initiated because there was an issue with the pharmacy obtaining insurance approval. RN #3 said she called the pharmacy and was told it took awhile to fill the order because Resident #15's health insurance refused to pay for the suppositories. According to RN #3, the prescription was filled on 1/7/19 after the facility agreed to pay for the medication. RN #3 said there was no documented evidence of notifying the physician of the suppositories being late until 1/7/19, the day the Anusol suppositories were started.	F 684			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		4/2/19	

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F 686	<p>Continued From page 91</p> <p>Based on observation, record review, staff interview, resident interview, and review of facility policies, it was determined the facility failed to implement interventions to prevent the worsening of pressure ulcers and ensure pressure ulcer prevention interventions were followed. This was true for 2 of 2 resident (Resident #1 and #318) reviewed for pressure ulcers. This deficient practice caused harm to Resident #318 when she developed Stage 2 pressure ulcers on her buttocks and placed Resident #1 at risk of developing pressure ulcers. Findings include:</p> <p>The facility's policy for Prevention and Treatment of Pressure Ulcers and Other Skin Alterations, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> * A risk assessment would be completed upon the resident's admission. * Residents at risk for developing pressure ulcers would be identified by the Braden Scale assessment tool. * Pressure ulcer interventions would be developed with participation of the interdisciplinary team, and the interventions would be implemented in order to "identify, prevent or reduce the risk of acquiring pressure and/or non-pressure related wounds or skin issues." * Basic or routine care could include interventions to redistribute pressure, minimize contact with moisture and keep skin clean, providing non-irritating surfaces, and maintaining/improving nutrition and hydration. <p>The National Pressure Ulcer Advisory Panel website (www.npuap.org), accessed on 2/4/19, documented the following:</p>	F 686	<p>F686</p> <p>Facility has requested IDR for this deficiency</p> <p>Resident Specific</p> <p>The clinical management reviewed resident #1. A skin assessment was updated, and interventions were put into place to decrease the risk of developing pressure ulcers. Resident #318 discharged from facility.</p> <p>Other Residents</p> <p>The clinical management team reviewed other residents at risk of development or worsening of pressure ulcers. Adjustments have been made as indicated.</p> <p>Facility Systems</p> <p>Licensed nursing staff are educated on prevention and management of pressure ulcers. Re-education was provided by CNO and/or designee to include prevention and management of pressure ulcers, timely assessment on admission for Braden and review of current wounds, immediate evidence of care planning and interventions placed to prevent and/or treat wounds, review of skin post return from hospital/ER visits to document changes, care conference notes to include discussion of impaired skin integrity, and physician updates documented for changes in DTI/wound appearance. The system is amended to include review by the clinical management team in clinical meeting of residents with wounds on admission and</p>		

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F 686	<p>Continued From page 92</p> <p>* Deep tissue injuries appear as areas of intact or non-intact skin with "persistent non-blanchable deep red, maroon, purple discoloration" that result from acute and/or lengthy pressure.</p> <p>* A pressure injury is damage to an area of skin and underlying soft tissue, usually located over a bony prominence, and may be associated with a medical or other device. The pressure injury can appear as intact skin or an open ulcer. A pressure injury results from severe and/or prolonged pressure or pressure with shearing.</p> <p>* A Stage 2 pressure injury is "partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister."</p> <p>The Lippincott Manual of Nursing Practice, tenth edition, documented measures to prevent pressure ulcer development included repositioning every two hours, using special devices to cushion the specific area, and use an alternating pressure mattress or air fluidized bed for patients who are at high risk.</p> <p>Resident #318 was admitted to the facility on 1/26/19, with multiple diagnoses including polyneuropathy (degeneration of nerves that spreads toward the center of the body), chronic heart disease, and severe chronic kidney disease. A progress note, dated 1/26/19 at 9:51 PM, documented Resident #318 was admitted to the facility prior to the noon meal.</p> <p>Resident #318's Braden Scale for Predicting Pressure Sore Risk, dated 1/26/19 at 10:22 PM approximately 9 hours after her admission,</p>	F 686	<p>those who have been out to the hospital/ER for documentation of current condition. Bedside pressure ulcer interventions are coded from the care plan to the kardex for line staff review and implementation.</p> <p>Monitor The CNO and/or designee will audit 5 residents atrisk of pressure ulcers or residents with alteration in skin integrity for plan implementation/healing weekly for 4 weeks, then monthly for 2 months. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p>		

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F 686	<p>Continued From page 93</p> <p>documented she was at high risk for developing pressure ulcers. Her ability to change and control her body position was very limited, and she was not able to make frequent or significant changes without assistance.</p> <p>Resident #318's Weekly Skin Check, dated 1/26/19 at 10:22 PM, documented there were skin conditions, changes, ulcers, or injuries. The coccyx (tailbone area) had a dark purple area surrounding the entire coccyx that was non-blanchable (indicating blood flow was not returning to the area and damage had occurred).</p> <p>Resident #318's Progress Notes, documented the following:</p> <ul style="list-style-type: none"> * On 1/26/19 at 9:51 PM, she arrived at the facility and her coccyx/sacrum was "deep purple" in color, which did not blanch. * On 1/27/19 at 3:11 AM, she was transferred to the hospital due to increased blood in the Foley (urinary) catheter, flank pain, and headache. * On 1/27/19 at 8:12 AM, she returned to the facility from the hospital. Her skin condition was not documented upon her return to the facility. <p>Resident #318's Multidisciplinary Care Conference notes documented the meeting was held on 1/28/19 at 1:30 PM, and identified an "effective date" of 1/26/19 at 10:38 PM. The notes did not include documentation Resident #318's skin issues were addressed in the care conference.</p> <p>Resident #318's Weekly Skin Alteration Report, dated 1/28/19 at 3:43 PM, documented a large bruise that covered the buttocks and sacral area</p>	F 686			

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F 686	<p>Continued From page 94 (the sacrum and coccyx are two bone located near the bottom of the spinal column/upper buttock). There was no skin loss, and there was discoloration with purple, pink, red, and yellow colors. There was no deterioration of the wound. The current treatment orders included barrier cream and monitoring.</p> <p>Resident #318's Weekly Pressure Ulcer Report, dated 1/28/19 at 3:45 PM, documented a new onset Stage 2 pressure ulcer on the coccyx that measured 0.3 cm by 0.3 cm by 0.1 cm and was first observed on 1/26/19.</p> <p>Resident #318's Weekly Pressure Ulcer Report, dated 1/28/19 at 3:48 PM, documented a new onset Stage 2 pressure ulcer on the right buttock that measured 2.5 cm by 3.5 cm by 0.1 cm and was first observed on 1/26/19.</p> <p>Resident #318's Weekly Pressure Ulcer Report, dated 1/28/19 at 3:50 PM, documented a Stage 2 pressure ulcer on the left buttock that measured 2 cm by 3 cm by 0.1 cm and was first observed on 1/26/19.</p> <p>The bruised, discolored area on Resident #318's coccyx and buttocks deteriorated into three Stage 2 pressure ulcers.</p> <p>Resident #318's January 2019 physician orders included the following:</p> <ul style="list-style-type: none"> * Cleanse Stage 2 pressure injury to coccyx with wound cleanser, apply barrier cream and apply dressing once daily and as needed, ordered on 1/28/19. * Cleanse Stage 2 pressure injury to left buttock 	F 686			

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F 686	<p>Continued From page 95</p> <p>with wound cleanser, apply barrier cream and apply dressing once daily and as needed, ordered on 1/28/19.</p> <p>* Cleanse Stage 2 pressure injury to right buttock with wound cleanser, apply barrier cream and apply dressing once daily and as needed, ordered on 1/28/19.</p> <p>* Daily monitoring of Stage 2 pressure ulcers to coccyx, left buttock, and right buttock.</p> <p>Resident #318's care plan documented the following:</p> <p>* She had Stage 2 pressure injuries to the right and left buttock, and coccyx, initiated on 1/28/19.</p> <p>* Interventions to prevent new areas of breakdown or altered skin integrity were initiated on 1/28/19, including reposition 2-3 times every 8 hours, use care during transfers and bed mobility, and weekly skin assessments by licensed nurse.</p> <p>* She required 2 staff participation with transfers and bed mobility.</p> <p>* She was at risk for skin impairment/pressure ulcer related to significant bruises, chronic progressive disease, cognitive impairment, heart failure, and overactive bladder.</p> <p>* Staff were directed to use pressure reduction on her bed and chair. Treatment and medications were to be implemented per physician orders, and the nurse was to be notified of skin impairment, bruises, or rashes.</p> <p>Resident #318's Bed Mobility records for repositioning and turning, documented she was provided with extensive or total assistance at the following times and frequency:</p>	F 686			

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F 686	<p>Continued From page 96</p> <ul style="list-style-type: none"> * 1/26/19 at 1:59 PM - one time * 1/27/19 at 2:12 AM, 1:59 PM, and 9:08 PM = 3 times Resident #318 was out of facility at the hospital for 5 hours (3:11 AM - 8:12 AM). * 1/28/19 at 4:05 AM, 11:13 AM, 8:11 PM - 8:13 PM, 9:59 PM, and 11:43 PM = 5 times * 1/29/19 at 4:14 AM 1:59 PM, 9:59 PM, and 10:56 PM = 4 times * 1/30/19 at 5:10 AM, 1:05 PM - 1:06 PM, and 9:38 PM - 9:48 PM = 3 times * 1/31/19 at 2:13 AM and 9:22 PM - 9:24 PM = 2 times <p>The documentation showed Resident #318 was repositioned 1 - 5 times per day, instead of 2 - 3 times per 8 hour shift.</p> <p>On 1/29/19 at 2:31 PM, RN #5 said she had not observed Resident #318's wounds because she was up in her chair. RN #5 said Resident #318 had bilateral wounds on her coccyx and sacrum. Resident #318 was sitting in her wheelchair and there was no cushion (for pressure reduction) on her wheelchair. The mattress on her bed was not an alternating pressure or air fluidized mattress.</p> <p>On 1/29/19 at 2:34 PM, Resident #318 said she had sores on her bottom and she did not have them before being admitted to the facility.</p> <p>On 1/29/19 at 2:43 PM, LPN #3 said Resident #318 was admitted over the weekend and she saw her on 1/28/19. LPN #3 said she measured what she observed on Resident #318's buttock area and documented she had a Stage 2 pressure ulcer to the right buttock and a Stage 2 pressure ulcer on her bottom. LPN #3 said the current interventions for the pressure ulcers</p>	F 686			

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F 686	<p>Continued From page 97</p> <p>included barrier cream with a cover dressing and repositioning every 2-3 hours.</p> <p>On 1/30/19 at 10:18 AM, LPN #3 was observed providing wound care to Resident #3's buttocks. LPN #3 said Resident #318 had a right buttock pressure wound that was a Stage 2 with irregular margins and a red base. There was no redness or swelling. LPN #3 said Resident #318's left buttock had a pressure wound that was a Stage 2 with irregular margins and a red base with bloody drainage. There was no redness or swelling.</p> <p>On 1/30/19 at 10:54 AM, LPN #3 said she did not know when the open areas appeared on Resident #318's buttocks. LPN #3 said when she observed Resident #318 on 1/28/19, her buttocks were purple with yellow color and a very small open area on the coccyx. LPN #3 said the open skin areas looked better at the present time. LPN #3 said Resident #318's initial skin assessment was done by another nurse. She was notified on 1/28/19 she needed to observe Resident #318's skin needed to be monitored because of the purple area to her buttocks.</p> <p>On 1/30/19 at 11:11 AM, LPN #6 said she assessed Resident #318's skin on admission and her buttocks and sacrum were deep purple in color. LPN #6 said she did not see any open skin areas on her buttocks at that time.</p> <p>On 1/30/19 at 12:03 PM, RCM #1 said when Resident #318 was admitted to the facility, she would have started Resident #318 on a turning schedule and contacted the wound nurse or physician to ask for recommendations regarding</p>	F 686			

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F 686	<p>Continued From page 98</p> <p>the dark purple color on her bottom.</p> <p>On 1/31/19 at 9:49 AM, the DNS said it was documented on admission Resident #318 had bruising on her bottom and it was documented she was assisted with bed mobility for the first couple of days after admission. The DNS said she did not see anything documented Resident #318 was turned every 2 hours. The DNS said she expected staff to follow care plan interventions.</p> <p>2. Resident #1 was admitted to the facility on 9/13/18 with multiple diagnoses, including difficulty in walking, generalized muscle weakness, history of falls, and unspecified dementia without behavioral disturbances.</p> <p>Resident #1's Admission MDS assessment, dated 9/20/18, and quarterly MDS assessment, dated 12/20/18, documented he was severely cognitively impaired. The assessment documented he required extensive assistance of staff for bed mobility, transfers, dressing, and toileting, and required limited assistance to walk in his room and to eat. The assessment stated Resident #1 was not steady or able to balance with transfers.</p> <p>Resident #1's care plan, revised on 12/17/18, documented he had moderate skin/tissue integrity risk due to diagnoses of immobility, deconditioning, sepsis, dementia, and incontinence. The goal was for Resident #1 to have intact skin. The interventions included using a pressure relieving device while in a chair.</p> <p>Resident #1 was observed sitting in his</p>	F 686			

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F 686	Continued From page 99 wheelchair on 1/28/19 at 2:14 PM, 1/29/19 at 8:18 AM, 1/30/19 at 12:00 PM, 12:27 PM, 5:31 PM, and 6:16 PM, 1/31/19 at 12:00 PM, 2:07 PM, 3:26 PM, 3:34 PM, and 4:30 PM. He sat in his wheelchair directly on the seat portion of the wheelchair and had no pressure relieving device in place. On 1/31/19 at 3:26 PM, Resident #1 sat in his wheelchair in the activity room next to the activity director. He did not have a pressure relieving device in place. The Activity Director verified Resident #1 did not have a cushion or pressure relieving device in the seat of his wheelchair. On 1/31/19 at 3:34 PM, CNA #1 verified Resident #1 did not have a pressure relieving device in the seat of his wheelchair. She stated she routinely cared for him on the 2:00 PM to 10:00 PM shift and he generally did not have a cushion or pressure relieving device in the seat of his wheelchair. She stated Resident #1 sat directly on the seat of the wheelchair when he was in the wheelchair.	F 686			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		4/2/19	

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F 688	<p>Continued From page 100 prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents received treatment and services to prevent further decrease in ROM (range of motion). This was true for 1 of 5 residents (#38) reviewed for treatment and services related to ROM. This deficient practice placed residents at risk of experiencing a decrease in mobility and function due to lack of active ROM (AROM) or passive ROM (PROM) services. Findings include:</p> <p>The facility's Range of Motion policy and procedure, dated 11/28/17, documented staff were to provide care and treatment to help residents reach and maintain his/her highest level of range of motion as a maintenance program or as a preventative measure to reduce the risk of or prevent avoidable decline.</p> <p>Resident #38 was admitted to the facility on 3/19/18 and was readmitted on 7/18/18, with multiple diagnoses which included diabetes mellitus, muscle weakness, and difficulty walking.</p> <p>A quarterly MDS assessment, dated 10/25/18, documented Resident #38 was cognitively intact and she had functional limitation of her lower</p>	F 688	<p>F688</p> <p>Resident Specific The clinical management team reviewed resident #38's restorative program to vavlidate the maintenance program is provided per directives.</p> <p>Other Residents The clinical management team reviewed other residents on Restorative to validate they are provided maintenance programs per directives.</p> <p>Facility Systems Nursing staff is in-serviced on restorative program by the CNO and/or designee to include but not limited to restorative programs are written to include frequency of program, documentation of program as implemented, and validate a plan is implemented for residents to receive their restorative program as scheduled per POC. The system is amended to review staffing plan for restorative nursing and to validate new restorative directives are complete to include frequency in clinical meeting. Weekly restorative meetings to</p>		

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F 688	<p>Continued From page 101 extremity on one side.</p> <p>A Restorative Services Referral form, signed on 12/13/18, documented Resident #38's restorative program was AROM, transfer training with her front wheeled walker, and for her to use a recumbent stepper for 10 minutes. The referral form did not include the frequency of her restorative nursing program.</p> <p>On 1/28/19 at 9:58 AM, Resident #38 said she used to have physical therapy almost daily but recently she had been to the gym only 3 times.</p> <p>An ADL ROM report, dated 12/25/18 through 12/31/18 (7 days), documented Resident #38 refused treatment on 12/26/18. The report did not include documentation Resident #38 received restorative nursing services the other 6 days.</p> <p>An ADL ROM report, dated 1/1/19 through 1/26/19 (26 days), documented Resident #38 completed transfer training with her front wheel walker on 5 days, on 1/15/19, 1/22/19, 1/23/19, 1/25/19 and on 1/26/19. The report did not include documentation Resident #38 received restorative nursing services the other 21 days.</p> <p>On 1/30/19 at 11:41 AM, the PT (Physical Therapy) Director said Resident #38 was discharged from the PT program on 12/24/18 and referred to the restorative program. The PT Director reviewed the referral form and said it was an incomplete request/order. The PT Director said Resident #38 should have 15 minutes for each of her restorative programs 6 days a week.</p>	F 688	<p>review residents on a restorative program and validate treatment is provided as ordered. Adjustment to be made as indicated.</p> <p>Monitor The CNO and/or designee will audit 5 random residents to validate they are receiving their restorative program per directive weekly for 3 weeks and monthly x2. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p>		

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F 688	Continued From page 102 On 1/30/19 at 2:54 PM, RCM #1, who was the RNA program supervisor, said Resident #38's restorative nursing program was for AROM, recumbent stepper, and transfer training with her front wheel walker 6 days a week, and 15 minutes for each exercise. RCM #1 reviewed at the ADL ROM documentation and said Resident #38 might have completed the restorative program and the RNA (Restorative Nursing Aide) forgot to document it. RCM #1 said there were times when the RNA was asked to work on the floor when the facility had unexpected sick calls. RCM #1 said the facility first called other staff members to work and if unable to fill the shift, the facility called the staffing agency to assist in filling the vacant shift. RMC #1 said if the agency could not provide staff, they asked the RNA to work on the floor. On 1/31/19 at 5:31 PM, CNA #10, who was the Transportation Coordinator, said she was asked to provide restorative nursing services on 1/30/19 and 1/31/19. On 2/1/19 at 9:10 AM, CNA #6, who was the RNA, said she used to be the only RNA in the facility and she was unable to meet the residents' needs. CNA #6 said she had 34 residents who needed restorative nursing services, and she worked with 15 residents per day. CNA #6 said she was also asked to work on the floor last month when they had unexpected sick calls, but this had not happened lately since the facility hired another RNA.	F 688			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		4/2/19	

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F 689	<p>Continued From page 103</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, family member and staff interview, policy review, and record review, it was determined the facility failed to provide adequate supervision to meet residents' needs and implement fall interventions. This was true for 3 of 9 residents (#1, #40, & #65) reviewed for supervision and falls. The facility also failed to ensure bed wheel locks were applied to prevent accidents and falls. This was true for 3 of 21 residents (#7, #24, & #41) reviewed for accidents. This created the potential for harm if residents experienced falls and injuries. Findings include:</p> <p>The facility's policy for Fall Response and Management, dated 11/28/17, directed staff to implement immediate interventions to prevent a repeat fall, review the post-fall evaluation and investigation, determine the cause, and revise the care plan interventions.</p> <p>The facility's Falling Star Program policy, dated July 2018, directed staff to place a star on a resident's door to identify the resident at high risk for falls. The purpose of the program was to alert staff that a resident was at a higher risk of falling.</p> <p>The facility's 1:1 staff procedure, dated September 2018, directed staff to be within view</p>	F 689	<p>F 689</p> <p>Resident Specific</p> <p>Resident 40's fall care plan preventions have been assessed and are in place. Resident 1's fall care plan has been reviewed with interventions assessed and deemed safe. Resident 41's bed was reviewed to ensure that bed brakes were locked. Resident 7's bed was reviewed to ensure that bed brakes were locked. Resident 65 has discharged from the facility. Resident 24 has discharged from the facility.</p> <p>Other Residents</p> <p>The ID team reviewed other residents with falls for appropriate supervision to prevent falls, those with 1:1s are trained in their responsibilities, staff validate understanding of the kardex location and care directives that include fall interventions, and staff are educated and monitored for the implementation of bed brakes. Adjustments have been made as indicated.</p> <p>Facility Systems</p>		

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F 689	<p>Continued From page 104 of the resident at-all-times and to have another staff member take over supervision if the assigned 1:1 staff needed to be relieved.</p> <p>These policies and procedures were not followed. Examples include:</p> <p>1. Resident #65 was admitted to the facility on 10/26/18, with multiple diagnoses including repeated falls, dementia, and disorientation.</p> <p>Resident #65's Fall Risk Assessments, dated 10/26/18 and 1/26/19, documented he was at risk for falling.</p> <p>Resident #65's admission MDS assessment, dated 11/2/18, documented he was severely cognitively impaired, exhibited physical and verbal aggression and wandering behaviors, and required the assistance of one-person while walking in his room and in a corridor.</p> <p>Resident #65's Frequent Checks Report, dated 10/27/18 at 5:00 PM through 11/4/18, documented he was checked by staff every 30 minutes.</p> <p>Resident #65 was not provided the supervision necessary to protect him from falls, as follows:</p> <p>* Resident #65's Incident Report, dated 10/28/18, documented he fell in his bathroom at 10:00 AM and had no injury. New interventions were to continue frequent checks and to add him on the Falling Star Program.</p> <p>Resident #65's care plan was revised on 10/28/18 and directed staff to check on him</p>	F 689	<p>Staff are educated in fall prevention and supervision to prevent accidents. Re-education will be provided by CNO and/or designee to include but not limited to fall intervention plans located on the kardex, 1:1 sitter responsibilities and education process, review of physical therapy orders for implementation of directives, and the protocol for bed brakes. The system is amended to include rounds to include review of fall intervention implementation and auditing for engagement of bed brakes., Clinical meeting to review therapy directives for care plan updates, and documentation of sitter education for scheduled staff.</p> <p>Monitor The CNO and/or designee will audit 5 residents with falls for implementation of their fall prevention plans and appropriate supervision, to include validation that the bed brakes are locked weekly for 3 weeks, then monthly for 2 months. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p>		

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F 689	<p>Continued From page 105</p> <p>frequently to meet his needs and to add him on the Falling Star Program for increased supervision.</p> <p>* Resident #65's Incident Report, dated 11/3/18, documented he fell in his room at 10:45 AM and had no injury. A new intervention was to add 1:1 staff supervision due to the frequency of Resident #65's falls and poor safety awareness.</p> <p>Resident #65's care plan was revised on 11/3/18 and directed staff to add a 1:1 sitter due to poor safety awareness. The intervention was discontinued on 11/4/18.</p> <p>* Resident #65's Incident Report, dated 11/18/15, documented he fell on the bathroom floor of the room adjacent to his room at 3:00 PM and had no injury. A new intervention was to move him to a room on a different side of the facility for increased supervision.</p> <p>Resident #65's care plan was revised on 11/19/18 and directed a room change to a different side of the building.</p> <p>Resident #65's progress note, dated 11/19/18 at 4:00 AM, documented he appeared confused and agitated with his new surroundings and became aggressive with staff.</p> <p>* Resident #65's Incident Report, dated 11/19/18, documented he was found on his bathroom floor in the fetal position at 5:00 AM and had no injury. New interventions included to move him to another room which was more visible to the nurses' station.</p>	F 689			

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F 689	<p>Continued From page 106</p> <p>Resident #65's care plan was revised on 11/19/18 and directed a room change to the opposite side of the building and to move him to a room in a more visible area (near the nurses' station).</p> <p>Resident #65's census list, dated 11/19/18, documented he changed rooms twice within a 24 hour period.</p> <p>Resident #65's progress note, dated 11/19/18 at 5:39 PM, documented he was moved to a room across from the nurses' station at 4:30 PM. A progress note, dated 11/20/18 at 1:22 AM, documented he appeared confused with the room change.</p> <p>* Resident #65's Incident Report, dated 11/20/18 at 10:30 AM, documented he fell or kneeled down on his hands and knees on his room floor and had no injury. Resident #65 said he was cleaning the floor. The intervention identified on the report was to continue with the new room directly across from the nurses' station.</p> <p>* Resident #65's Incident Report, dated 11/20/18 at 1:30 PM, documented he was found on his bathroom floor attempting to "fix" his sink and had no injury. A new intervention was to add 1:1 staff supervision for the night of 11/20/18, to determine Resident #65's intent. The follow-up section documented he purposely laid on the floor the night of 11/20/18.</p> <p>Resident #65's progress note, dated 11/21/18 at 4:56 AM, documented the 1:1 sitter observed Resident #65 lay down on the floor of his room because he was more comfortable on the floor</p>	F 689			

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F 689	<p>Continued From page 107 and was offered a blanket and a pillow where he slept for hours.</p> <p>Resident #65's care plan was revised on 11/21/18 and directed staff for a 1:1 sitter through the night of 11/20/18 to establish patterns and intent. Resident #65 was noted to purposely lay on the floor during this time.</p> <p>* Resident #65's Incident Report, dated 11/21/18, documented he was found on his bathroom floor with a small bump to his forehead. A new intervention was to add 1:1 staff supervision for safety.</p> <p>Resident #65's care plan was revised on 11/21/18 and directed staff for a 1:1 sitter continuously to be within arms length as Resident #65 would allow. Resident #65 did not fall again until 1/23/19.</p> <p>* Resident #65's Incident Report, dated 1/23/19, documented he was found on his bathroom floor with a skin tear to his right forearm. The report documented CNA #1, who worked for a contracted staffing agency, said Resident #65 was agitated and needed to use the toilet. The reported stated CNA #1 allowed Resident #65 to go to the bathroom by himself. The report documented CNA #1 then closed the bathroom door and sat down in the chair in Resident #65's room. The report documented CNA #1 heard a noise in the bathroom a few minutes later, opened the bathroom door, and found Resident #65 on the floor. The report stated CNA #1 was educated to be within arms length of Resident #65 for safety. The new intervention was to continue 1:1 staff supervision and staff to be</p>	F 689			

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F 689	<p>Continued From page 108 nearby Resident #65 at all times.</p> <p>On 1/28/19 at 11:58 AM, Resident #65 was sitting at a dining room table with three other residents eating his lunch meal without staff within arms reach. At 12:06 PM, CNA #2, who worked for the contracted staffing agency and was Resident #65's 1:1 staff for that shift, was in the dining room passing out lunch plates to other residents and not within arms reach of Resident #65. At 12:14 PM, four staff members were standing near the meal service area, more than 3 feet away with their backs turned to Resident #65, who was seated at a nearby table. During this time, CNA #2 had delivered several meals to other residents' rooms. At 12:23 PM, CNA #2 squatted next to Resident #65, asked him about his meal, said she was going to help other residents, and walked away to deliver more meals to other residents. At 12:33 PM, CNA #2 placed a chair next to Resident #65 and walked away. At 12:35 PM, CNA #2 sat down next to Resident #65 and asked if he was done with his meal. He said he wanted to go back to his room.</p> <p>On 1/28/19 at 12:45 PM, CNA #2 said that day was her first time as a 1:1 staff and said the training she received was from the 1:1 staff previously assigned to Resident #65. She said she was not given instructions from the nurse or provided with the facility's 1:1 staff procedures. She said she was to be with him at all times due to his behaviors, falls, and wandering.</p> <p>On 1/29/19 at 9:54 AM, CNA #12 said she had been one of Resident #65's 1:1 staff for two months and said he could get agitated with large groups.</p>	F 689			

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F 689	<p>Continued From page 109</p> <p>On 1/30/19 at 12:06 PM, Resident #65 was seated at the dining room next to CNA #12 when he abruptly stood up and walked away from the table as CNA #12 walked along side of him.</p> <p>On 1/31/18 at 9:55 AM, Resident #65's room door was open and at the closest edge of the A wing nurses' station a one-foot corner section of Resident #65's room could be seen. Due to the diagonal angle of the room from the nurses' station, the remainder of the room was not visible.</p> <p>On 1/31/19 at 12:06 PM, the DNS said after the 10/28/18 fall, Resident #65 was placed on the Falling Star Program and he was to be checked on every hour. She said the Falling Star Program alerted staff that he was a high fall risk. The DNS said the Falling Star Program did not direct staff on how the intervention would keep Resident #65 from falling. The DNS said after the 11/3/18 fall, a 1:1 staff was initiated and she was not sure why the intervention was discontinued the next day. The DNS said after the 11/18/18 fall, Resident #65 was moved to a room on the opposite side of the building to increase supervision due to a higher staff to resident ratio, which helped increase visualization. The DNS said after the 11/19/18 fall, Resident #65 was moved to a room close to the nurses' station where there was more traffic in and around the nurses' station and he could be seen more frequently. The DNS said after the 11/20/18 fall, a temporary 1:1 staff was placed for the night to see if Resident #65 was placing himself on the floor or falling and found that he had intentionally laid on the floor during the night. The DNS said this intervention was</p>	F 689			

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F 689	<p>Continued From page 110</p> <p>more of an investigation to determine Resident #65's patterns. The DNS said after the 1:1 staff was taken away, Resident #65 fell again on 11/21/18, and then a 1:1 staff was placed permanently with him. The DNS said CNA #1 should not have left Resident #65 alone in the bathroom on 1/23/19, as the staff was to be within arms reach of him. The DNS said CNA #2 should have been within arms reach instead of delivering meals during the 1/28/19 meal observation. The DNS said 1:1 staff were to report to each other when taking over for each other, were to talk to the nurse, and review the resident's care plan.</p> <p>The facility failed to provide adequate supervision to protect Resident #65 from repeated falls, when interventions failed to:</p> <ul style="list-style-type: none"> * direct staff what to do to keep him from falling, * ensure adequate supervision while relying on higher traffic areas to provide that supervision, * continue a 1:1 staff intervention twice without adequate time to test its effectiveness, and * train 1:1 staff adequately to keep him safe by following the 1:1 staff procedures and Resident #65's care plan. <p>2. Resident #40 was admitted to the facility on 12/21/18, with diagnoses including schizophrenia, aphasia (loss of ability to understand or express speech due to brain damage), dementia, abnormal involuntary movements, restlessness, agitation, and convulsions.</p> <p>Resident #40's History and Physical, dated 12/28/18, documented, "I met with [Resident #40] today to admit him to our facility. Due to his</p>	F 689			

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F 689	<p>Continued From page 111</p> <p>dementia and schizophrenia he is non-verbal and requires assistance with all ADLs . . . He is sitting up in his chair and appears to be comfortable."</p> <p>Resident #40's progress note, dated 1/21/19 at 5:16 AM, documented, "Resident was found on the floor this morning. He was lying on his left side, in a fetal position, head at the end of the bed. Redness noted to his right forehead . . . No bleeding noted. Slight abrasion to the forehead . . . resident indicating no pain. Resident assisted back to bed without signs of discomfort."</p> <p>Resident #40's Incident Report, dated 1/21/19, documented he was found on floor in his room at 5:00 AM. He had a minor abrasion to his forehead. The intervention was to place his bed in the low position when he was in bed with bilateral mats at the bedside.</p> <p>Resident #40's physician orders, dated 1/21/19, documented an order for, "Bed in low position with bilateral mats on floor."</p> <p>Resident #40's care plan was revised on 1/21/19 to include fall mats at his bedside with his bed in the low position.</p> <p>On 1/28/19 at 2:12 PM, Resident #40's family member said she was notified when the resident was found on the floor with his head at the foot of the bed in the fetal position. The family member said Resident #40 was able to move his legs.</p> <p>On 1/28/19 at 2:20 PM, 1/29/19 at 9:25 AM, and on 1/30/19 at 11:08 AM, Resident #40 was in his bed. His bed was not in the lowest position and there were no fall mats on the floor to either side</p>	F 689			

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F 689	<p>Continued From page 112 of his bed or elsewhere in the room.</p> <p>On 1/31/19 at 2:22 PM, Resident #40 was in bed and his bed was not in the lowest position. RN #3 said Resident #40's bed was not in the low position. CNA #2, also present, said she did not know Resident #40's care plan had changed to include the fall mats and the low bed.</p> <p>Fall prevention interventions included in Resident #40's care plan were not followed.</p> <p>3. Resident #1 was admitted to the facility on 9/13/18, with multiple diagnoses including a history of falls, difficulty walking, muscle weakness, and dementia without behavioral disturbances. Resident #1's admission MDS assessment and the quarterly MDS assessment, dated 09/20/18 and 12/20/18, respectively, documented he was severely cognitively impaired, required extensive assistance of staff for bed mobility, transfers, dressing, and toileting; and required limited assistance to walk in his room and eat; and he was not steady or able to balance with transfers. Resident #1's care plan, revised on 12/24/18, directed staff that he was at risk for falls due to actual falls with no injuries and due to dementia with poor safety awareness, poor balance, poor communication/comprehension, confusion, incontinence, vision/hearing problems, and unsteady gait. Resident #1's Incident Reports, dated 9/16/18 at 6:30 AM, 9/29/18 at 12:40 PM, 11/26/18 at 11:25 PM, 12/8/18 at 3:00 AM, and on 12/21/18 at 11:40 PM, documented he experienced unwitnessed falls from his bed. Resident #1's Incident Report, dated 11/26/18 at</p>	F 689			

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F 689	<p>Continued From page 113</p> <p>11:25 PM, documented he experienced an unwitnessed fall from his bed and was found with his knees on the floor and his torso on the bed. The recommendation was for the Physical Therapist to evaluate mobility "to see if current interventions are appropriate." According to the investigation, the bed was in the low position and a fall mat was in place at the time of this fall. Resident #1's Physical Therapy Evaluation & Plan of Treatment, dated 11/28/18, documented, "Patient has shown increased potential for transfers, gait, and bed mobility. He still has notable confusion but can follow simple single step instruction . . . D/C [discontinue] use of bed-side mat and low-bed. Patient is at risk for falling with mat in place." The low bed and the use of the bed side mat was not listed on the care plan.</p> <p>On 1/29/19 at 2:20 PM and 3:38 PM, Resident #1 rested in bed with the bed in the low position and a mat on the floor beside the bed. The mat was on the floor beside the bed during intermittent observations conducted on all days of the survey and was also next to the bed when Resident #1 was not in bed during the day and evening shifts from 1/28/19 through 2/1/19.</p> <p>On 1/30/19 at 2:54 PM, RN #3 said Resident #1 had experienced falls and his bed was placed in the low position, with one side of the bed against the wall, and a mat on the floor to prevent him from falling.</p> <p>On 1/31/19 at 3:34 PM, CNA #1 said she routinely cared for Resident #1 during the 2:00 PM to 10:00 PM shift. CNA #1 said Resident #1's bed was always in the low position with the mat on the floor beside the bed when he was in bed.</p> <p>On 2/1/19 at 9:30 AM, the Clinical Resource Nurse said the Physical Therapist recommended</p>	F 689			

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F 689	<p>Continued From page 114</p> <p>discontinuing the low bed and fall mat, but the facility did not review and implement the recommendation.</p> <p>4. The facility's Resident Mobility - Safety policy and procedure, dated 11/28/17, documented bed mobility, repositioning and transfer assistance needs were communicated to the staff. Staff were trained by persons demonstrating knowledge and competency in the Safe Resident Handling and Movement. The policy and procedure did not direct staff in the use and care of resident beds.</p> <p>The facility's Operation and Maintenance Manual for Alterra MAXX Long Term Care Bed, dated 1/1/17, documented the bed was equipped with two brakes locks; one on the head end of the bed and one on the foot end. To operate the brake locks, press down on the red pedal from either side of the bed. To unlock, press the green foot pedal from either side of the bed. Always use the brake locks except when moving the bed. Pads can be adjusted by rotating them clockwise or counter-clockwise to ensure proper contact with floor. Secure the individual locking casters. If all four casters are not locked, swivel and wheel rotation will allow bed motion with little or no resistance. This can result in loss of balance, fall and personal injury. Ensure that all four casters are locked to avoid any bed movement during resident transfer and/or use.</p> <p>Staff did not follow instructions in the facility's Operation and Maintenance Manual for Alterra MAXX Long Term Care Bed, to promote residents' safety. Examples include</p> <p>a. Resident #7 was admitted to the facility on</p>	F 689			

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F 689	<p>Continued From page 115</p> <p>6/28/18, with multiple diagnoses including history of falls, cognitive communication deficit, difficulty walking, and generalized muscle weakness.</p> <p>Resident #7's care plan, dated 7/3/18, documented she was at risk for falls and directed staff to lock the bed brakes.</p> <p>Resident #7's admission MDS assessment, dated 7/5/18, documented she was cognitively intact, at risk for falls, and she required the assistance of one person with some ADLs.</p> <p>On 1/28/19 at 10:40 AM, Resident #7 was lying in bed watching television, and the bed was observed in an unlocked position. On the same date at 12:00 PM, Resident #7 was observed sitting in the dining room, and her bed was observed in an unlocked position.</p> <p>On 1/29/19 at 12:13 PM, Resident #7 was observed sitting in the dining room, and her bed was observed in an unlocked position. On the same date at 2:44 PM, Resident #7 was observed going to the bathroom, and her bed was observed in an unlocked position.</p> <p>b. Resident #24 and Resident #41 shared a room. Resident #24 was admitted to the facility on 11/21/18, with multiple diagnoses including history of falls, cognitive communication deficit, and depression. Resident #41 was admitted to the facility on 11/17/18, with multiple diagnoses including history of falls, cognitive communication deficit, difficulty walking, and generalized muscle weakness.</p> <p>Resident #41's care plan, dated 11/20/18,</p>	F 689			

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F 689	<p>Continued From page 116</p> <p>directed two staff were required to assist her with ADLs and transfers using with Hoyer (mechanical) lift.</p> <p>Resident #41's admission MDS assessment, dated 12/15/18, documented her cognition was moderately impaired, at risk for falls, and she required 2-person assist with ADLs.</p> <p>On 1/28/19 at 3:24 PM, and on 1/29/19 at 2:39 PM, Resident #24 was observed sitting on the edge of the bed and #41 was observed sitting in her wheelchair and their beds were observed in an unlocked position.</p> <p>On 1/29/19 at 9:40 AM, CNA #3 and CNA #5 were observed unlocking Resident #41's bed from a locked position with the red foot lock in place, to an unlocked position with the green foot lock in place, while transferring Resident #41 to the bathroom. Resident #41 was transferred with a Hoyer lift from her wheelchair to her bed, from her bed to the commode, from the commode to the bed, and from the bed to the wheelchair. After cares, Resident #41's bed was observed in an unlocked position.</p> <p>On 1/29/19 at 3:00 PM, the Maintenance Director stated the beds in the rooms of Residents' #7, #24 and #41 were not locked in place. The Maintenance Director stated the beds should be locked. The Maintenance Director stated staff training on how to use the beds should be coordinated by the Staff Development Coordinator.</p> <p>On 1/29/19 at 3:15 PM, the Staff Development Coordinator, with CNA #1 present, stated she</p>	F 689			

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F 689	Continued From page 117 had been employed since November 2018 and was not aware of all the things staff were to be trained on. The Staff Development Coordinator stated she was not trained on the use of the beds and had not trained other staff. CNA #1 stated she was trained on the use of beds and had been working to train others. On 1/30/19 at 2:32 PM, CNA #5 stated she had been working at the facility since December 2018, and was trained on locking the beds in place with the green/red locks. CNA #5 stated she had known the bed were not locked in place during and after transport while providing cares for Resident #41 on 1/29/19 at 9:40 AM, as noted above.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon	F 690		4/2/19	

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F 690	<p>Continued From page 118</p> <p>as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and record review, it was determined the facility failed to ensure the bowel protocol was followed and implemented for 1 of 2 residents (#267) reviewed for bowel and bladder care. This had the potential to place residents at risk for fecal impaction. Findings include:</p> <p>The facility's Bowel Care Protocol, updated on June 2018, stated CNAs were to document each shift residents' number of bowel movement or lack of bowel movement, bowel consistency, and size of bowel movement. When a resident did not have documented bowel movement in the last 48 hours, the night nurse was responsible to ensure the physician's orders included approval to follow the Bowel Care Protocol or other bowel regime orders.</p> <p>Resident #267 was admitted to the facility on 12/26/18, with multiple diagnoses which included</p>	F 690	<p>F690</p> <p>Resident Specific Resident #267 discharged from the facility.</p> <p>Other Residents The clinical management team reviewed other residents to evaluate that the bowel protocol is implemented per physician orders. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses are educated to the facility's Bowel Care Protocol. Re-education was provided by CNO and/or designee to include but not limited to review of reports for residents that</p>		

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F 690	<p>Continued From page 119 depression and hypertension.</p> <p>Resident #267's January 2019 Physician Order summary included the following:</p> <ul style="list-style-type: none"> * Milk of Magnesia (MOM) suspension 1200 mg/15 ml if no bowel movement for 2 days. * Dulcolax suppository 10 mg, insert 1 suppository rectally, as needed, if no result from MOM concentrate within 8 hours, for constipation. * Fleet enema 7-19 gm/18 ml, give if no results from Dulcolax suppository in 8 hours <p>Resident #267's bowel movement records and MAR, dated 12/31/18 through 1/29/18, documented the following:</p> <ul style="list-style-type: none"> * Resident #267 did not have a bowel movement between 12/31/18 and 1/6/18 (7 days). Resident #267's MAR documented she was administered MOM with no results on 1/2/19, and on 1/7/19, 5 days later, she was administered MOM at 9:51 AM and a Fleet Enema with positive results. Resident #267 did not receive a Dulcolax suppository at any time during the 7 day period, after there were no results from the MOM. Resident was administered MOM and a Fleets enema on 1/7/19. There was not a physician's order for MOM to be given at that time, and the Fleets enema was administered on day 7 without a bowel movement. Resident #267's physician's orders, if followed, required the Fleets enema to be given on day 4 of no bowel movement. * Resident #267 did not have a bowel movement between 1/9/19 and 1/16/19 (8 days). Resident #267's MAR documented she received MOM with 	F 690	<p>have not had a bowel movement, following of physician orders including the frequency as indicated, if residents need additional bowel care notify the physician, document directives, and implement. The system is amended to include night shift printing of bowel care needs and review in clinical meeting for timely implementation.</p> <p>Monitor The CNO and/or designee will audit Bowel movement list in morning meeting for residents requiring intervention daily for 3 weeks and then weekly for 2 months. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months.</p>		

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F 690	Continued From page 120 no results on 1/13/19, instead of 1/11/19, day 3 without a bowel movement. On 1/14/19 Resident #265 was administered a Dulcolax suppository with no result. Three days later, on 1/17/19, Resident #267 was administered a Fleets enema with positive results. The Fleets enema was not administered 8 hours after she was administered a Dulcolax suppository with no result. On 1/30/19 at 3:38 PM, the DNS reviewed Resident #267's bowel movement record and said the resident's bowel care protocol was not consistently followed.	F 690			
F 692 SS=D	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	F 692		4/2/19	

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F 692	Continued From page 121 by: Based on staff interview and record review, it was determined the facility failed to ensure residents' weights were monitored in accordance with their nutritional assessment and plan of care. This was true for 1 of 8 residents (#44) reviewed for weight loss. This failure created the potential for harm if Resident #44 experience further weight loss and interventions were not in place in timely manner. Findings include: The facility's Weight Measurement policy and procedure, dated 11/28/17, directed staff to weigh residents at least monthly and as needed. Resident #44 was admitted to the facility on 8/6/18, with multiple diagnoses which included diabetes mellitus, dysphagia (difficulty swallowing), gastroparesis (stomach cannot empty itself of food in a normal fashion). A quarterly MDS assessment, dated 11/3/18, documented Resident #44 was cognitively impaired and she required extensive assistance of 2 staff members for activities of daily living. A Nutritional care plan, revised on 11/6/18, documented Resident #44 had a potential for altered nutritional status related to dementia, diabetes mellitus, dysphagia, and gatroparesis, shortness of breath, and hernia repair. The care plan documented Resident #44 was on a therapeutic diet and wandered out of the dining room in her wheelchair during meals. Interventions included in her care plan revised on 12/12/18, directed staff to obtain her weights daily. Resident #44's November 2018 Weight Flow Sheet, documented her weights as follows: *11/11/18: 175 pounds *11/15/18: 176 pounds *11/20/18: 172.2 pounds	F 692	F692 Resident Specific Resident #44 was weighed and weight schedule was modified. Other Residents The clinical management team reviewed other residents for timely weights per protocol and/or physician orders. Adjustments were made as indicated. Facility Systems Nursing staff are educated that weights are obtained per plan of care to include physician orders. CNO and/or designee re-educated nursing staff to include but not limited to the policy for weights, following physician orders for daily and/or increased frequency of weights, and follow-up with physician regarding order updates as indicated. The system is amended to include weights of increased frequency on the MAR for review in clinical meeting. In addition, monthly weights are reviewed in weekly nutrition meeting to validate timeliness. Monitor The CNO and/or designee will audit weights of increased frequency and timeliness of monthly weights weekly for 3 weeks and then monthly for 2 months. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months.		

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F 692	Continued From page 122 *11/25/18: 171.6 pounds Resident #44's clinical record did not include documentation her weight was obtained in December 2018. On 1/30/19 at 3:45 PM, the RD said Resident #44's weights were obtained 4 times in November and her weight was not checked or obtained in December 2018. The RD said Resident #44's weight was not obtained daily in accordance with her care plan. On 1/30/19, Resident #44's weight was obtained and she weighed 163.4 pounds. On 1/31/19 at 6:21 PM, RCM #2 said Resident #44's weights were not obtained in December 2018. RCM #2 said Resident #44 had experienced weight loss and he did not know the reason Resident #44 was not weighed daily according to her care plan.	F 692			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, observation, and interviews with staff and a resident, it was determined the facility failed to ensure a physician's order was in place prior to a resident receiving oxygen therapy. This was true for 1 of 1 resident (#318) reviewed for oxygen.	F 695	F695 Resident Specific Residents #318 discharged from the facility.	4/2/19	

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F 695	<p>Continued From page 123</p> <p>This failure created the potential for harm if residents received oxygen inconsistent with physician orders. Findings include:</p> <p>The facility's policy and procedure for Oxygen Therapy, dated 11/14/17, documented staff were to verify the physician's order prior to initiating oxygen.</p> <p>Resident #318 was admitted to the facility on 1/26/19 with multiple diagnoses, including chronic heart disease, pulmonary hypertension, and acute respiratory failure with hypoxia (low oxygen level).</p> <p>On 1/28/19 at 11:20 AM, Resident #318 was in her room and had oxygen in place by nasal cannula at 2.5 liters per minute.</p> <p>On 1/29/19 at 3:32 PM, Resident #318 was in her room and had oxygen in place by nasal cannula at 1.5 liters per minute. A physician order for Resident #318's oxygen was not found in her record at that time.</p> <p>On 1/28/19 at 2:54 PM, Resident #318 was in her room and did not have oxygen in place. Resident #318 said she should be receiving oxygen.</p> <p>On 1/29/19 at 3:38 PM, RN #5 said she expected there to be an order for Resident #318's oxygen, and she did not see an order in her clinical record.</p> <p>On 1/30/19 at 12:09 PM, RCM #1 said she expected to have a physician's order prior to oxygen being administered to a resident. RCM #1 said Resident #318's hospital discharge</p>	F 695	<p>Other Residents Residents reviewed by clinical team to ensure residents receiving oxygen therapy have physician's order in place. Adjustment were made as indicated.</p> <p>Facility Systems Licensed nurses were educated by CNO and/or designee on or before 4/2/2019 regarding oxygen use. Re-education included but was not limited to use of the need for physician orders, and ongoing documentation to the use of oxygen therapy. The system is amended to include clinical management team review of oxygen order changes and resident use of oxygen on admission or return from ER in clinical meeting.</p> <p>Monitor The CNO and/or designee will audit 3 random residents for oxygen orders weekly x 3 weeks and then monthly x 2. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p>		

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F 695	Continued From page 124 orders did not indicate oxygen, but her history and physical from the hospital documented she was dependent on oxygen at 1 liter per minute.	F 695			
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, policy review, record review, and interviews with staff and a resident's family member, it was determined the facility failed to ensure that prior to the placement of bed rails, residents were thoroughly assessed for the risk of entrapment and a consent was in place. This was true for 1 of 4 residents (#54) reviewed for bed rail use, and created the potential for	F 700	F700 Resident Specific Resident #54 has discharged from the facility. Other Residents The clinical management team reviewed	4/2/19	

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F 700	<p>Continued From page 125</p> <p>harm from entrapment or injury related to the use of bed rails. Findings include:</p> <p>The facility's policy for Restraints, dated 11/28/17, documented prior to use of bed rails, the facility would assess the resident for risk of entrapment, review the risks and benefits of bed rails with the resident or their representative, and obtain informed consent prior to installing the bed rails.</p> <p>Resident #54 was admitted to the facility on 11/29/18, with multiple diagnoses including hemiplegia and hemiparesis (weakness and paralysis on one side) following cerebral infarction (stroke) affecting the right side, and difficulty walking.</p> <p>On 1/28/19 at 3:47 PM and 1/30/19 at 2:36 PM, bilateral bed canes (small bed rails) were present on Resident #54's bed. Resident #54's representative was present at the time and said she did not recall signing a consent form for the use of the bed canes.</p> <p>Resident #54's clinical record did not document an assessment for the safety of the bed canes or consent from Resident #54 or his representative for use of the bed canes.</p> <p>On 1/30/19 at 4:40 PM, RCM #1 said she did not find documentation of when Resident #54 received the bed canes on his bed. RCM #1 said she did not see a safety assessment for Resident #54's use of the bed canes in his clinical record. RCM #1 said there would be a separate consent form for the bed canes, and she did not see documentation of consent from Resident #54 or</p>	F 700	<p>other residents with side rails to validate safety assessment and consent is in place. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses were educated by the CNO and/or designee on the need for resident safety assessment and consent when utilizing a mobility bar/side rail. The system is amended to include review in clinical meeting of residents with new orders for mobility bar/side rail to validate proper assessment and consent are in place use. In addition, review of restrains/potential restrains will occur by the MDS team with newly completed assessments.</p> <p>Monitor The CNO and/or designee will audit 3 random residents who have mobility bars/side rails to validate proper assessment and consent in place weekly for 3 week and monthly x2 months. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 weeks, as it deems appropriate.</p>		

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F 700	Continued From page 126	F 700			
F 812 SS=F	his representative for the use of the bed canes. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the dishwasher was maintained at an appropriate rinse temperature to ensure the dishes and utensils were sanitized, and failed to ensure food was placed on and held at a safe temperature on the steam table. These deficient practices placed the 79 of 79 residents who resided in the facility (each consumed food prepared by the facility) at risk of contracting foodborne illnesses. Findings include:	F 812	F 812 Resident Specific No specific resident identified. Other Residents All residents have the potential to be affected. Facility Systems	4/2/19	

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F 812	<p>Continued From page 127</p> <p>1. On 1/30/19 at 11:13 AM, FSE (Food Service Employee) #1 ran pots, pans, and utensils through the dishwasher. The rinse temperature of the dishwasher reached 173 degrees Fahrenheit (F) when she ran the pots/pans through the dishwasher, and 169 degrees (F) when she ran the rack of silverware through the dishwasher. She continued using the dishwasher even though the rinse temperature did not reach 180 degrees (F).</p> <p>On 1/30/19 at 11:15 AM, FSE #1 said she had not checked the water temperature and did not know what temperature the rinse was required to reach.</p> <p>On 1/30/19 at 11:15 AM, the Dietary Manager said the rinse temperature should have reached 180 degrees (F) in accordance with the manufacturer's instructions.</p> <p>On 1/30/19 at 11:17 AM, FSE #2 removed the silverware from the clean end of the dishwasher and began preparing them for transport to the units for the noon meal. The Dietary Manager redirected FSE #2 to stop and place the silverware back through the dishwasher after he got the rinse temperature back to 180 degrees (F). The Dietary Manager stated the rinse temperature dropped because of build up in the machine that was causing the water temperature to drop. After he cleaned the dishwasher, the rinse temperature reached 180 degrees (F).</p> <p>On 1/30/19 at 3:39 PM, the Registered Dietician provided the manufacturer's instruction and facility policy for the dishwasher. Review of the manufacturer's instructions for the Hobart</p>	F 812	<p>Kitchen staff is educated to the proper temperatures needed while washing dishes and serving food. CDM re-educated kitchen staff on the process to validating proper temperatures needed while washing/rinsing dishes and how to manage temperatures that are below the safety standards for serving food. The system is amended to include directives on the top of the temperature logs that directs staff on how to manage variances.</p> <p>Monitor The CDM and/or designee will audit food temperatures and dishwashing temperatures three times weekly for 3 weeks, then weekly for 2 months. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 3 months.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2019
NAME OF PROVIDER OR SUPPLIER CASCADIA OF NAMPA			STREET ADDRESS, CITY, STATE, ZIP CODE 900 N HAPPY VALLEY RD NAMPA, ID 83687		
(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 812	<p>Continued From page 128</p> <p>Dishwasher documented the minimum rinse temperature for the dishwasher was 180 degrees (F). Review of the facility's undated policy for Dish Machine Temperature Log documented "The food service manager will train dishwashing staff to monitor dish machine temperatures revealed throughout the dishwashing process." The Registered Dietitian stated it did not reach 180 degrees (F) and stated if the surveyor had not noticed the temperature was low, the utensils would have been used at the noon meal without being properly sanitized.</p> <p>2. Review of the facility's policy for Food Safety, dated 11/28/17, documented food was to be stored and distributed in a manner to minimize the risk of foodborne illness.</p> <p>Review of the facility's policy for Food Preparation, dated 11/28/17, documented hot foods must be held and distributed at 135 degrees (F) or hotter to minimize the risk of foodborne illness.</p> <p>On 1/30/19 at 11:53 AM, pans of food for the steam table were removed from the heated cart on the B unit and placed in the steam table for the noon meal. After placing the food on the steam table, FSE #3 obtained the temperature of the food items. At that time, the mechanical soft roast beef was 131 degrees (F) and the pureed carrots were 134 degrees (F). FSE #3 began serving at 12:00 PM without ensuring the mechanical soft meat and puree carrots were at least 135 degrees (F) or higher. At 12:18 PM, FSE #3 obtained the temperature of the mechanical soft roast beef a second time and it registered 124 degrees (F). FSE #3 verified the</p>	F 812			

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

PRINTED: 04/18/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2019
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F 812	Continued From page 129 temperature to the surveyor and continued serving the mechanical soft roast beef.	F 812			



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
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June 20, 2019

Brantley Shattuck, Administrator
Cascadia Of Nampa
900 N Happy Valley Rd,
Nampa, ID 83687

Provider #: 135144

Dear Mr. Shattuck:

On **February 1, 2019**, an unannounced on-site complaint survey was conducted at Cascadia Of Nampa. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007939

ALLEGATION #1:

A resident's representative was not notified when he fell.

FINDINGS #1:

An onsite complaint survey was performed on January 28, 2019 through February 1, 2019.

The records of nine residents who fell in the facility were reviewed. Four staff members were interviewed. Incidents and Accidents were reviewed for the previous six months.

One resident's record documented he fell multiple times within a short period of time. Three of the Fall Investigations for this resident documented his family member was notified of each fall. All other reviewed falls for other residents documented appropriate notification of their family or representative. All reviewed Incidents and Accidents documented appropriate notification of their family or representative.

CONCLUSIONS:

Based on the investigative findings, the allegation could not be substantiated.

ALLEGATION #2:

The facility failed to notify a residents' representative when the resident experienced a change in condition.

FINDINGS #2:

The records of three residents who experienced a change in condition were reviewed. Four staff members were interviewed. Incidents and accidents for the prior six months were reviewed.

One resident's record documented he fell multiple times within a short period, then he exhibited increased confusion and difficulty with mobility. The next morning, the same resident was unresponsive. The physician was in the facility, evaluated the resident, and was unable to waken him. The resident's family member was visiting, and the physician ordered immediate transport to the emergency room. There was no documentation of when the resident became unresponsive and when his family member was notified of his change in condition.

CONCLUSIONS:

Based on the investigative findings, the allegation was substantiated and the facility was cited at F580 as it related to their failure to notify the family and/or representative and physician of changes in the resident's condition.

ALLEGATION #3:

The facility failed to administer ordered medication to residents.

FINDINGS #3:

The Medication Administration Record was reviewed for five residents. The administration of 25 different medications was observed, including oral medication, medication through a gastrostomy tube, and injectable medication. Four residents were interviewed.

The Medication Administration Records of 5 residents documented all medications were administered as ordered. Upon observation of medication administration, 25 of 25 medications were administered as ordered. Four of four residents had no concerns about receiving their ordered medications.

Brantley Shattuck, Administrator
June 20, 2019
Page 3

One resident's record documented an ordered medication was to be administered three times a day for bowel care. The same resident's record documented the medication was administered as ordered from his admission until the order was discontinued and a new order was started. The resident was transferred to the hospital and the ordered medication was documented as not given because he was hospitalized and not in the facility.

CONCLUSIONS:

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Thank you for the courtesies and assistance extended to us during our visit. Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/slj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
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June 20, 2019

Brantley Shattuck, Administrator
Cascadia of Nampa
900 N Happy Valley Rd,
Nampa, ID 83687

Provider #: 135144

Dear Mr. Shattuck:

On **February 1, 2019**, an unannounced on-site complaint survey was conducted at Cascadia of Nampa. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007968

ALLEGATION #1:

The facility did not have enough staff and call lights were not answered in a timely manner.

FINDINGS #1:

An unannounced complaint survey was investigated in conjunction with the recertification survey conducted on 1/28/19 through 2/1/19.

Twenty-two residents were observed for Quality of Care issues. Call light response times were observed. The facility's grievances were reviewed, as well as Incident and Accident reports. The facility's nursing schedule was also reviewed for staffing. Residents and staff were interviewed and a Resident Council meeting was attended.

The facility's three week nursing schedule was reviewed and there was no concern noted.

Several residents attended the Resident Council meeting and said they have waited 30 minutes or more before their call lights were answered. Eleven of the 13 residents said their cares were not being met. The residents said the facility did not consistently respond to concerns/grievances, especially verbal concerns.

Call light response time was observed by different surveyors in different halls. Call lights were observed to be answered within 15 minutes.

The Administrator was interviewed and said the facility was aware of the residents' concerns with the staff response times to answering call lights. Concerns were brought to the facility's Quality Assurance Performance Improvement meetings. Several call light response time audits were performed and audits were ongoing. The Administrator said the result of audits were favorable and the call lights were answered in less than 15 minutes.

The Administrator provided minutes for the monthly group meetings with the chef, and for the monthly group meetings with the residents. The minutes did not consistently include evidence of the facility's response to the concerns/grievances shared at the group meeting with the residents. The grievances were not all resolved.

CONCLUSIONS:

It could not be established the call light response times were excessive. Therefore, the allegation was unsubstantiated. However, deficiencies were cited at F565 related to the Resident/Family Group and F585 related to the facility's failure to address grievances or residents' concerns.

ALLEGATION #2:

Residents were not being assisted during meals or with bathing.

FINDINGS #2:

During the investigation, meal observations were conducted, staff interviews were conducted, 22 resident records were reviewed, the facility's grievance file was reviewed, and the facility's Incident and Accident reports were reviewed.

Bathing/Shower Flowsheets were reviewed and five residents did not have their shower/bath provided consistently.

A Certified Nursing Assistant (CNA), who was the Shower Aide, said it was difficult for her to complete the bath/shower of the residents. She said her busiest day was Monday with 17 residents scheduled to receive their baths/showers. The CNA said the only time she could

complete all of baths/showers was when some of the residents refused their showers. The CNA said there was a time when she was pulled to the floor because somebody called in sick and she was unable to complete any of the baths/showers. The CNA said she always documented when the resident refused a bath/shower.

One resident's record documented staff were to assist her with eating and drinking. The resident was observed lying in bed watching television and an over-bed table was approximately two feet away from her bed. On top of the over-the-bed table was a tray of food, which consisted of one-half banana, a full glass of apple juice, a small bowl of oatmeal with plastic cover, a plate with a cover, a bowl of fruit with plastic cover, and utensils that were wrapped together with a brown cloth. The same observation was noted at four other times on the same day. Several staff members entered the resident's room during the observations and did not ask the resident if she wanted or needed assistance to eat.

The Director of Nursing Services (DNS) said the resident was able to feed herself. The DNS said the Certified Nursing Assistants (CNAs) should have repositioned the resident to eat, set-up her meal, removed the plate cover, and ensured the food was within her reach.

CONCLUSIONS:

Based on the investigative findings, the allegation was substantiated and the facility was cited at F677 related to the facility's failure to ensure residents were provided assistance with bathing and eating consistent with their needs.

ALLEGATION #3:

The facility did not prevent residents from falling and receiving injuries.

FINDINGS #3:

The records of nine residents were reviewed for falls and supervision, the facility's grievance file was reviewed, as well as Incident and Accident Reports. Thirteen residents, three family members, and staff members were also interviewed.

The facility's policy for Fall Response and Management directed staff to implement immediate interventions to prevent a repeat fall, review the post-fall evaluation and investigation, determine the cause, and revise the care plan interventions.

One resident's record, admitted to the facility in 12/2018, included a progress note which documented, "Resident was found on the floor this morning. He was lying on his left side, in a fetal position, head at the end of the bed. Redness noted to his right forehead . . . No bleeding

noted. Slight abrasion to the forehead . . . resident indicating no pain. Resident assisted back to bed without signs of discomfort."

An Incident Report documented he was found on the floor in his room at 5:00 AM. He had a minor abrasion to his forehead. The intervention was to place his bed in the low position when he was in bed with floor mats on each side of the bed. The resident's record included physician orders for his bed to be in a low position with bilateral mats on the floor. The resident's care plan was also revised to include fall mats at his bedside with his bed in the low position.

On 1/28/19 at 2:20 PM, 1/29/19 at 9:25 AM, and on 1/30/19 at 11:08 AM, the resident was in his bed. His bed was not in the lowest position and there were no fall mats on the floor to either side of his bed or elsewhere in the room.

A CNA said she did not know the resident's care plan had changed to include the fall mats and the low bed.

A second resident's record documented he was severely cognitively impaired, required extensive assistance of staff for bed mobility, transfers, dressing, and toileting, and required limited assistance to walk in his room. The resident's care plan directed staff that he was at risk for falls due to actual falls with no injuries and due to dementia with poor safety awareness, poor balance, poor communication/comprehension, confusion, incontinence, vision/hearing problems, and unsteady gait.

Incident Reports documented he experienced five unwitnessed falls from his bed.

During an interview an RN said the resident had experienced falls and his bed was placed in the low position, with one side of the bed against the wall, and a mat on the floor to prevent him from falling. A CNA said the resident's bed was always in the low position with the mat on the floor beside the bed when he was in bed.

The Clinical Resource Nurse said the Physical Therapist recommended discontinuing the low bed and fall mat, but the facility did not review and implement the recommendation.

CONCLUSIONS:

Based on the investigative findings the allegation was substantiated and the facility was cited at F689 related to the facility's failure to provide adequate supervision to meet residents' needs and implement fall interventions.

Brantley Shattuck, Administrator
June 20, 2019
Page 5

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Thank you for the courtesies and assistance extended to us during our visit. Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson", is positioned above the typed name.

LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/slj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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June 25, 2019

Brantley Shattuck, Administrator
Cascadia of Nampa
900 N. Happy Valley Rd.
Nampa, ID 83687

Provider #: 135144

Dear Mr. Shattuck:

On **January 28, 2019** through **February 1, 2019**, seven surveyors conducted an unannounced on-site complaint survey and federal recertification survey at Cascadia of Nampa. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008015

ALLEGATION #1:

Call Lights are not answered in a timely manner.

FINDINGS #1:

Observations were conducted throughout the facility on both day and evening shifts. Interviews were conducted with residents, family members and staff. Twenty-two residents' records were reviewed.

During observations, all call lights were answered within 15 minutes. However, residents in individual interviews and during the resident group meeting, voiced concerns about call lights not being answered timely and taking over 30 minutes for call lights for staff to respond.

Review of grievances also documented a complaint of call lights not being answered timely with no resolution to the complaint or grievance being given by the facility to address the complaint.

Based on investigative findings, the allegation was substantiated, and the facility was cited for deficient practice at regulation F565, relating to resident/family group concerns and facility response to them, and at regulation F585, relating to grievances about call lights and other complaints not being addressed by the facility.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility did not provide timely incontinence care/toileting for residents.

FINDINGS #2:

Observations of one resident were conducted over five days of the survey. During each observation, the resident was not wet/urine soaked and staff were observed assisting him to the toilet and changing his clothes after each meal. No odor was present in the resident's room, in his wheelchair, or recliner chair.

One resident observed during toileting/incontinence care with a wet brief was not noted to be excessively wet. The resident 's skin was checked and there was no redness or excoriation present to indicate he had been left wet for extended periods of time.

Six additional residents were reviewed for activities of daily living, including toileting. During observations none of the residents were noted to be urine soaked. During interviews with two additional family members of residents who required incontinence care, did not voice concerns about their family member being urine soaked.

Based on investigative findings, the allegation could not be substantiated due to lack of evidence of deficient practice, and no citations were cited.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility did not ensure residents were adequately groomed.

FINDINGS #3:

During intermittent observations of one resident over five days of the survey, the resident was not observed to have inadequate grooming. His fingernails were trimmed and clean and his toenails appeared thick, but were not excessively long. In an interview with the Resource Nurse and Director of Nursing, they stated the resident was on the list to see a podiatrist the first week of February 2019.

Nineteen residents and three family members were interviewed. Residents were asked if staff assisted them with bathing and grooming. Five of the residents and one of the family members interviewed each stated they or their family member did not receive an adequate number of showers.

Review of one resident's care plan, whose family member stated the resident did not receive an adequate number of showers, documented the resident was totally dependent on staff to provide a bath/shower two times a week. The resident's shower record documented the resident did not receive a shower from 12/26/18 through 1/7/19 (a 12-day span), 1/9/19 to 1/21/19 (an 11-day span), and 1/23/19 to 1/30/19 (a seven-day span). The only refusals documented were on 1/14/19, and 1/16/19. In an interview with the Certified Nurse Aide (CNA) who was responsible for the resident's showers, verified the resident did not receive showers during the time frames noted above.

During an interview with another resident, the resident stated he was supposed to have a shower twice a week. He stated received a shower approximately every 11 days. He said he wanted his showers twice a week. The resident's record documented the resident was to receive showers on Tuesdays and Saturdays. Review of the resident's shower schedule from 1/1/19 through 1/31/19 documented 5 scheduled showers were marked "NA.". In an interview with the CNA responsible for the resident's showers, she stated when the shower was marked "NA," it indicated the shower was not given.

Based on investigative findings, the allegation was substantiated, and the facility was cited for deficient practice at regulation F677, relating to the facility providing activities of daily living care for dependent residents.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

Residents' medications are not being given according to physician's orders.

FINDINGS #4:

Review of the facility's policy for Medication Management, documented if ordered medications were unavailable from the pharmacy or the facility, the physician was to be contacted for notification and further orders.

During an interview with one resident, the resident stated he had to wait for 30 days for his foot fungal cream. Review of the resident's record documented he had a telephone order signed by the physician on 9/21/18 for Mupirocin (an anti-fungal cream) to be applied to his toe twice a day as needed and for Jublia solution (a medication used to treat toenail fungus) to be applied to his toe every day for 48 weeks. Review of the resident ' s medication administration record documented the medications were started on 9/22/18. There was no delay in treatment.

In the same interview, the resident stated he had to wait for a suppository ordered by the physician and it took 11 days for the facility to receive the suppository from the pharmacy. Review of the resident's medication administration record documented an order from a physician for suppositories on 12/28/18, but the suppositories were not started until 1/7/19. In an interview with the resident ' s nurse, she stated she called the pharmacy and was told it took a while to fill the order due to the health insurance refusal to pay for the suppositories. In an interview with the Clinical Resource Nurse, she verified the resident's medication was ordered on 12/28/18, was not started on 1/7/19, and the physician was not notified of the delay in treatment.

In an interview with another resident, the resident stated the facility was two weeks late obtaining a foot medication because they lost the prescription. Review of the resident's record included a physician's order dated 12/27/18 for Terbinafine (anti-fungal medication) to be applied to the resident ' s feet twice a day daily for 2 weeks. Review of the resident's medication record documented the first time the medication was applied to the resident's feet was on 1/6/19 (a delay of 10 days). In an interview with the Clinical Resource Nurse, she stated the pharmacy was late delivering the medication due to insurance issues. The Clinical Resource Nurse verified the physician should have been notified.

Based on investigative findings, the facility was cited for deficient practice at regulation F580, relating to the facility not notifying the physician when residents were not given medications in the prescribed time.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

The facility did not follow preventative measures for residents at risk for falls.

FINDINGS #5:

Review of one resident's record documented he was identified at risk for falls. Review of the resident's Post-Fall Investigation report, Incident Follow-up documentation form, and nursing notes documented the resident experienced unwitnessed falls on 9/16/18, 9/29/18, 11/26/18, 12/8/18 and 12/21/18.

A Post-Fall Investigation report and the resident's Incident Follow-up and Recommendation form documented on 11/26/18 the resident experienced an unwitnessed fall from his bed. The recommendation was for Physical Therapy to evaluate the resident's mobility and if current fall interventions were appropriate. The investigation documented the bed was in the low position and a fall mat was in place at the time of the fall. Review of the Physical Therapy Evaluation and Plan of Treatment documented, the patient showed increased potential for transfers, gait, and bed mobility. It further documented to discontinue the use of the bedside mat and low-bed as the resident was at risk for falling with the mat in place. The low bed and use of the bedside mat were not listed on the plan of care.

The resident was observed in bed twice on 1/29/19 with the bed in low position and a mat on the floor beside the bed. The mat was also observed on the floor by the bed at intermittent times on all days of the survey when the resident was not in the bed.

In interviews with one of the resident's nurses and CNA, they stated they kept the bed low, one side of the bed against the wall, and a mat on the floor on the other side of the bed when the resident was in bed. The nurse verified the resident had experienced falls.

In an interview with the Clinical Resource Nurse, she verified the Physical Therapist had recommended discontinuing the low bed and fall mat, and the facility did not review and implement the recommendation.

Based on investigative findings, the facility was cited for deficient practice at regulation F689, relating to accident supervision and failing to address/incorporate Physical Therapy's recommendation to prevent future falls.

CONCLUSIONS:

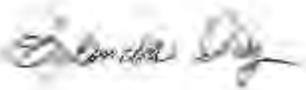
Substantiated. Federal deficiencies related to the allegation are cited.

Brantley Shattuck, Administrator
June 25, 2019
Page 6 of 6

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Belinda Day".

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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July 29, 2019

Brantley Shattuck, Administrator
Cascadia of Nampa
900 N Happy Valley Rd,
Nampa, ID 83687

Provider #: 135144

Dear Mr. Shattuck:

On **February 1, 2019**, an unannounced on-site complaint survey was conducted at Cascadia of Nampa. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007964

ALLEGATION #1:

Resident call lights were not answered in a timely manner.

FINDINGS #1:

An unannounced recertification and complaint survey was conducted on 1/28/19 to 2/1/19. During the investigation a Resident Group Interview was conducted, staff were interviewed, Resident Council Meeting minutes were reviewed, and call light audits were reviewed.

A Resident Group Interview was held on 1/29/19 at 10:30 AM, with 13 residents in attendance. Eleven of the 13 residents stated their cares were not being met and voiced concerns of possible retaliation, such as cares not being provided, if they voiced or filed grievances. Residents said call light response times were a problem last month, with 30 to 90 minutes elapsing before the lights were answered - with the worst response times being before breakfast, bed time, shift

change, and weekends. The residents said the nurses did not answer lights and did not help residents near change of shift, so the next shift would have to take care of the residents' needs. The residents said the night shift had the best call light response times with about a five-minute response time.

During an interview on 1/30/19, the Activities Director and the Administrator stated the Resident Community Meetings were about activities and confirmed they did not address residents' concerns/grievances, or follow-up from previous meetings. The Activities Director said the calendar showed monthly menu reviews with the chef every second Tuesday, followed by a group discussion with the Administrator to go over concerns or recommendations.

On 1/31/19, the Administrator provided minutes for the monthly group meetings he attended with the residents. The grievances were not all resolved. The Administrator provided the Performance Improvement Plan (PIP) for call light response times. When asked about a lack of grievances, which reported concerns about call light responses, he agreed there was only one grievance form filled out for call lights, and said the Ombudsman told him there were call light response concerns. The Administrator then said he had not interviewed the residents to find out when the problems with call lights were happening. The Administrator confirmed the minutes should reflect a logical flow to the Resident Council concerns that detailed the process of forwarding concerns to the department heads, the actions taken by the department heads to resolve the concerns or provide resolutions to the residents, and whether or not the residents confirmed resolution of the concerns. The Administrator confirmed he did not interview residents about call light response times.

Review of the call light audits showed several random call light audits were performed. The Administrator acknowledged the call light audits may not necessarily be for the times the residents complained about because the residents were not interviewed about call lights.

The allegation was substantiated and the facility was cited at F565 related to the failure of the facility to address concerns/grievances and requests that resulted from the Resident Council and at F585 related to the failure of the facility to ensure grievances were responded to, investigated, and resolved.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

Residents did not receive showers/baths on a regular basis.

FINDINGS #2: During the investigation six resident records were reviewed, residents were interviewed, and staff were interviewed.

One resident's record documented he had severe cognitive impairment and he required extensive assistance of 1 to 2 staff member for activities of daily living. The resident's record documented he was totally dependent on staff and the staff were to provide him a bath or shower two times a week. The resident did not receive a shower for 11 days on two occasions and did not receive a shower for 6 days on another occasion.

The resident's representative was interviewed and stated she did not know how often he was bathed. She stated she had asked the staff about how often they bathed or showered him and no one provided her with an answer.

A second resident's record documented he was cognitively intact and required the assistance of one staff member for activities of daily living. The resident's care plan, revised on 1/2/19, documented he required the assistance of one staff member with bathing and personal hygiene related to his weakness and shortness of breath. His record documented he did not receive a bath/shower for 10 days on one occasion, 8 days on a second occasion, and 6 days on a third occasion.

On 1/28/19, the resident stated he was to have a shower twice a week and said he received a shower "about every 11 days." He stated he wanted to have his showers twice weekly.

On 1/31/19, a CNA stated she was the shower aide and responsible for providing showers to up to 20 residents a day. She stated she was scheduled to work Sunday through Thursday and the aides who worked on the floor were to complete the Friday and Saturday showers. The CNA stated the first resident did not receive showers during the timeframes noted above and she could not see him refusing two showers in a row.

The allegation was substantiated and the facility was cited at F677 related to the failure of the facility to ensure residents were provided assistance with bathing/showering.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

Residents were not provided water in their room.

Brantley Shattuck, Administrator
July 29, 2019
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FINDINGS #3:

During the investigation observations were conducted and residents were interviewed.

A resident was interviewed regarding the availability of water. He stated the staff do change his water regularly and it is available on his bedside table. Four additional residents were interviewed and stated they had no concerns with water being available for them.

Observations were conducted of water availability at residents' bedside. Eight residents were observed to have water at their bedside and it was within reach. Two residents did not have water at their bedside, but these residents had orders for thickened liquids due to swallowing difficulties.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Thank you for the courtesies and assistance extended to us during our visit. Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/slj



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September 20, 2019

Brantley Shattuck, Administrator
Cascadia of Nampa
900 N. Happy Valley Rd.
Nampa, ID 83687

Provider #: 135144

Dear Mr. Shattuck:

On **January 28, 2019** through **February 1, 2019**, an unannounced on-site complaint survey was conducted at Cascadia of Nampa. The complaint was investigated in conjunction with the annual recertification survey. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008008

ALLEGATION #1:

The facility failed to ensure call lights were answered in a timely manner, resulting in resident falls.

FINDINGS #1:

Observations of call light response times were conducted throughout the facility. Interviews were conducted with 19 residents, 4 family members, and 12 staff members including nurses, Certified Nursing Assistants, the Director of Nursing, and the Administrator. A resident council interview was conducted with 15 residents in attendance. The clinical records of nine residents were reviewed. Incident and Accident Reports were reviewed for six months prior to the survey.

During the survey, observed call lights were answered within a reasonable time frame; however, 11 of 15 residents in the Resident Council interview said call lights were not responded to for 30 to 90 minutes, and response times were the worst before breakfast, at bedtime, shift change, and on weekends. The facility's Quality Assurance Committee began a Performance Improvement Plan to resolve prolonged call light response times, but the issue had not been resolved.

One resident's record documented he had seven falls in 12 weeks. He had memory problems and poor safety awareness, and he attempted to transfer and ambulate without asking for assistance. Interventions included educating staff to ensure the call light was within reach and encouraging him to use his call light.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F689 as it related to accidents and supervision.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility failed to ensure resident care plans were modified appropriately. The facility also failed to communicate with residents/family members in a timely manner and hold care conferences.

FINDINGS #2:

Interviews were conducted with 19 residents, 4 family members, and 5 staff members including the Social Worker, Clinical Resource Nurse, Dietary Manager, Resident Care Manager, and Director of Nursing. A resident council interview was conducted with 15 residents in attendance. The care plans of 22 residents were reviewed.

Review of residents' clinical records showed the care plan was not updated to reflect their current needs for 2 residents, care conferences were not conducted within an appropriate time frame for 3 residents, and 1 resident was not invited to the care conference.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F657 as it related to reviewing the care plan and involving residents' or their representatives in developing the care plan.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility failed to ensure resident care/services were provided as ordered by the physician.

FINDINGS #3:

Interviews were conducted with 19 residents, 4 family members, and the Director of Nursing. A resident council interview was conducted with 15 residents in attendance. The records of 2 residents were reviewed.

One resident's clinical record documented the bowel protocol was not followed. There was no bowel movement for a period of 7 days, and during another period of time there was no bowel movement for 8 days. There was a physician's order to administer Milk of Magnesia if no bowel movement for 2 days, and then a Dulcolax suppository if no results from Milk of Magnesia within 8 hours. The Dulcolax suppository was not administered as ordered by the physician.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F690 as it related to bowel care.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The facility failed to ensure residents were appropriately dressed for external appointments.

FINDINGS #4:

Interviews were conducted with 19 residents and 4 family members. A resident council interview was conducted with 15 residents in attendance. The clinical records of 22 residents were reviewed. Residents were observed for being appropriately dressed throughout the survey.

During interviews with residents and resident family members, there were no other expressed concerns regarding residents going out of the facility without being appropriately dressed for the weather.

One resident's record documented he went with the facility's driver to a physician's appointment on a day when recorded temperature was a low of 16 degrees Fahrenheit and high of 35 degrees Fahrenheit with sunny skies. The facility's driver noticed it was cold and the resident was not wearing a coat when she picked him up, so she loaned him her coat.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility failed to ensure appropriate documentation accompanied residents when they were transferred to another facility for care or services.

FINDINGS #5:

Interviews were conducted with 19 residents, 4 residents' family members, and 2 staff members including the Director of Nursing and a Resident Care Manager. The clinical record of three residents were reviewed.

The clinical record of 1 resident documented she was transferred to the emergency room. The record did not contain documentation regarding her transfer summary or what information was provided to the receiving facility at the time of her transfer.

Based on the investigative findings, the allegation was substantiated, and the facility was cited at F622 as it related to transfer and discharge.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

The facility failed to ensure residents received appropriate assistance with feeding.

FINDINGS #6:

Observations were conducted in the dining room and in residents' rooms throughout the facility. Interviews were conducted with 19 residents and 4 residents' family members. A resident council interview was conducted with 15 residents in attendance. The clinical records of 8 residents were reviewed.

There were no expressed concerns regarding residents receiving needed assistance with feeding. During observations of 1 resident, he was able to feed himself. Other residents were observed receiving assistance with feeding as needed.

Brantley Shattuck, Administrator
September 20, 2019
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Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

Facility failed to ensure medications were administered appropriately and as ordered.

FINDINGS #7:

Interviews were conducted with 19 residents and 4 residents' family members. A resident council interview was conducted with 15 residents in attendance. The record of 3 residents were reviewed. Two nurses were observed administering medication to a total of 12 residents.

During observation and record review of 2 residents, it was found they were allowed to self-administer medications without being assessed to safely do so, and medication was left at the bedside without the nurse observing whether the medication was taken.

Based on the investigative findings, the allegation was substantiated, and the facility was cited with deficient practice at F554 as it related to appropriate medication administration.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this findings letter, as it will be addressed in the provider's Plan of Correction.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,



Laura Thompson, RN, Supervisor

Brantley Shattuck, Administrator
September 20, 2019
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Long Term Care Program