



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
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3232 Elder Street  
P. O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

March 15, 2019

Gary "Paul" Arnell, Administrator  
Orchards Of Cascadia, The  
404 North Horton Street  
Nampa, ID 83651-6541

Provider #: 135019

Dear Mr. Arnell:

On **February 15, 2019**, a survey was conducted at Orchards Of Cascadia, The by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 25, 2019**. Failure to submit an acceptable PoC by **March 25, 2019**, may result in the imposition of penalties by **April 17, 2019**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by April 5, 2019 (**Opportunity to Correct**). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 16, 2019**. A change in the seriousness of the deficiencies on **April 5, 2019**, may result in a change in

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the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 16, 2019** includes the following:

Denial of payment for new admissions effective **May 16, 2019**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 14, 2019**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 16, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

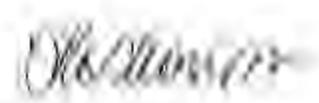
- BFS Letters (06/30/11)

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

This request must be received by **March 25, 2019**. If your request for informal dispute resolution is received after **March 25, 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 Laura Thompson, RN or Belinda Day, RN Co-Supervisors at (208) 334-6626, option 5.

Sincerely,



Laura Thompson, RN, , Chief  
Bureau of Facility Standards

lt/dr

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

PRINTED: 04/12/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135019</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/15/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>ORCHARDS OF CASCADIA, THE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 NORTH HORTON STREET NAMPA, ID 83651</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification and complaint investigation survey conducted from February 11 through February 15, 2019.  The surveyors conducting the survey were:  Cecilia Stockdill, RN, Team Coordinator Wendi Gonzales, RN Susan Devereaux, RN  Survey Abbreviations: ADL = Activities of Daily Living ADON = Assistant Director of Nursing cm = Centimeters CNA = Certified Nursing Assistant CNO = Chief Nursing Officer DON = Director of Nursing ER = Emergency Room LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = Milligram POST = Physician Orders for Scope of Treatment PRN = As Needed RN = Registered Nurse SBP = Systolic Blood Pressure	F 000			
F 578 SS=D	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	F 578		4/5/19	

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

TITLE

(X6) DATE

Electronically Signed

03/25/2019

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

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F 578	<p>Continued From page 1</p> <p>be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure: residents were assisted to formulate</p>	F 578	<p>F578 Resident Specific The Clinical Management Team reviewed</p>		

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F 578	<p>Continued From page 2</p> <p>Advance Directives if necessary, residents' records included documentation of this process, and a copy of the residents' Advance Directives, or documentation of their decision not to formulate Advance Directives, was documented in their clinical record. This was true for 3 of 24 residents (#31, #35, and #44) whose records were reviewed for Advance Directives. These failures increased the residents' risk of not having their decisions honored and respected when unable to make or communicate health care preferences. Findings include:</p> <p>The facility's policy for Advanced Directives/Health Care Decisions, dated 10/1/17, documented the following:</p> <ul style="list-style-type: none"> <li>* Advance Directives include Living Wills and Durable Power of Attorney for Health Care.</li> <li>* The POST (Physician Orders for Scope of Treatment) is an order from a physician, nurse practitioner, or physician's assistant with instructions "that complements an advanced directive by converting an individual's wishes regarding life-sustaining treatment and resuscitation into physician orders."</li> <li>* The facility would determine on admission whether the resident had an Advance Directive or other instructions to indicate the resident's wishes.</li> <li>* If the resident or their legal representative executed an Advanced Directive, the facility obtained a copy upon admission and "incorporates and consistently maintains them in the same section of the resident's medical record</li> </ul>	F 578	<p>residents #31, 35, 44. Obtained advanced directive for residents #31 and 44. Resident #35 offered assistance with DPOA and living will. Resident has declined at this time.</p> <p>Other Residents The Clinical Management Team reviewed other residents for advanced directive or whether the facility had provided information regarding formulation of an advanced directive. Adjustments made as needed.</p> <p>Facility Systems Clinical leadership team and licensed nurses are educated by Executive Director and/or designee on or before April 5, 2019 to assist with formulating advanced directives to include but not limited to obtain copies of advanced directives upon resident admission, offer information about advanced directives upon admission or as indicated, review directives quarterly and with change of condition documenting resident/resident advocate decisions, and validate that the advanced directives are located in the clinical record. The system is amended to include review of advanced directives in clinical meeting for new admission, residents with quarterly care conferences scheduled, and other residents as needed with a change of condition.</p> <p>Monitor The Director of Nurses and/or designee will audit new admissions and residents due for quarterly assessments for</p>		

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F 578	<p>Continued From page 3 readily retrievable for any facility staff."</p> <p>* If the resident had not executed an Advance Directive, the facility advised them of the right to formulate an Advance Directive, offered assistance if the resident wished to execute an Advance Directive, and advised the resident of their option to execute an Advance Directive but did not require the resident to do so.</p> <p>* The facility documented in the resident's clinical record discussions about Advance Directives and any healthcare decisions executed by the resident.</p> <p>* If the resident desired to develop an Advanced Directive, a nurse or social worker provided the resident with written information about their right under state law to make decisions about medical care.</p> <p>* The facility identified, clarified, and reviewed at least quarterly, after a life-altering event, and after returning from hospitalization, the resident's healthcare instructions and whether the resident desired to alter or continue the instructions.</p> <p>1. Resident #44 was readmitted to the facility on 12/17/18 with multiple diagnoses including multiple sclerosis (a potentially disabling disease of the brain and spinal cord), muscle weakness, and hypertension (high blood pressure).</p> <p>Resident #44's Admission MDS assessment, dated 12/24/18, documented he had moderate cognitive impairment.</p> <p>Resident #44's physician orders documented a</p>	F 578	<p>advanced directives weekly for 3 weeks, then 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. Date of Compliance 4/5/2019</p>		

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F 578	<p>Continued From page 4</p> <p>code status of Full Code was ordered on 12/17/18. Resident #44's POST documented a code status of DNR and was signed by him on 9/29/18.</p> <p>Resident #44's care plan, initiated on 1/3/19, documented the code status on his POST was DNR.</p> <p>On 2/12/19 at 9:11 AM, Resident #44's POST documented a code status of DNR and the physician's order documented a conflicting code status of Full Code. There was no Advanced Directive, Living Will, or Durable Power of Attorney found in his clinical record.</p> <p>On 2/13/19 at 10:56 AM the LSW said she mailed a letter to Resident #44's family to request his Living Will. On 2/13/19 at 1:33 PM, the LSW provided a copy of a letter she sent to families to request a copy of residents' Living Will. The letter was dated 1/30/19 and did not have a resident's name, family member's name, or address. There was no documentation in Resident #44's clinical record the letter was mailed to his family.</p> <p>On 2/14/19 at 9:04 AM, the LSW said she previously requested Resident #44's Living Will from his family and she did not document it. The LSW said prior to this year (2019) it was not a facility policy for facility staff to request the Living Will from residents on admission.</p> <p>On 2/15/19 at 9:00 AM, the CNO said Resident #44's code status physician's order was updated to DNR as of 2/12/19, after the facility did an audit and found it did not match the POST.</p>	F 578			

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F 578	<p>Continued From page 5</p> <p>2. Resident #35 was readmitted to the facility on 12/20/18 with multiple diagnoses including muscle weakness, Type 2 diabetes mellitus, and hepatic (liver) failure.</p> <p>Resident #35's quarterly MDS assessment, dated 12/21/18, documented she was cognitively intact.</p> <p>Resident #35's POST documented her code status was Full Code, and it was signed by her on 1/5/16.</p> <p>Resident #35's care plan, initiated on 5/10/18 and revised on 1/30/19, documented she had a physician's order for Full Code, and did not wish to have a Power of Attorney,</p> <p>Resident #35's Progress Notes documented Quarterly Care Conferences were held on 12/9/17, 6/5/18, 9/4/18, and 12/11/18. There was no documentation an Advanced Directive was offered or discussed during the care conferences.</p> <p>There was no documentation in Resident #35's clinical record of an Advanced Directive.</p> <p>On 2/14/19 at 9:08 AM, the LSW said she had been talking about Durable Power Of Attorney with Resident #35, and there was no documentation of the discussion. The LSW said there was only a POST in Resident #35's record.</p> <p>3. Resident #31 was admitted to the facility on 4/3/18, with multiple diagnoses including chronic kidney disease, Type 2 diabetes mellitus, and paroxysmal atrial fibrillation (irregular heart rhythm).</p>	F 578			

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F 578	Continued From page 6  Resident #31's quarterly MDS assessment, dated 12/25/18, documented severe cognitive impairment.  Resident #31's physician orders, documented a code status of Do Not Resuscitate (DNR) was ordered on 4/3/18.  Resident #31's POST documented a code status of DNR, and was signed by her representative on 4/4/18.  Resident #31's clinical record documented a Durable Power of Attorney For Financial Management only.  Resident #31's care plan, initiated on 6/27/18 and revised on 2/6/19, documented she had a code status of DNR on her POST and a copy of Durable Power of Attorney for Health Care/Living Will was requested.  Resident #31's Progress Notes documented Care Conferences were held on 4/5/18, 5/15/18, and 11/20/18. There was no documentation an Advanced Directive was offered or discussed.  There was no documentation in Resident #31's clinical record of an Advanced Directive or Living Will.  On 2/14/19 at 9:09 AM, the LSW said she requested the Living Will and Power of Attorney from Resident #31's son on 1/30/19, and it was documented on the care plan that she requested it.	F 578			

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F 578	Continued From page 7 On 2/15/19 at 10:12 AM, the CNO provided a copy of Resident #31's Power of Attorney, and said it was for financial Power of Attorney only.	F 578			
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)  §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.  The facility must provide- §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.  §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;  §483.10(i)(3) Clean bed and bath linens that are in good condition;  §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);  §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		4/5/19	

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F 584	<p>Continued From page 8</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on policy review, observation, resident and staff interview, and review of the Facility's Assessment, it was determined the facility failed to ensure residents' clothing was appropriately separated by color, washed, sorted, and returned to residents in a timely manner. This was true for 7 of 13 residents (#4, #21, #27, #56, #60, #67, and #71) reviewed for laundry services. This failure placed residents at risk of diminished quality of life and lack of clean and appropriate clothing. The failure also had the potential to place a financial burden on residents if they had to buy new clothes because their clothes were lost or misplaced. Findings include:</p> <p>The facility's Work Practices - Linen &amp; Laundry policy and procedure, dated 11/28/17, did not address laundry service practices for separating residents' clothes by color, washing clothes, sorting clothes, and returning residents' clothes in a timely manner. The policy also did not include processes to follow when a resident's clothing items were not returned to the resident and were missing.</p> <p>The Facility Assessment, dated 11/30/18, documented the purpose of the assessment was to determine what resources were necessary to care for residents competently during day-to-day</p>	F 584	<p>F584 Resident Specific The Clinical Management Team reviewed residents #4, 21, 27, 56, 60, 67, 71. Inventory of possible missing clothing obtained from each resident. Missing items replaced by facility. Other Residents Facility audit of residents to determine additional missing clothing items was completed on or before April 5, 2019 by social worker or designee. Additional missing items replaced by facility. Facility Systems Laundry and housekeeping staff were educated by Executive Director and/or designee on or before April 5, 2019 on laundering of resident personal items to include but not limited to separating clothing by color for washing, management for worn/faded/damaged clothing process, and utilization of the grievance form process for missing clothing items. The system is amended to validate in stand-up meeting that laundry concerns are managed through the grievance process. Monitor The Executive Director and/or designee</p>		

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F 584	<p>Continued From page 9</p> <p>operations. The assessment would help make decisions about direct care staff needs, as well as providing services to the residents in the facility. The assessment for laundry procedures directed staff to handle and keep clean and soiled laundry separate.</p> <p>The Facility Admission Agreement, undated, recommended residents needed four to six complete changes of clothing during their stay at the facility, directed staff to provide quality care for laundry, and to wash personal clothing daily.</p> <p>a. Resident's voiced the following concerns regarding laundry services:</p> <p>* On 2/12/19 at 11:05 AM, Resident #4 stated she had not received two pairs of pants and her tank tops back from the laundry for a couple of weeks.</p> <p>On 2/13/19 at 9:15 AM, Resident #4 stated she had a couple of tank tops and a pair of pants returned to her from the laundry. At 3:30 PM she stated she still had missing items.</p> <p>* On 2/13/19 at 9:15 AM, Resident #21 stated she was told by housekeeping they were not able to separate her white undergarments with all the clothes. Resident #21 stated housekeeping told her they were not able to wash her sweaters and keep them from bleeding to other clothing, and her daughter would have to wash them. Resident #21 opened her drawers and pointed out her dark gray undergarments. Resident #21 stated since she did not have enough undergarments there were times she had to wear them two or three days in a row because the soiled</p>	F 584	<p>will audit 10 random residents weekly for 3 weeks, then monthly for 3 months to ensure these residents do not have any missing clothing. 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 4/5/2019</p>		

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F 584	<p>Continued From page 10</p> <p>undergarments had not returned from the laundry.</p> <p>* On 2/11/19 at 4:26 PM, Resident #67 was observed entering the laundry room and stated to Laundry Staff #2 he was missing two extra-large plaid pants for three days. Laundry Staff #2 told Resident #67 one of the washers had been broken and laundry services were behind. in catching up with Laundry Staff #2 also stated three big bins of clothing were clean and needed to be sorted.</p> <p>On 2/12/19 at 10:03 AM, Resident #67 stated he had not yet received his pants and he asked staff about it that day. Staff told him they would have to look for them in the bins and had not been able to do so.</p> <p>b. On 2/13/19 at 11:00 AM, during Resident Council Meeting, the residents stated concerns of missing clothing, clothing not being returned in a timely manner due to the washer being broken for two weeks, and whites and dark items being washed together. The residents' concerns included:</p> <p>* Resident #27 stated the "whites were horrible" and she was missing a white top undergarment.</p> <p>* Resident #56 stated she had been missing two pairs of pants for a while.</p> <p>* Resident #60 stated Laundry Staff #1 told her the facility could not bleach whites and told her they could not separate whites and colors to be washed because it would take too long to separate the items and get their work done.</p>	F 584			

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

PRINTED: 04/12/2019  
FORM APPROVED  
OMB NO. 0938-0391

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F 584	<p>Continued From page 11</p> <p>* Resident #60 stated she washed her own white undergarments.</p> <p>* Resident #67 stated he had not received his pants from laundry services.</p> <p>* Resident #71 stated he was tired of his white undergarments being gray. He also stated he was missing jackets and sweaters for three months to a year. He said staff did not pay attention when they returned laundry to residents and misplaced the items with other residents.</p> <p>On 2/11/19 at 4:26 PM, Laundry Staff #2 stated the washer had been broken for two weeks and the dryer broke down today, and both were fixed today. She stated the facility tried to catch up with laundry this past weekend and complete the linen and personal laundry for those residents who did not have extra clothing. Laundry Staff #2 stated they were unable to get caught up with all the personal laundry for residents. Laundry Staff #2 also stated housekeeping was short staffed, as there was one person doing laundry and one person in training. She stated she worked on the floor along with other staff who tried to help with the laundry. Laundry Staff #2 stated there were three big bins of clean resident clothing that needed to be sorted and returned to the residents. She also stated residents' personal laundry items were washed together whether they were white or colored clothes.</p> <p>On 2/12/19 at 2:28 PM, Laundry Staff #2 stated she was not aware of any concerns of residents who needed laundry items separated. Laundry Staff #2 stated residents had been receiving</p>	F 584			

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F 584	Continued From page 12 some of their clothes and stated the usual turnaround time for personal laundry was the next day.  On 2/14/19 at 9:30 AM, the CNO stated she did not know there were problems with laundry. The CNO stated the Staff Development Coordinator did not provide competencies for housekeeping staff related to washing clothes. The CNO stated the washer had been broken for two weeks, and the parts were ordered and available to fix the washer.  On 2/15/19 at 8:41 AM, Laundry Staff #1 stated she had been working for the facility and doing laundry the same way for nine years. She stated she received clothes from the CNAs in the bins numbered by floor, tried to keep the clothes together, and stuffed what she could in the washer. Laundry Staff #1 stated she did not separate the white and colored clothes. She stated residents had complained several times about the laundry. Laundry Staff #1 stated she told residents there was nothing she could do because there were not enough staff to separate the laundry. Laundry Staff #1 stated she did let the past administration know of residents' concerns over a year ago and she was told they were working on getting more staff. Laundry Staff #1 stated one washer broke two weeks ago, and after waiting for parts, was finally fixed this week. Laundry Staff #1 stated when residents had clothes missing, she instructed them to complete a grievance form.	F 584			
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)  §483.10(j) Grievances.	F 585			4/5/19

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F 585	<p>Continued From page 13</p> <p>§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.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§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:</p> <p>(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</p>	F 585			

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F 585	Continued From page 14 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 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,	F 585			

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F 585	<p>Continued From page 15 and the date the written decision was issued;</p> <p>(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</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on policy review, record review, review of grievances, and resident, family, and staff interview, it was determined the facility failed to ensure grievances were responded to, investigated, and prompt corrective action was taken to resolve the grievances. This was true for 1 of 17 residents (Resident #30) reviewed for grievances. This failure created the potential for harm if the resident grievance, both verbal and written, was not acted upon and the resident did not receive appropriate care. Findings include:</p> <p>The facility's Filing Grievances/Complaints policy and procedure, undated, directed staff to assist residents, their representatives, other interested family members, or advocates in filing grievances or complaints when such requests were made. Concerned persons were encouraged to assist the facility to overcome any shortcomings by calling attention to anything that failed to meet their expectations. The resident, or person filing the grievance and/or complaint on behalf of the resident, would be informed of the findings of the</p>	F 585	<p>F 585 Resident Specific The Clinical Management Team reviewed resident #30. The resident advocate was contacted and verbalized acceptable closure. No additional concerns were noted.</p> <p>Other Residents Interdisciplinary team was interviewed and no additional undocumented grievances have been identified. Review of current grievance forms completed by Executive Director or designee on or before April 5, 2019 to ensure facility grievance policy was followed.</p> <p>Facility Systems Facility staff educated by Executive Director or designee on or before April 5, 2019 to include but not limited to grievance policy, appropriate response and investigation process for grievances,</p>		

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F 585	<p>Continued From page 16 investigation and the actions that would be taken to his or her designee. A written summary of the report would also be provided to the resident, and a copy would be filed in the facility.</p> <p>1. Resident #30 was admitted to the facility on 10/6/17 with multiple diagnoses including depression, dementia, contractures, and age-related physical debility.</p> <p>Resident #30's quarterly MDS assessment, dated 12/21/18, documented her cognition was severely impaired and required extensive assistance with two-person assist with ADLs.</p> <p>Resident #30's care plan, dated 6/27/18, documented she had an ADL self-care deficit and she required the assistance of two people, and needed encouragement to participate to the fullest extent possible with each interaction. The care plan documented she resisted ADLs and directed staff to reassure her, leave and return, and try again.</p> <p>Resident #30's ADL flowsheets, dated 1/27/19 from 6:00 AM to 2:00 PM, did not document Resident #30's acceptance, refusal or declination, or staffs' encouragement or offerings of ADLs.</p> <p>On 2/12/19 at 8:15 AM, Resident #30's daughter was interviewed by phone. She said she had planned a birthday party for Resident #30 on 1/27/19. She said she called ahead to let staff know as she wanted to make sure her mother was up and ready to have a party and celebrate her birthday. Resident #30's daughter stated when she showed up to the facility at 1:30 PM on</p>	F 585	<p>and timely follow up of grievances from residents. The system is amended to include discussion in stand-up meeting regarding grievances not yet documented and validate that the grievance tool is submitted.</p> <p>Monitor The Executive Director or designee will audit facility grievance forms to ensure facility grievance policy is followed including timely follow up weekly x 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p>		

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F 585	<p>Continued From page 17</p> <p>1/27/19, her mother was not dressed or groomed, had dirty pants, and had not been provided lunch or water. Resident #30's daughter stated a staff member came to Resident #30's room after she arrived and helped with getting her mother ready. Resident #30's daughter stated she called the facility and filed a grievance with the LSW on 1/28/19. Resident #30's daughter stated the LSW assured her this would not happen again and she would follow up with her regarding the incident. Resident #30's daughter said the facility did not follow up with her related to the incident on 1/27/18.</p> <p>On 1/28/19, Resident #30's daughter filed a grievance with the facility. The grievance was not available in the grievance binder record. The grievance documented on 1/27/19, Resident #30 was not out of bed until 1:30 PM, was dirty, was not provided with water or lunch, and was in her pajamas. The grievance documented Resident #30's daughter had called ahead because she was having a birthday party for Resident #30.</p> <p>On 2/13/19 at 9:40 AM, the LSW stated she did not follow up with Resident #30's daughter related to the grievance made on 1/28/19. The LSW stated she assured Resident #30's daughter on the day the grievance was made, the facility would ensure staff provided care and services to Resident #30. The LSW stated the care plan was not updated, but staff met as a group and addressed the incident. The LSW stated she would provide the documentation related to the incident.</p> <p>On 2/13/19 at 1:30 PM, the LSW stated Resident #30's daughter was not contacted for follow up</p>	F 585			

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F 585	Continued From page 18 related to the incident on 1/27/19. The LSW provided the grievance form document and stated there was no other documentation. The LSW stated she did not know why the grievance form was not part of the grievance binder record and stated the CNO said the incident was followed up with the LSW. The LSW stated the facility did follow up with the staff, and they were educated.  On 2/14/19 at 9:30 AM, the CNO stated she did not follow up with Resident #30's family related to the grievance made on 1/28/19, and the issue had been resolved with the LSW the day of the grievance. The CNO stated the facility followed up with staff and provided education. The CNO stated she did not provide a plan to prevent the incident from reoccurring.	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 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;	F 622		4/5/19	

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F 622	<p>Continued From page 19</p> <p>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c) (1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this</p>	F 622			

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NAME OF PROVIDER OR SUPPLIER  <b>ORCHARDS OF CASCADIA, THE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>404 NORTH HORTON STREET NAMPA, ID 83651</b>		
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F 622	<p>Continued From page 20</p> <p>section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure the required documentation was completed and the appropriate information was communicated to the receiving facility when a resident was transferred to the hospital. This was true for 1 of 3 residents (Resident #35) reviewed for transfer to the hospital, and had the potential to cause harm if the resident was not treated</p>	F 622	<p>F622 Resident Specific Resident #35, who is currently in facility, will have the required documentation completed and the appropriate information communicated to receiving facility if discharge should occur.</p> <p>Other Residents</p>		

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F 622	<p>Continued From page 21</p> <p>appropriately or in a timely manner due to a lack of information. Findings include:</p> <p>The facility's policy for Transfer and Discharge, dated 11/28/17, documented the 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, "all information necessary to meet the resident's needs..." and additional information as indicated in the transfer agreement. The required information should be communicated as close as possible to the time of transfer.</p> <p>Resident #35 was readmitted to the facility on 12/20/18, with multiple diagnoses including Type 2 diabetes mellitus.</p> <p>A physician's order, dated 12/19/18 at 12:35 PM, documented to send Resident #35 to the ER for evaluation and treatment because she did not feel well and felt dehydrated.</p> <p>A Progress Note, dated 12/19/18 at 3:42 PM, documented Resident #35 was transferred to the hospital due to increased confusion, not feeling well, and she thought she was dehydrated. The note also documented Resident #35's vital signs were not within normal parameters. The note also documented the physician was notified and a message was left for Resident #35's family member. There was no documentation of the information that was communicated to the receiving facility or any other information</p>	F 622	<p>Current residents will have the required documentation completed and the appropriate information communicated to receiving facility if discharge should occur.</p> <p>Facility Systems Licensed nurses were educated by Director of Nurses or designee on or before April 5, 2019 on facility transfer and discharge policy including but not limited to completing the required documentation when a resident is transferred or discharged. The system is amended to include review of the required documentation of residents who are transferred or discharged from facility in clinical meeting.</p> <p>Monitor The Director of Nursing and/or designee will audit residents transferred or discharged for completion of required documentation weekly for 3 weeks, then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p>		

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F 622	Continued From page 22 regarding the transfer to the hospital in Resident #35's clinical record.  On 2/14/19 at 10:41 AM, the CNO said she would look for all the required documentation regarding Resident #35's transfer to the hospital.  On 2/15/19 at 9:05 AM, the CNO said there was no transfer form completed for Resident #35's transfer to the hospital on 12/19/18.	F 622			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.  §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or 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-	F 623		4/5/19	

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F 623	<p>Continued From page 23</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual 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</p>	F 623			

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F 623	<p>Continued From page 24</p> <p>C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, observation, and staff interviews, it was determined the facility failed to ensure there was documented evidence for 3 of 3 residents (#35, #45, and #74) reviewed for hospital transfers, that the resident, and/or the resident's representative, was provided a written transfer notice when the resident was transferred to the</p>	F 623	<p>F623 Resident Specific Resident #45 and 74 have been discharged from facility. Resident #35, who is currently in facility, will have the required documentation completed if discharge should occur.</p>		

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F 623	<p>Continued From page 25</p> <p>hospital. This failure created the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's Transfer and Discharge policy, dated 11/28/17 documented:</p> <p>* For residents who are discharged or transferred, the resident and, if known, the family member, surrogate or legal representative, are notified at least 30 days prior to the transfer, unless the transfer is effected when:</p> <ul style="list-style-type: none"> <li>- There is endangerment to the health or safety of others in the facility</li> <li>- The resident has urgent medical needs requiring more immediate transfer</li> <li>- For exceptions to the 30-day notice rule, notice is given as soon as practicable.</li> </ul> <p>* The written notice of transfer/discharge includes:</p> <ul style="list-style-type: none"> <li>- Reason for transfer/discharge</li> <li>- Effective date of transfer/discharge</li> <li>- Location to which the resident is transferred/discharged</li> <li>- Statement that the resident has the right to appeal the action to the state</li> <li>- Name, address, and telephone number of the state long term care ombudsman</li> <li>- As applicable, mailing address and telephone number of the agency responsible for protection and advocacy of developmentally disabled or mentally ill individuals</li> </ul> <p>1. Resident #74 was admitted to the facility on 11/1/18 with medical diagnoses that included spina bifida (a birth defect where the bones in the</p>	F 623	<p>Other Residents</p> <p>The clinical management team reviewed other residents 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.</p> <p>Facility Systems</p> <p>Licensed nurses and Social Workers were educated by Director of Nurses or designee on or before April 5, 2019 to provide notice of transfer in writing to a resident and/or their representative when the resident is transferred to the hospital. The system is amended to include review of the required notice of transfer in writing to a resident and/or their representative when the resident is transferred to the hospital in clinical meeting.</p> <p>Monitor</p> <p>The Director of Nursing or designee will audit 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 x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p>		

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F 623	<p>Continued From page 26</p> <p>vertebral column do not fully cover the spinal cord, leaving it exposed) and chronic pain syndrome.</p> <p>An attempt was made to interview Resident #74 on 2/11/19 at 3:37 PM and he was in bed and very lethargic, indicating he did not want to talk. On 2/12/19, at 8:34 AM, Resident #74 was not in his room and a staff nurse stated he was hospitalized on 2/11/19.</p> <p>Resident #74's Progress Notes documented the following:</p> <p>On 2/11/19 at 5:29 PM: "Resident transfer form completed. See form for details."</p> <p>On 2/11/19 at 6:45 PM: Resident #74 returned to the facility from being out with family for the weekend. When the nurse administered evening medications at approximately 4:30 PM, Resident #74 was difficult to arouse, had slurred speech, bloodshot eyes, and abnormal vital signs. Resident #74's blood pressure was 85/52 (normal blood pressure is 120/80) and respirations were 10 (normal respirations are 16 to 20 per minute). The CNA also noted red colored urine in the Foley catheter bag. The medical practitioner was notified and ordered to transfer Resident #74 to the hospital. He was sent by non-emergent transport to the hospital for further evaluation at approximately 6:30 PM on 2/11/19. The nurse called Resident #74's sister and left a message.</p> <p>On 2/12/19 at 6:45 AM: Resident #74 was admitted to the hospital.</p>	F 623			

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F 623	<p>Continued From page 27</p> <p>Resident #74's clinical record did not document he and his representative were provided a written transfer notice identifying the reason he was transferred to the hospital on 2/11/19.</p> <p>On 2/15/19 at 9:45 AM, the CNO stated the provided packet of papers was the packet sent to the hospital with Resident #74 and no written transfer notice was provided to him or his representative.</p> <p>2. Resident #45 was admitted to the facility on 12/13/18 with multiple diagnoses including chronic obstructive pulmonary disease (obstruction of lung airflow that interferes with normal breathing) and cardiac arrhythmia (irregular heart rhythm).</p> <p>Resident #45's Progress Notes, dated 1/14/19 at 7:01 AM, documented the Resident #45 was found very lethargic, pale, and clammy and was difficult to arouse. The note also documented Resident #45 had a breathing treatment earlier without much effect. The note documented Resident #45's oxygen saturation was 88-89% on 3 liters of oxygen and the physician was called. The note documented a physician order was received to send Resident #45 to the ER for treatment and evaluation. The note also documented the daughter of Resident #45 was informed of his change in condition.</p> <p>Resident #45's clinical record did not document he and/or his representative were provided a written transfer notice identifying the reason Resident #45 was transferred to the hospital on 1/14/19.</p>	F 623			

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F 623	<p>Continued From page 28</p> <p>On 2/15/19 at 9:40 AM, the CNO stated there was no written transfer notice provided to Resident #45 and/or his representative.</p> <p>On 2/15/19 at 4:10 PM, LPN #3 stated when a resident was being transferred from the facility, she would tell the resident about their change of condition, talked about choice of hospitals, and clarified who the resident wanted to be called, but there was nothing in writing.</p> <p>3. Resident #35 was readmitted to the facility on 12/20/18, with multiple diagnoses including Type 2 diabetes mellitus.</p> <p>A physician's order, dated 12/19/18 at 12:35 PM, documented to send Resident #35 to the ER for evaluation and treatment because Resident #35 felt dehydrated and did not feel well.</p> <p>A Progress Note, dated 12/19/18 at 3:42 PM, documented Resident #35 was transferred to the hospital due to increased confusion, not feeling well, and she thought she was dehydrated. The note also documented Resident #35's vital signs were not within normal parameters. The note documented the physician was notified and a message was left for Resident #35's family member on her cell phone. There was no documentation of written notification being provided to Resident #35 or her representative regarding her transfer to the hospital on 12/19/18.</p> <p>On 2/14/19 at 10:41 AM, the CNO said she would look for all the required documentation regarding Resident #35's transfer to the hospital.</p>	F 623			

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F 623	Continued From page 29 On 2/15/19 at 9:05 AM, the CNO said there was no written notice of transfer provided to Resident #35 or her representative regarding her transfer to the hospital on 12/19/18.	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, policy review,	F 625		4/5/19	
			F625		

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F 625	<p>Continued From page 30</p> <p>observation, and resident and staff interview, it was determined the facility failed to ensure the bed-hold policy was provided to residents. This was true for 2 of 3 residents (#35 and #74) reviewed for transfers to the hospital. This failure created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include:</p> <p>The facility's policy for Transfer and Discharge, dated 11/28/17, documented the resident and their family member or representative would be provided written notice of the bed hold policy that identified the duration of the bed hold and criteria for readmission after the bed hold period expired.</p> <p>The facility's policy for Bed-Hold Readmission, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> <li>* The first bed hold notice would be provided "well in advance of any transfer..."</li> <li>* The second bed hold notice would be provided to the resident and their representative, if applicable, at the time of transfer, or within 24 hours of transfer in case of an emergency transfer.</li> <li>* In case of an emergency transfer, the bed hold notice would be provided to the resident or their representative upon transfer and may be included in the papers sent to the hospital with the resident.</li> <li>* If the facility was unable to notify the resident's representative, they would continue attempts to notify the representative and document the attempts.</li> </ul> <p>1. Resident #74 was admitted to the facility on</p>	F 625	<p>Resident Specific Resident #74 have been discharged from facility. Resident #35, who is currently in facility, will have the required documentation completed if discharge should occur.</p> <p>Other Residents The clinical management team reviewed other residents for providing notice bed hold policy in writing to a resident and/or their representative when the resident is transferred to the hospital. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nurses were educated by Director of Nurses or designee on or before April 5, 2019 to provide notice bed hold policy in writing to a resident and/or their representative when the resident is transferred to the hospital. The system is amended to include review of the required notice of transfer in writing to a resident and/or their representative when the resident is transferred to the hospital in clinical meeting.</p> <p>Monitor The Director of Nursing or designee will audit residents for completion of required bed hold policy in writing to a resident and/or their representative when the resident is transferred to the hospital weekly for 3 weeks, then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust</p>		

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F 625	<p>Continued From page 31</p> <p>11/1/18 with medical diagnoses that included spina bifida and chronic pain syndrome.</p> <p>An attempt was made to interview Resident #74 on 2/11/19 at 3:37 PM and he was in bed and very lethargic, indicating he did not want to talk. On 2/12/19, at 8:34 AM, Resident #74 was not in his room and a staff nurse stated he was hospitalized on 2/11/19.</p> <p>Resident #74's Progress Notes documented the following:</p> <p>On 2/11/19 at 5:29 PM: "Resident transfer form completed. See form for details."</p> <p>On 2/11/2019 at 6:45 PM: Resident #74 returned to the facility from being out with family for the weekend. When the nurse administered evening medications at approximately 4:30 PM, Resident #74 was difficult to arouse, had slurred speech, bloodshot eyes, and abnormal vital signs. Resident #74's blood pressure was 85/52 (normal blood pressure is 120/80) and respirations were 10 (normal respirations are 16 to 20 per minute). The CNA also noted red colored urine in the Foley catheter bag. The medical practitioner was notified and ordered to transfer Resident #74 out. He was sent by non-emergent transport to the hospital for further evaluation at approximately 6:30 PM. The nurse called Resident #74's sister and left a message.</p> <p>On 2/12/2019 at 6:45 AM: Resident #74 was admitted to the hospital.</p> <p>Resident #74's clinical record did not document he and his resident representative were provided</p>	F 625	<p>the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p>		

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F 625	Continued From page 32 a bed hold notice when he was transferred to the hospital on 2/11/19.  On 2/15/19 at 9:45 AM, the CNO stated the provided packet of papers was the same packet sent to the hospital with Resident #74, and no bed hold policy was included or provided to Resident #74 and/or his representative.  2. Resident #35 was readmitted to the facility on 12/20/18, with multiple diagnoses including Type 2 diabetes mellitus.  A physician's order, dated 12/19/18 at 12:35 PM, documented to send Resident #35 to the ER for evaluation and treatment because she did not feel well and felt dehydrated.  A Progress Note, dated 12/19/18 at 3:42 PM, documented Resident #35 was transferred to the hospital due to increased confusion, not feeling well, and she thought she was dehydrated. The note also documented Resident #35's vital signs were not within normal parameters. The note also documented the physician was notified and a message was left for Resident #35's family member. There was no documentation in Resident #35's clinical record she and/or her family member was provided bed-hold policy information when she was transfer to the hospital.  On 2/15/19 at 9:05 AM, the CNO said there was no notice of the bed-hold policy being provided to Resident #35 or her family member when she was transferred to the hospital on 12/19/18.	F 625			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657			4/5/19

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F 657	Continued From page 33  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' care plans were updated to maintain consistency and accuracy. This was true for 1 of 18 residents (Resident #31) whose care plans were reviewed. This failure created the potential for harm if cares and/or services were not provided due to inaccurate	F 657	F657 Resident Specific Resident #31's care plan was reviewed by clinical management team and care plan was updated to maintain consistency and accuracy.  Other Residents		

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F 657	<p>Continued From page 34 information on the care plan. Findings include:</p> <p>The facility's policy for Care Plans, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> <li>* A team of qualified individuals monitors the resident's condition and the effectiveness of the care plan. The team revises the care plan quarterly, annually, with significant change assessments, or more frequently as needed.</li> <li>* The care plan is reviewed following each assessment, except discharge assessments, and is revised according to the resident's changing goals, preferences, and needs.</li> </ul> <p>Resident #31 was admitted to the facility on 4/3/18 with multiple diagnoses, including chronic obstructive pulmonary disease and obstructive sleep apnea.</p> <p>Resident #31's physician orders, dated 2/14/18, documented the following:</p> <ul style="list-style-type: none"> <li>* CPAP (Continuous Positive Airway Pressure) at 15 cm water on room air with humidification. Start at bedtime, off in AM, ordered on 8/30/18.</li> <li>* CPAP Machine Daily Care, ordered on 8/31/18.</li> <li>* CPAP Machine Non-Disposable Tubing Care, ordered on 8/31/18.</li> <li>* CPAP Machine Weekly Care, ordered on 8/31/18.</li> <li>* CPAP/BiPap (Bilevel Positive Airway Pressure): Check skin under the mask for skin integrity with applying and removing the mask. Notify the physician as needed, twice a day, ordered on 8/31/18.</li> </ul> <p>Resident #31's current care plan did not</p>	F 657	<p>Residents care plans were reviewed by clinical management team on or before April 5, 2019 to ensure care plans were updated to maintain consistency and accuracy.</p> <p>Facility Systems Licensed nurses were educated by Director of Nurses or designee on or before April 5, 2019 regarding facility policy to ensure resident care plans are updated to maintain consistency and accuracy. The system is amended to include review in clinical meeting new admission residents, readmission residents, and residents with new orders to include CPAPs for timely care plan updates.</p> <p>Monitor The Director of Nurses or designee will audit 15 random care plans weekly x 3 weeks and then 15 random care plans monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p>		

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F 657	Continued From page 35 document the use of CPAP or orders related to the CPAP machine.  Resident #31's January 2019 and February 2019 MAR documented the CPAP and CPAP care was administered each day and each week as ordered.  Resident #31's Progress Note, dated 1/23/19 at 10:01 AM, documented CPAP machine daily care was completed.  On 2/14/19 at 2:58 PM, the CNO said Resident #31's CPAP was not documented on her care plan and it needed to be on the care plan.	F 657			
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, review of Incident and Accident Reports, and staff interviews, it was determined the facility failed to ensure professional standards of practice for completion of neurological assessments after a fall, medications were administered to residents prior to being documented as given, and pain medications were administered timely. This was true for 1 of	F 684	F684 Resident Specific LPN #1 was provided education regarding medication standards of practice to include but not limited to signing for medication not personally provided to the resident.  Residents #60 has no adverse issues	4/5/19	

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F 684	<p>Continued From page 36</p> <p>18 residents (Resident #31) reviewed for quality of care and 2 of 23 residents (#60 and #61) reviewed for medications. This failure placed residents at risk of a) adverse outcomes if medications were administered when contraindicated, b) increased pain due to delays in administering pain medication, and c) undetected neurological changes after falls. Findings include:</p> <p>The facility's General Dose Preparation and Medication Administration policy, dated 1/1/13, directed staff to verify each time a medication was administered it was the correct medication, the correct dose, the correct route, the correct rate, the correct time, and for the correct resident. The policy also directed staff to document necessary medication administration/treatment information, such as when medications were given on appropriate forms.</p> <p>The facility's Medication Management policy and procedure, dated 11/28/17, directed staff to develop policy, procedures and clinical practice guidelines to manage medications so they were safely provided and administered to residents. The policy documented authorized staff who administer medications were responsible for staying proficient in administering medication following evidenced-based practice guidelines.</p> <p>1. Resident #60 was admitted to the facility on 2/11/13, with multiple diagnoses including hypertension, congestive heart failure, anxiety, depression, diabetes mellitus type 2, generalized muscle weakness, and difficulty walking.</p>	F 684	<p>related to eye drops or by providing medication when outside of parameters. Physician was notified and directives received.</p> <p>Resident #61 is pleased to expect that her routine pain medications be provided within one hour (before or after) the scheduled time.</p> <p>Resident #31 has had a neurological assessment and found without deficit. The physician was updated regarding current status and missed neurochecks. No additional directives were received from the physician.</p> <p><b>Other Residents</b> The clinical management team reviewed other residents for completed neurological checks following unwitnessed falls and medication administration through random medication pass audits completed on or before April 5, 2019 by Director of Nurses or designee. Adjustments have been made as indicated.</p> <p><b>Facility Systems</b> Licensed nurses are by the Director of Nursing Services and/or designee on or before April 5, 2019 to include but not limited to complete neurological checks following unwitnessed falls, timely passing of meds within 1 hour of time ordered, and only documenting medications the nurse provided. The system is amended to include review in</p>		

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F 684	<p>Continued From page 37</p> <p>Resident #60's quarterly MDS assessment, dated 1/15/19, documented she was cognitively intact.</p> <p>Resident #60's care plan, dated 2/7/16 and 2/23/18, documented she had impaired visual function related to dry eyes and directed staff to administer ophthalmic medication as ordered. The care plan also documented she had altered cardiovascular status related to hypertension and directed staff to administer medications as ordered.</p> <p>a. A physician's order for Resident #60, dated 7/13/18, documented to instill Olopatadine hydrochloric acid solution 0.7%, instill one drop in both eyes one time a day for dry eyes</p> <p>On 2/12/19 at 11:10 AM, during medication administration, LPN #1 asked Resident #60 if she had received her eyedrops in the morning. Resident #60 stated she had received her eyedrops that morning. LPN #1 documented Resident #60 was administered her eyedrops. LPN #1 stated she did not administer eyedrops to Resident #60. LPN #1 stated she trusted what the resident had said about receiving her eyedrops and documented the eyedrops were given by the morning nurse. LPN #1 stated she should not have documented the administration of the eyedrops.</p> <p>b. A physician's order dated 7/13/18, documented to administer Hydralazine hydrochloric acid to Resident #60, one 10 mg tablet by mouth every 8 hours for hypertension. The order directed staff to hold the medication if SBP was less than 120.</p> <p>Resident #60's MAR, documented Hydralazine</p>	F 684	<p>clinical meeting for thorough completion of neurological checks following unwitnessed falls, medications not provided within the order time frame, and review of medications provided outside of parameters. In addition, periodic surveillance of licensed nurses during medication administration pass will provide real-time feedback and education as indicated.</p> <p>Monitor The Director of Nursing or designee will audit residents for completion of neurological checks following unwitnessed falls weekly for 3 weeks and then monthly x 3. The Director of Nursing or designee will audit the timeliness of medication administration and compliance with parameters set by the physician by completing 3 random medication passes for 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p>		

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F 684	<p>Continued From page 38</p> <p>medication was administered when her SBP was less than 120, on the following dates:</p> <p>On 2/2/19 at 9:00 PM, SBP was 99 On 2/4/19 at 9:00 PM, SBP was 90 On 2/5/19 at 5:00 AM, SBP was 112 On 2/5/19 at 9:00 PM, SBP was 97 On 2/6/19 at 9:00 PM, SBP was 93 On 2/8/19 at 1:00, SBP was 96 On 2/9/19 at 9:00 PM, SBP was 117</p> <p>On 2/15/19 at 11:51 AM, the CNO stated the February 2019 MAR documented Resident #60 was administered Hydralazine several times when her SBP was less than 120. The CNO stated she interviewed the nurses who administered the medication and they stated they did not administer the medication when Resident #60's SBP was less than 120 and the documentation was in error. The CNO stated the documentation errors were due to medications being documented as given before Resident #60's blood pressure was assessed. The CNO said the medication was then wasted when Resident #60's SPB was found to be less than 120.</p> <p>2. Resident #61 was admitted to the facility on 10/16/18 and was readmitted on 1/15/19 with medical diagnoses that included multiple sclerosis (a potentially disabling disease of the brain and spinal cord), Type 2 diabetes mellitus, chronic pain syndrome, and low back pain.</p> <p>On 2/12/19 at 8:26 AM, Resident #61 stated "It would be nice to get my pain medications on time instead of an hour or two hours late." She stated that even with her pain medication her pain level</p>	F 684			

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F 684	<p>Continued From page 39</p> <p>was a "7 to 8 (out of 10)." Review of Resident #61's pain assessments documented she consistently rated her pain at "7 to 8" on a scale of 1 to 10.</p> <p>Resident #61's care plan documented she had acute/chronic pain related to arthritis, chronic back pain, history breast cancer, wounds, multiple sclerosis, history of cerebral vascular accident (stroke), and chronic pain syndrome. She often reported pain at a high level due to chronic pain. Staff were directed to administer medications as ordered, and monitor for effectiveness and side effects.</p> <p>Resident #61's MAR, dated February 2019, documented an order for an Oxycontin Tablet extended release 30 mg be given two times a day for chronic pain, ordered on 10/17/18. The medication administration times were scheduled at 8:00 AM and 8:00 PM.</p> <p>Resident #61's MARs were requested with the documented times of her pain medications. The facility was not able to provide Resident #61's MARs. The facility provided the Narcotic Sign-out sheets for January 29, 2019 through February 13, 2019. A review of the narcotic logs documented the following doses were signed out over an hour late from the scheduled administration time at 8:00 PM as follows:</p> <p>1/29/19 at 9:16 PM 2/1/19 at 9:02 PM 2/4/19 at 9:24 PM 2/5/19 at 9:22 PM 2/7/19 at 9:08 PM 2/9/19 at 9:10 PM</p>	F 684			

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F 684	<p>Continued From page 40 2/11/19 at 9:51 PM 2/12/19 at 9:23 PM</p> <p>On 2/15/19 at 9:20 AM, Resident #61 stated she was still waiting for her 8:00 AM dose of pain medication.</p> <p>On 2/15/19 at 9:28 AM, LPN #3 stated she was getting a dose of pain medication for [a different resident name], who was getting a dressing change. LPN #3 noted the time on the electronic medical record MAR was 9:21 AM and said she was going to Resident #61 next.</p> <p>On 2/15/19 at 2:12 PM, the CNO stated the expectation was medications would be administered within one hour before to one hour after the scheduled administration time.</p> <p>3. The facility's policy for Fall Response and Management, dated 11/28/17, documented neurological assessments should be done after an unwitnessed fall per the physician's order, or monitor every 15 minutes for one hour, every 30 minutes for one hour, then every hour for two hours or until the condition stabilizes. The resident's condition should be monitored for at least 72 hours after the fall.</p> <p>The website <a href="http://www.hcpro.com/LTC-287387-10704/Neurological-checks-for-head-injuries.html">http://www.hcpro.com/LTC-287387-10704/Neurological-checks-for-head-injuries.html</a>, accessed 2/21/19, documented the following:</p> <p>* "Neurological assessments include (at a minimum) pulse, respiration, and blood pressure measurements; assessment of pupil size and reactivity; and equality of hand grip strength."</p>	F 684			

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F 684	<p>Continued From page 41</p> <p>* Neurological assessments should be performed every 15 minutes for two hours, every 30 minutes for two hours, every hour for four hours, every eight hours for 16 hours, and every eight hours for at least 72 hours and until the resident is stable.</p> <p>Resident #31 was admitted to the facility on 4/3/18 with multiple diagnoses, including dementia left leg amputation below the knee, muscle wasting and atrophy, and generalized muscle weakness.</p> <p>Resident #31's quarterly MDS assessment, dated 12/25/18, documented she had severe cognitive impairment.</p> <p>Resident #31's care plan documented she was at risk for falls due to deconditioning and directed staff to follow the facility's fall protocol, initiated on 4/3/18.</p> <p>Resident #31's Progress Note, dated 1/2/19 at 11:02 PM, documented she was found sitting on the floor next to her bed. She attempted to self-transfer from bed to her wheelchair and fell onto her buttocks. The note documented the nurse assessed Resident #31 and would continue to monitor her.</p> <p>An Incident and Accident Report, dated 1/2/19 at 8:40 PM, documented Resident #31 was found on the floor next to her bed, and she was attempting to self-transfer from bed to her wheelchair.</p> <p>A Post Fall Investigation, dated 1/2/19 at 11:14</p>	F 684			

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PRINTED: 04/12/2019  
FORM APPROVED  
OMB NO. 0938-0391

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F 684	Continued From page 42 PM, documented Resident #31 had an unwitnessed fall on 1/2/19 at 8:30 PM. She was found in her room sitting on the floor next to her wheelchair.  A Neurological Record documented Resident #31's eye opening, level of alertness, speech, and extremity movement were assessed on 1/3/19 at 8:30 AM and 12:30 PM, and on 1/4/19 at 12:30 AM. Her vital signs were documented on 1/2/19 at 10:00 PM, 10:30 PM, and 11:30 PM, on 1/3/19 at 12:30 AM, 4:30 AM, 8:30 AM, and 12:30 PM, and on 1/4/19 at 12:30 AM. A second page of the Neurological Record documented another resident's name that was crossed out and Resident #31's name was written in, and it documented her vital signs and neurological checks were completed at 15 minute intervals three different times, but there was no documented date or time.  On 2/14/19 at 2:55 PM, the CNO said neurological checks should be done after any unwitnessed fall or when the resident hits their head. The CNO said the neurological checks were not completed appropriately for Resident #31.  On 2/15/19 at 9:26 AM, LPN #5 said neurological checks should be performed anytime it was known the resident hit their head and anytime there was an unwitnessed fall. LPN #5 said she would have to look it up to see the required intervals and length of time neurological checks should be completed.	F 684			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		4/5/19	

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F 686	<p>Continued From page 43</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(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</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, policy review, and record review, it was determined the facility failed to consistently follow physician orders for treatment of a pressure ulcer for 1 of 3 residents (Resident #44) reviewed for pressure ulcers. The failure created the potential for Resident #44 to experience delayed healing, or further deterioration, of a Stage 4 pressure ulcer, and/or develop additional pressure ulcers.</p> <p>Findings include:</p> <p>The facility's policy for Prevention and Treatment of Pressure Ulcers and Other Skin Alterations, dated 11/28/17, documented basic or routine care to prevent pressure ulcers could include redistributing pressure, such as repositioning.</p> <p>The Lippincott Manual of Nursing Practice, tenth edition, documented measures to prevent pressure ulcers include repositioning every 2 hours.</p>	F 686	<p>F686 Resident Specific The clinical management team reviewed resident #44. A skin assessment was performed and interventions were put into place to decrease the risk of developing pressure ulcers.</p> <p>Other Residents The clinical management team reviewed other residents for risk of development or worsening of pressure ulcers. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nursing staff were educated by Director of Nurses or designee on or before April 5, 2019 on prevention and management of pressure ulcers including but not limited to following care plan developed for residents at risk for</p>		

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F 686	<p>Continued From page 44</p> <p>Resident #44 was readmitted to the facility on 12/17/18 with multiple diagnoses, including Multiple Sclerosis (a potentially disabling disease of the brain and spinal cord), muscle weakness, postprocedural wound closure, disruption of external surgical wound, and Stage 4 pressure ulcer of the sacral region (low back/upper buttock area).</p> <p>Resident #44's MDS assessment, dated 12/24/18, documented the following:</p> <ul style="list-style-type: none"> <li>* One unhealed Stage 4 Pressure ulcer.</li> <li>* He required extensive assistance for bed mobility and transfers.</li> </ul> <p>Resident #44's physician orders, dated 2/15/19, documented the following:</p> <ul style="list-style-type: none"> <li>* Ordered on 12/17/18: Avoid supine (lying on back) position. Position side to side using pillows and wedges. Bed flat. May elevate head of bed up to 30 degrees for meals and for 30 minutes after meals.</li> <li>* Ordered on 1/15/19: Bedrest with offloading by turning side to side until further evaluation by [a named physician].</li> <li>* Ordered on 2/12/19: Dressing change twice a week and as needed, with wound vacuum on continuously to Resident #44's sacrum.</li> </ul> <p>Resident #44's care plan directed staff to follow the facility's protocols for treatment of his skin injury, initiated on 8/14/18, and to turn and reposition him every 2 hours, initiated on 2/13/19.</p> <p>On 2/12/19 at 7:54 AM, Resident #44 was observed lying in bed on his back. LPN #4 said</p>	F 686	<p>development or worsening of pressure ulcers. The system is amended to include review of residents with changes of condition in clinical meeting to implement preventative measure.</p> <p>Monitor The Director of Nursing and/or designee will audit 10 residents for risk of pressure ulcers and residents with alteration in skin integrity weekly for 3 weeks, then monthly x 3 months. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p>		

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F 686	Continued From page 45 Resident #44 had a pressure ulcer on his sacrum.  On 2/12/19 at 8:45 AM, RN #2 was observed performing a dressing change to Resident #44's sacral wound. The pressure ulcer measured 2.5 cm by 4 cm. LPN #6, also present, said Resident #44 came from the hospital with the pressure ulcer, and he had a wound flap (a flap is a unit of tissue that can be moved to cover a wound while surviving on its own blood source) placed in November 2018 and it failed.  Resident #44 was observed lying in bed on his back on 2/13/19 at 11:47 AM, 2:32 PM, and 3:59 PM, and on 2/14/19 at 2:17 PM.  On 2/13/19 at 11:53 AM, LPN #4 said Resident #44's position was to be alternated from his right side and left side, unless the order changed it when the wound vacuum was resumed. LPN #4 said Resident #44 was not to be positioned on his back.	F 686			
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii)  §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.	F 687		4/5/19	

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F 687	<p>Continued From page 46</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and record review, it was determined the facility failed to ensure residents received proper treatment and care to maintain good foot health. This was true for 1 of 14 residents (Resident #7) reviewed for foot care. This failed practice created the potential for harm should residents experience complications from their medical condition related to the lack of proper foot care. Findings include:</p> <p>The facility's policy for Nail Care, dated 3/31/18, documented nail care would be provided to promote "hygiene, comfort, neatness, wellbeing and prevent injuries and/or infections." Nail care would be provided by nursing personnel, and if the resident had a diagnosis of diabetes a licensed nurse must provide the nail care. Staff were directed to document refusal of nail care.</p> <p>Resident #7 was readmitted to the facility on 9/8/17 with multiple diagnoses, including primary osteoarthritis, lack of coordination, weakness, repeated falls, and varicose veins of the lower extremity with ulcer on another part of the lower leg.</p> <p>Resident #7's quarterly MDS assessment, dated 11/20/18 documented he required extensive assistance of one person with personal hygiene and extensive assistance of two persons with bed mobility.</p> <p>Resident #7's care plan documented the following:</p>	F 687	<p>F687 Resident Specific Resident #7 discharged from the facility.</p> <p>Other Residents The clinical management team reviewed other residents for proper treatment and care to maintain good foot health. Adjustments have been made as indicated.</p> <p>Facility Systems Licensed nursing staff were educated by Director of Nurses or designee on or before April 5, 2019 on facility policy for nail care.</p> <p>Monitor The Director of Nursing and/or designee will audit 10 residents for proper treatment and care to maintain good foot health for 3 weeks, then monthly x 3 months. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p>		

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F 687	<p>Continued From page 47</p> <p>* He had potential issues with skin integrity related to edema of both legs with a history of venous stasis ulcers. There was a purple hue to the second, third, and fourth toes. The focus area was initiated on 12/8/16 and revised on 2/1/19.</p> <p>* He had a self care deficit with activities of daily living related to weakness, edema, wounds, and preferring to stay in bed. The focus area was initiated on 12/8/16 and revised on 1/28/19.</p> <p>On 2/11/19 at 9:47 AM, 2/12/19 at 7:13 AM, and 2/13/19 at 8:14 AM, Resident #7 was in bed and did not respond to verbal stimuli. His toenails on both feet were very long and in poor condition. The skin on his feet was scaling and his feet were discolored with a purple hue.</p> <p>On 2/13/19 at 8:57 AM, RN #1 said up until about 2 weeks ago Resident #7 would refused everything and it was documented on the MAR he refused cares. RN #1 said a CNA could trim Resident #7's nails.</p> <p>There was no documentation in Resident #7's clinical record nail care was offered or performed, and no documentation he refused nail care.</p> <p>On 2/13/19 at 9:10 AM, the CNO said Resident #7 was on the podiatrist list and he could not tolerate getting up, so the facility was trying to find a podiatrist who would come to the facility but was not able to find one.</p> <p>On 2/13/19 at 1:21 PM, the CNO said said it was not documented the last time Resident #7's nails were trimmed.</p>	F 687			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		4/5/19	

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F 695	<p>Continued From page 48</p> <p>§ 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:</p> <p>Based on observation, record review, policy review, and staff interviews, it was determined the facility failed to ensure residents received respiratory care as ordered by a physician. This was true for 1 of 5 residents (Resident #7) reviewed for oxygen therapy. This failure created the potential for harm if residents did not receive oxygen therapy to maintain adequate oxygen levels. Findings include:</p> <p>The facility's policy for Oxygen Therapy, dated 11/14/17, documented oxygen was indicated for documented or suspected hypoxia (low oxygen level) and directed staff to verify the physician's order prior to initiating oxygen therapy. Staff were also directed to monitor the resident for tolerating the oxygen, including relief of physical symptoms and improvement of oxygen saturation.</p> <p>According to the Mayo Clinic website for symptoms of hypoxemia (low oxygen level in the blood), accessed on 2/20/19, normal pulse oximeter readings are usually 95 to 100 percent, and less than 90% is considered low.</p> <p>Resident #7 was readmitted to the facility on</p>	F 695	<p>F 695 Resident Specific Residents #7 discharged from the facility.</p> <p>Other Residents Residents reviewed by Director of Nursing or designee on or before 4/5/2019 to ensure any residents receiving oxygen therapy have physicians order in place and order followed.</p> <p>Facility Systems Licensed nurses were educated by Director of Nurses or designee on or before 4/5/2019 regarding facility policy on oxygen therapy including but not limited to physician order in place and order followed. The system is amended to include clinical management team to review oxygen orders in clinical meeting.</p> <p>Monitor The Director of Nurses or designee will audit 10 random residents for oxygen orders weekly x 3 weeks and then monthly x 3. Any concerns will be</p>		

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F 695	<p>Continued From page 49</p> <p>9/8/17, with multiple diagnoses including cerebral infarction (stroke) and pulmonary embolism (blood clot that has traveled to the lung) with acute cor pulmonale (dilation of the right side of the heart).</p> <p>Resident #7's quarterly MDS assessment, dated 11/20/18 documented he received oxygen while a resident.</p> <p>Resident #7's physician orders, dated 1/31/19, documented the following:</p> <ul style="list-style-type: none"> <li>* Monitor oxygen saturation/pulse oximetry every shift, ordered on 9/8/17.</li> <li>* Oxygen 3 liters per minute per nasal cannula as needed for shortness of breath, use for oxygen saturation less than 92%.</li> </ul> <p>Resident #7's care plan documented he had oxygen as needed and often refused, initiated on 8/25/17 and revised on 2/13/19.</p> <p>Resident #7's MARs from January and February 2019 documented his oxygen saturation was less than 92 percent on 43 out of 62 opportunities in January 2019 and on 23 out of 25 opportunities in February 2019. The oxygen saturation was not documented by the day shift on 2/2/19. There was no documentation oxygen was administered to Resident #7 or that he refused oxygen on any of the opportunities where his oxygen level was less than 92 percent.</p> <p>Resident #7 was observed lying in bed in his room on multiple occasions throughout the survey. He was not wearing oxygen and there was no oxygen equipment in his room at any</p>	F 695	<p>addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p>		

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F 695	Continued From page 50 time during the survey.  On 2/13/19 at 8:57 AM, RN #1 said she noticed Resident #7's oxygen saturation was 88 percent "a couple times," and she just checked it and it was 91 to 92 percent. RN #1 said Resident #7's oxygen saturation was checked daily, and he thought everything was poison and did not want the oxygen. RN #1 said she did not know whether it was documented Resident #7 refused oxygen.  On 2/13/19 at 9:10 AM, the CNO said she would follow up about Resident #7's oxygen, and she acknowledged the order for oxygen and documentation his oxygen saturation had been less than 92 percent.  On 2/13/19 at 1:21 PM, the CNO said Resident #7's physician was consulted and he said there should never have been an order for oxygen to be administered if the oxygen saturation was less than 92%, but the order should have been for oxygen if there were signs and symptoms of respiratory distress.  Resident #7 did not receive oxygen as ordered by the physician when his oxygen level was less than 92 percent.	F 695			
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		4/5/19	

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F 761	Continued From page 51 applicable.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on policy review, observation, review of the medication refrigerator temperature and maintenance logs, and staff interview, it was determined the facility failed to ensure expired medications were not available for administration, expired biological supplies were removed for resident use, multi-dose vials were dated when opened, and proper refrigerator temperature controls were within range for safe storage. This was true for 2 of 4 medication storage rooms and 2 of 3 refrigerators reviewed for safe storage and labeling medication. This failure created the potential for harm to all residents in the facility should residents receive medications with decreased efficacy, potency and safety. Findings include:	F 761	F 761 Resident Specific No specific residents were identified.  Other Residents For all resident medication storage rooms, clinical management team discarded all items that were expired, purchased new refrigerators for medication storage rooms and ensured that any multi-dose vials are dated on or before April 5, 2019.  Facility Systems Licensed nurses were educated by Director of Nurses or designee on or before April 5, 2019 regarding facility		

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F 761	<p>Continued From page 52</p> <p>The facility's Storage and Expiration of Medications, Biologicals, Syringes and Needles policy and procedure, dated 10/31/16, documented:</p> <p>* Staff were to ensure medications and biologicals having an expiration date on the label were stored separated from other medications until destroyed or returned to the pharmacy or supplier.</p> <p>* After any medication or biological package was opened, the facility should follow the manufacturer guidelines with respect to expiration dates. Staff should record the date opened on the medication container when the medication had a shortened expiration date after opened.</p> <p>* Staff were to ensure medications and biologicals were stored at appropriate temperatures according to the Unites States Pharmacopeia guidelines of temperature ranges and monitor the temperature of vaccines twice a day. The refrigerator temperatures should be 36-46 degrees Fahrenheit (F).</p> <p>The Centers for Disease Control and Prevention website (<a href="http://www.cdc.gov">www.cdc.gov</a>) accessed on 3/14/19, states: "Medication vials should always be discarded whenever sterility is compromised or questionable. In addition, the United States Pharmacopeia (USP) General Chapter 797 [16] recommends the following for multi-dose vials of sterile pharmaceuticals: If a multi-dose has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a</p>	F 761	<p>policy on storage and expiration of medications, biologicals, syringes and needles to include but not limited to expired meds, appropriate medication temperatures and dating of multi-dose vials. The system is amended to include review of medication storage areas on clinical rounds at least once weekly and to validate vials are dated, refrigerator temps are within range or adjustments are implemented and documented.</p> <p>Monitor The Director of Nurses or designee will audit medication storage rooms for compliance with expired meds, medication temperatures and appropriate dating of multi-dose vials weekly x 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p>		

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F 761	<p>Continued From page 53 different (shorter or longer) date for that opened vial."</p> <p>On 2/14/19 at 9:00 AM, during medication storage review with the ADON, the following issues were noted:</p> <p>a. The Tuberculin Vaccine vial in the Unit #3 medication refrigerator was open and dated 1/3/19. The ADON stated the vaccine was opened 1/3/19 and past the 28 day of use, and should be discarded.</p> <p>b. Five Toothbrush/Suction Kits in the Unit #3 medication storage room had an expiration date of 12/3/18. The ADON stated the kits had expired and should be discarded.</p> <p>c. The Influenza Vaccine vial in the Unit #5 medication refrigerator was open and not dated. The ADON stated the vaccine was opened, not dated, and should be discarded.</p> <p>d. The facility's Medication Refrigerator Maintenance policy and procedure, dated 11/28/17, directed staff to review the functionality of medication refrigerators periodically and as needed to ensure acceptable temperature ranges and document corrective actions when applicable. The policy directed staff to implement preventive maintenance protocols when any of the recorded temperatures were outside the acceptable temperature range.</p> <p>On 2/14/19 at 9:00 AM, during medication storage review, the Unit #3 medication refrigerator/freezer temperature log documented 25 refrigerator temperature entries in January</p>	F 761			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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PRINTED: 04/12/2019  
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OMB NO. 0938-0391

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F 761	Continued From page 54 2019, and 15 refrigerator temperature entries in February 2019, were outside the acceptable temperature range of 36 - 46 degrees F, as noted in the facility's policy. The dates included:  January 2019 - - 1/5/19 = AM Check 28 degrees F - 1/6/19 = AM Check 26 degrees F - 1/14/19 = AM Check 34 degrees F - 1/15/19 = AM Check 34 degrees F - 1/16/19 = AM Check 32 degrees F - 1/17/19 = AM Check 32 degrees F, PM Check 28 degrees F - 1/18/19 = AM Check 34 degrees F - 1/19/19 = AM Check 30 degrees F, PM Check 32 degrees F - 1/20/19 = AM Check 30 degrees F, PM Check 32 degrees F - 1/21/19 = AM Check 32 degrees F, PM Check 48 degrees F - 1/22/19 = AM Check 32 degrees F - 1/23/19 = AM Check 32 degrees F, PM Check 62 degrees F - 1/24/19 = AM Check 30 degrees F, PM Check 32 degrees F - 1/26/19 = AM Check 32 degrees F, PM Check 32 degrees F - 1/25/19 = AM Check 32 degrees F - 1/29/19 = PM Check 32 degrees F - 1/30/19 = PM Check 30 degrees F - 1/31/19 = PM Check 50 degrees F  February 2019 - - 2/2/19 = PM Check 34 degrees F - 2/3/19 = PM Check 28 degrees F - 2/4/19 = AM Check 32 degrees F, PM Check 32 degrees F - 2/5/19 = AM Check 32 degrees F, PM Check 32	F 761			

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F 761	Continued From page 55 degrees F - 2/6/19 = PM Check 54 degrees F - 2/8/19 = PM Check 32 degrees F - 2/5/19 = AM Check 30 degrees F, PM Check 30 degrees F - 2/10/19 = AM Check 30 degrees F, PM Check 32 degrees F - 2/11/19 = AM Check 31 degrees F, PM Check 30 degrees F - 2/12/19 = PM Check 32 degrees F  The Maintenance Check Medication Room Refrigerator for Unit #3, dated on 1/7/19, 1/14/19, 1/21/19 and 1/28/19, did not document issues with the Unit #3 refrigerator.  On 2/14/19 at 2:45 PM, the CNO stated the nurses documented the medication refrigerator temperatures two times a day at the beginning of each shift when they initially opened the refrigerator. The CNO stated the medication refrigerator was temperamental and when the temperatures were outside the temperature range, they adjusted the temperature to the correct temperature. She said they did not document the adjusted and corrected temperature.	F 761			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		4/5/19	

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F 880	<p>Continued From page 56</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility</p>	F 880			

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F 880	<p>Continued From page 57</p> <p>must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and policy review, it was determined the facility failed to ensure: a) Clean mechanical lift slings were stored on the clean side of the laundry area, b) Staff personal protective equipment was stored on the dirty side of the laundry room, and c) Ventilation in the laundry area did not blow air from the contaminated laundry side to the clean side of the room. These failures created the potential for harm due to the increased the risk of cross contamination, and had the potential to affect all residents in the facility. Findings include:</p> <p>The facility's policy for Infection Prevention and Control, dated 10/31/17, documented the following:</p>	F 880	<p>F 880 Resident Specific No specific residents were identified.</p> <p>Other Residents Mechanical lift slings were relocated to clean side of the laundry room. Staff PPE was relocated to dirty side of the laundry room. The fan blowing air from the contaminated side to the clean side was relocated to the clean side of the laundry room.</p> <p>Facility Systems Housekeeping and Laundry staff were educated by Executive Director and/or designee on or before April 5, 2019</p>		

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F 880	<p>Continued From page 58 "COMPONENTS:</p> <p>1. The Infection Prevention and Control Program include processes to minimize healthcare associated infection through an organization-wide program. These processes include but are not limited to the:</p> <p>a. As necessary, and at least annually, review and revise the infection control risk assessment.</p> <p>1) New risks are identified</p> <p>2) New services have been added,</p> <p>3) New sites of care have been added,</p> <p>4) Opportunities for improvement are identified</p> <p>5) There are emerging or reemerging community healthcare problems</p> <p>b. Establishing facility wide engineering and work practice to reduce risk of exposure to and transmission of healthcare associated infections."</p> <p>On 2/14/19 at 10:20 AM, the laundry room was inspected with the Housekeeping and Laundry Manager (HLM). The HLM confirmed the division between dirty and clean was demonstrated by a difference in tile color (the clean side had a light (white/cream tile with a row of red tile, and the dirty side had grayish colored tile). There was no physical barrier separating the clean side from the dirty side. A fan was mounted approximately mid-way up the wall between dirty/clean areas (approximately 6 to 7 feet in height), blowing in an oscillating mode from dirty to clean. This</p>	F 880	<p>regarding infection control practices in the laundry to include but not limited to process to determine clean from dirty, keeping items on the respective clean/dirty areas to prevent cross contamination, specific storage of clean linen/slings and PPE as well as proper location of fans in laundry room. The system is amended to include routine rounds for infection control monitoring in the laundry that is reported to the infection control committee.</p> <p>Monitor The Executive Director or designee will audit laundry room for compliance with infection control weekly x 3 weeks and then monthly x 3. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate.</p> <p>Date of Compliance 4/5/2019</p>		

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F 880	<p>Continued From page 59</p> <p>increased the risk for cross contamination due to no barrier to prevent air flow from the dirty area to the area where clean laundry was stored. A rack with mechanical lift slings was mounted on the wall by the washing machine (on the dirty side). The HLM confirmed the slings were clean, but were stored on the dirty side of the laundry room. On the edge of the wall by the handwashing sink, a fire extinguisher hung with a gown and mask hanging over the extinguisher. The HLM confirmed the gown was hanging half on clean side, half on dirty side, and could not be considered clean.</p> <p>On 2/14/19 at 10:20 AM, the HLM stated all laundry for the facility (including all bed and bath linens) was done in that laundry room.</p> <p>On 2/15/19 at 12:51 PM, the Administrator stated he was not aware of laundry room issues.</p>	F 880			



IDAHO DEPARTMENT OF  
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June 19, 2019

Gary "Paul" Arnell, Administrator  
The Orchards of Cascadia  
404 North Horton Street  
Nampa, ID 83651-6541

Provider #: 135019

Dear Mr. Arnell:

On **February 15, 2019** through **February 11, 2109**, three surveyors conducted an unannounced on-site complaint survey at The Orchards of Cascadia. The complaint allegation, findings and conclusions are as follows:

**Complaint #ID00007976**

ALLEGATION #1:

Facility failed to ensure residents received proper skin/peri care.

FINDINGS #1:

Observations were conducted throughout the facility, including skin care observations. Interviews were completed with 16 residents, 3 family members, nurses and administrative staff. Eighteen residents were included in the survey sample, six were reviewed for skin care issues.

Residents' records were reviewed and weekly skin checks were documented with appropriate wound assessments and interventions. During interviews with residents and family members, there were no complaints regarding inappropriate skin care. A review of wound assessment included documentation wounds were healing and being monitored by practitioners.

Gary "Paul" Arnell, Administrator  
June 19, 2019  
Page 2 of 2

One resident reviewed had a skin assessment completed three days prior to discharge but did not receive a discharge skin assessment; therefore, the resident's skin condition was not documented at the time of her discharge.

Although the allegation that the facility failed to provide skin/peri-care was substantiated for one resident reviewed, the facility was not cited with deficient practice because the investigation did not substantiate current deficient practice.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

The allegation was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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 cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj