



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
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March 15, 2019

Trent Clegg, Administrator
Creekside Transitional Care And Rehabilitation
1351 West Pine Avenue
Meridian, ID 83642-5031

Provider #: 135125

Dear Mr. Clegg:

On **March 1, 2019**, a survey was conducted at Creekside Transitional Care And Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **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 30, 2019**. A change in the seriousness of the deficiencies on **April 15, 2019**, may result in a change

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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 30, 2019** includes the following:

Denial of payment for new admissions effective **May 30, 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 28, 2019**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 30, 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)

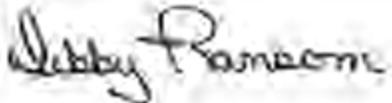
2001-10 Long Term Care Informal Dispute Resolution Process

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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



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

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: 135125	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/01/2019
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NAME OF PROVIDER OR SUPPLIER CREEKSIDE TRANSITIONAL CARE AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from February 25, 2019 to March 1, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Cecilia Stockdill, RN, Team Coordinator Presie Billington, RN Brad Perry, LSW Katheryn Davis, RN</p> <p>Survey Abbreviations: ADL = Activities of Daily Living ADON = Assistant Director of Nursing CNA = Certified Nursing Assistant DON = Director of Nursing DNR = Do Not Resuscitate DPOA = Durable Power of Attorney LPM = Liters per Minute LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set assessment POST = Physician Orders for Scope of Treatment PRN = As Needed RN = Registered Nurse TAR = Treatment Administration Record</p>	F 000		
F 561 SS=D	<p>Self-Determination CFR(s): 483.10(f)(1)-(3)(8)</p> <p>§483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section.</p>	F 561		4/5/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/25/2019
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 561	Continued From page 1 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, resident interview, and staff interview, it was determined the facility failed to ensure a resident received showers as he desired and as care planned. This was true for 1 of 19 residents (Resident #24) reviewed for choices. This deficient practice had the potential for harm should a resident experience a decreased sense of well-being, lack of self-worth, and frustration when his desire to receive a shower was not accommodated. Findings include: The facility's Resident Care policy, revised 5/2007, documented showers and/or baths were	F 561	Corrective actions taken for those residents who may have been affected by this deficiency: 1) Resident #24 was assessed and a shower was given. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: 1) CNA flow task sheets were audited and		

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F 561	<p>Continued From page 2</p> <p>provided to "promote cleanliness, stimulate circulation, and assist in relaxation."</p> <p>The facility's policy for Monitoring of Resident Care, revised 5/2007, documented each resident would be provided with the necessary care and services to allow them to reach or maintain their highest practicable physical, mental, and psychosocial well-being, according to the comprehensive care plan. Residents would receive services with reasonable accommodation of their needs and preferences, except when it would endanger the health or safety of the resident or other residents.</p> <p>Resident #24 was admitted to the facility on 1/30/19, with multiple diagnoses including Alzheimer's disease, generalized muscle weakness, and anxiety disorders.</p> <p>Resident #24's admission MDS assessment, dated 2/5/19, documented he was cognitively intact and required the physical assistance of one person for bathing.</p> <p>Resident #24's care plan documented he required the assistance of one person with showering twice a week on days or evenings, as he wished and as necessary, initiated on 2/8/19.</p> <p>Resident #24's CNA task flowsheet for February 2019 documented he received a shower on 2/4/19, 2/7/19, 2/10/19, 2/11/19, 2/14/19, 2/21/19, and 2/28/19. There was no documentation Resident #24 received a second shower the week of 2/17/19 and the week of 2/24/19.</p> <p>On 2/25/19 at 2:54 PM, Resident #24 appeared</p>	F 561	<p>compared to resident shower schedule. In cases a shower was not provided, the resident was asked if they would like a shower and if confirmed, a shower was provided.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>1) CNAs and shower aids were inserviced on following resident care plans, regarding personal care and showers. ¿ CNAs were inserviced on proper and timely documentation care.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>¿ CNA Task Flow Sheets will be audited randomly (30 residents) weekly X 6 weeks by Nurse Case Manager (or designee), to ensure that CNAs are adhering to resident care plans and documenting care. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.</p>		

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F 561	Continued From page 3 somewhat disheveled and said he was not receiving showers. When asked about the last time he received a shower, Resident #24 shrugged his shoulders, appeared agitated, and said he was not getting a shower and said he expected to be kept clean. On 2/27/19 at 12:01 PM, CNA #1 said Resident #24's shower day was twice a week and she did not know when he last received a shower. On 2/27/19 at 12:15 PM, LPN #1 said Resident #24 should get a shower at least two days a week and she did not keep track of it because the CNAs did it. On 2/27/19 at 12:31 PM, the DON said staff tried to offer a shower twice a week and as needed if the resident requested it. The DON said Resident #24 did not receive two showers a week. The DON said the shower aide broke her foot during one of the weeks and it was difficult to get showers, but the CNAs were still responsible for getting them done.	F 561			
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation	F 645		4/5/19	

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F 645	<p>Continued From page 4</p> <p>performed by a person or entity other than the State mental health authority, prior to admission,</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services; or</p> <p>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.</p> <p>§483.20(k)(2) Exceptions. For purposes of this section-</p> <p>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.</p> <p>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-</p> <p>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,</p> <p>(B) Who requires nursing facility services for the condition for which the individual received care in</p>	F 645			

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F 645	<p>Continued From page 5 the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.</p> <p>§483.20(k)(3) Definition. For purposes of this section-</p> <p>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).</p> <p>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, policy review, and record review, it was determined the facility failed to ensure the Preadmission Screening and Resident Review (PASRR) was complete and accurate for 1 of 5 residents (Resident #24) whose PASRRs were reviewed. This failure created the potential for harm if residents required, but did not receive, specialized services for mental health while residing in the facility.</p> <p>Findings include:</p> <p>The facility's policy for PASRR, revised 10/2007, documented the following:</p> <p>* Each resident was appropriately screened using the PASRR as specified by the state. * Based on the assessment, the facility would ensure a proper referral was made to the appropriate state agency for specialized services for residents with mental illness/mental</p>	F 645	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>?? 1) Resident #24's PASARR was updated and the resident was seen by the facilities contracted phycologist.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>1) All resident PASARR were audited and compared to current medication list to ensure resident PASARRs were current. Any incorrect PASARR was immediately corrected.</p> <p>Measures that will be put into place to</p>		

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F 645	<p>Continued From page 6 retardation.</p> <p>* Social Services would contact the appropriate state agency for a referral of specialized care and services the resident may need.</p> <p>Resident #24 was admitted to the facility on 1/30/19, with multiple diagnoses including Alzheimer's disease and depression with anxiety.</p> <p>A progress note, dated 1/23/19 and signed by a nurse practitioner, documented Resident #24 was taking escitalopram (antidepressant medication) 20 mg once a day, and mirtazapine (antidepressant medication) 7.5 mg at bedtime.</p> <p>Resident #24's PASRR documented he had no major mental illnesses (such as depressive disorders and anxiety disorders), did not have anxiety or depression, and was not referred for further evaluation. The PASRR was signed by Resident #24 on 1/28/19 and signed by a nurse practitioner on 1/29/19.</p> <p>Resident #24's care plan documented he had potential for mood problems related to major depressive disorder and anxiety disorder, initiated on 1/31/19 and revised on 2/4/19. Interventions included "Social services to provide support and follow up as needed."</p> <p>Resident #24's admission MDS assessment, dated 2/5/19, documented the following:</p> <p>* He was cognitively intact.</p> <p>* He had verbal behavioral symptoms directed at others (threatening, screaming, cursing at others), and his behavioral symptoms significantly interfered with his care.</p>	F 645	<p>ensure that this deficiency does not recur:</p> <p>1) Nurse Managers and Social Workers will be educated on maintaining an updated PASARR for all residents.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>1) All resident PASARRs will be audited weekly X 8 weeks by DON or designee, to ensure that they are up to date with current medication lists. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.</p>		

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F 645	Continued From page 7 * He received antidepressant medication on 7 out of the 7 previous days. Resident #24's physician orders included mirtazapine (antidepressant medication) 7.5 mg (milligrams) at bedtime for depression. Resident #24's record included a Diagnosis Report, dated 2/27/19 at 3:37 PM, which documented he had diagnoses of Major Depressive Disorder on 1/30/19, and anxiety disorders on 1/30/19. On 2/27/19 at 11:42 AM, the LSW said he could not confirm Resident #24's diagnoses of depression and anxiety did not come at the same time as the PASRR evaluation. He said the PASRR was done on 1/29/19, and the diagnoses were entered on 1/30/19. The LSW said he did not compare Resident #24's PASRR to the diagnoses. On 2/27/19 at 2:45 PM, the LSW said he first looked at Resident #24's PASRR when he was admitted and saw each box was checked "no." The LSW said he did not compare Resident #24's diagnoses with his History and Physical. The LSW said Resident #24's PASRR should have identified depression, indicating a major mental illness. The LSW said if the PASRR had documented Resident #24's depression it would have been sent out to the noted agencies and returned with recommendations. The LSW said there was no Level 2 PASRR for Resident #24.	F 645			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		4/5/19	

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F 656	Continued From page 8 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656			

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F 656	<p>Continued From page 9 section.</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 develop and implement comprehensive resident-centered care plans that included a resident's code status. This was true for 1 of 19 residents (Resident #76) whose care plans were reviewed. This failure created the potential for residents to receive inappropriate or inadequate care and for their resuscitation code status to not be honored. Findings include:</p> <p>The facility's Comprehensive Care Planning policy, dated 8/2017, documented a comprehensive care plan would be developed to meet a resident's medical, nursing, mental, and psychosocial needs.</p> <p>Resident #76 was admitted to the facility on 11/15/18, with multiple diagnoses including Alzheimer's disease.</p> <p>Resident #76's record documented she had a DPOA. Her POST, dated and signed by the DPOA on 11/15/18, documented her code status was a Full Code.</p> <p>Resident #76's physician orders, dated 11/15/18, documented her code status was a Full Code.</p> <p>Resident #76's care plan did not include her code status.</p> <p>On 2/28/19 at 11:12 AM, LPN #2 said a resident's code status was found on the main screen of their electronic medical record, on the face sheet,</p>	F 656	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>Resident #76's code status on their care plan was updated to match the code status on the resident's POST.</p> <p>∩∩ How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All resident care plans were audited to ensure that the resident's code status on their care plan, matched each resident's code status on their POST.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>All licensed nursing staff were educated on the need to ensure that every resident's code status on their care plan, match the code status on the resident POST.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>∩ Resident care plan will be audited weekly x 8 weeks by DON or designee, to ensure that the code status for every resident's</p>		

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F 656	Continued From page 10 and on the POST forms. On 2/28/19 at 2:00 PM, RN #1 said a resident's code status was found on the face sheet, the POST form, the advanced directives, and on the admission record. On 2/28/19 at 3:49 PM, the DON said Resident #76's care plan did not include documentation of her code status.	F 656	care plan, matches the code status on the POST. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of 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	F 657		4/5/19	

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F 657	<p>Continued From page 11 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' care plans were revised and updated as needed. This was true for 3 of 19 residents (#13, #14 and #49) whose care plans were reviewed. This created the potential for harm if cares and/or services were not provided appropriately due to inaccurate information on the care plan. Findings include:</p> <p>The facility's Comprehensive Care Planning policy, revised on 8/2017, documented the care plan would be reviewed and/or revised by the interdisciplinary team after each assessment.</p> <p>1. Resident #49 was admitted to the facility on 7/11/18, with multiple diagnoses including sleep apnea (cessation of breathing during sleep).</p> <p>Resident #49's care plan, initiated on 11/28/18, documented he had altered respiratory status/difficulty breathing related to sleep apnea and staff were directed to provide him with his Continuous Positive Airway Pressure (CPAP) machine as ordered.</p> <p>A Social Services progress note, dated 11/7/18 at 11:11 AM, documented Resident #49 told the LSW he was not using his CPAP machine because it was not being cleaned as it should.</p> <p>A Nurse's Note, dated 11/9/18 at 10:48 PM, documented Resident #49 refused to wear his</p>	F 657	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>Resident #49 was interviewed regarding his desire to continue use of his CPAP. The resident indicated that he doesn't intend to use the CPAP, even if it is cleaned on a regular basis. The CPAP order was discontinued and the CPAP was removed from the resident's care plan.</p> <p>Resident #13 code status on the care plan was updated to Full Code, to match the code status on the resident's POST.</p> <p>Resident #14's oxygen was immediately adjusted to the correct LPM as indicated on the orders, and the resident's care plan was corrected to reflect the correct LPM as ordered.</p> <p>¿¿</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents currently using a CPAP were audited to determine accuracy of their care plan to their written orders. Residents were also interviewed to determine if staff were cleaning the</p>		

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F 657	<p>Continued From page 12 CPAP machine.</p> <p>A Social Services progress note, dated 11/12/18, documented Resident #49 was refusing to use his CPAP machine despite being cleaned appropriately by the staff. It was unclear what kind of cleaning schedule Resident #49's CPAP required. The progress note also documented the CPAP tubing was to be cleaned once a week and the entire unit was to be rinsed daily with antibacterial soap per the manufacturer's suggestion.</p> <p>A Nurse's Note, dated 11/13/18 at 9:58 AM, documented Resident #49 was told a new order directed staff to clean his face mask in front of him every morning, and on his dialysis days the night shift aide was going to clean his face mask before he left for dialysis.</p> <p>On 2/25/19 at 11:45 AM, Resident #49 said he was not using his CPAP machine because it was not being cleaned by the staff.</p> <p>On 2/27/19 at 3:57 PM, RN #1 said Resident #49's CPAP machine was discontinued on 11/18/18, due to his refusals to use the machine because of cleaning issues. RN #1 said the care plan should have been updated.</p> <p>2. Resident #13 was admitted to the facility on 6/5/18, with multiple diagnoses including profound intellectual disabilities and epilepsy. Resident #13's record documented she had a guardian.</p> <p>Resident #13's care plan, dated 12/3/18, documented her code status was DNR.</p>	F 657	<p>equipment as indicated on their care plan.</p> <p>All resident care plans were audited to ensure that the DNR status of each resident, matches the DNR status on their POST.</p> <p>All resident with orders for the use of oxygen were checked to ensure that they were receiving the correct LPM as ordered. All care plans for residents with oxygen orders were audited to ensure that their care plans included the correct LPM level, as outlined in the oxygen orders.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>All licensed staff were in-serviced on following care plan instructions as they relate to handling resident equipment. And following the cleaning schedule indicated on the TAR.</p> <p>All licensed nursing staff were educated on the need to ensure that every resident's code status on their care plan, match the code status on the resident POST.</p> <p>All licensed nursing staff were educated on the need to ensure that the care plan for resident's with oxygen orders, contain the same LPM levels, as indicated on the oxygen orders. Measures that will be implemented to</p>		

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F 657	<p>Continued From page 13</p> <p>A care conference note, dated 2/11/19, documented the LSW and ADON were present when Resident #13's guardian agreed to change her code status from DNR to a Full Code. Resident #13's POST form, signed and dated by her guardian on 2/11/19, documented her code status was a Full Code.</p> <p>On 2/28/19 at 3:21 PM, the LSW said Resident #13's care plan was not updated to reflect her status was a Full Code.</p> <p>On 2/28/19 at 3:38 PM, the DON said Resident #13's code status was not revised on her care plan when her code status changed from DNR to Full Code.</p> <p>3. Resident #14 was admitted to the facility on 10/18/14, with multiple diagnoses including chronic obstructive pulmonary disease.</p> <p>Resident #14's quarterly MDS assessment, dated 1/2/19, documented she was cognitively intact and required oxygen therapy.</p> <p>Resident #14's care plan documented she had oxygen related to congestive heart failure, initiated on 12/5/18. The care plan also documented Resident #14 received oxygen continuously at 2 LPM by nasal cannula, initiated on 12/5/18 and revised on 12/13/18.</p> <p>Resident #14's physician orders, dated 10/25/18, documented oxygen was ordered at 3 LPM continuously.</p> <p>On 2/26/19 at 9:55 AM and on 2/26/19 at 10:38</p>	F 657	<p>monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>¿</p> <p>The DON or designee will audit CPAP equipment weekly x 6 weeks, to ensure equipment is being cleaned according to the TAR and properly documented and care planned.</p> <p>Resident care plans will be audited weekly x 8 weeks by DNS or designee, to ensure that the code status for every resident's care plan, matches the code status on the POST. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.</p> <p>The care plan for residents with oxygen orders will be audited weekly x 8 weeks by the DON or designee, to ensure that the LPM levels on the care plan, match the LPM levels on the oxygen orders. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.</p>		

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F 657	Continued From page 14 AM, Resident #14 was in the community TV area with oxygen on at 2 LPM. On 2/27/19 at 10:35 AM, CNA #1 said Resident #14's oxygen was on at 2 LPM and it should have been at 3 LPM. On 2/27/19 at 10:42 AM, LPN #1 said Resident #14's oxygen should be on at 3 LPM, and she was responsible for adjusting the oxygen. On 2/27/19 at 11:22 AM, the DON said the nurse was responsible to ensure the oxygen flow rate was set as ordered. The DON said Resident #14's oxygen was supposed to be at 3 LPM. On 2/27/19 at 1:29 PM, the DON said Resident #14's care plan should have documented oxygen at 3 LPM, and the care plan should have been updated when the order was received. The DON said the unit managers reviewed orders daily and should double check whether the care plan was updated if needed.	F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure bathing and/or grooming and urinary care needs were provided consistent with residents' needs. This was true for 2 of 4 residents (#14 and #31) who	F 677	Corrective actions taken for those residents who may have been affected by this deficiency: 1) Resident #31 was assessed and a shower was given and facial hair was	4/5/19	

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F 677	<p>Continued From page 15</p> <p>were reviewed for ADL care. This failure created the potential for residents to experience skin breakdown and a negative effect to their psychosocial well-being when care was not provided as needed. Findings include:</p> <p>1. The facility's Resident Care policy, dated 5/2007, directed staff to assist residents with bathing to promote cleanliness and to provide residents with the necessary care to maintain the highest practicable physical well-being.</p> <p>Resident #31 was admitted to the facility on 5/8/18, with multiple diagnoses including muscle weakness and difficulty in walking.</p> <p>Resident #31's quarterly MDS assessments, dated 10/4/18 and 1/2/19, documented she required extensive assistance of one-person with bathing and personal hygiene.</p> <p>Resident #31's care plan, dated 12/28/18, directed staff to provide her showers twice a week and she required the assistance of one person with personal hygiene.</p> <p>Resident #31's ADL flowsheet for February 2019, documented she received a shower on 2/11/19 and 2/25/19, 14 days apart. The flowsheet also documented she received showers on 2/14/19, 2/18/19, and 2/21/19, which was signed by the ADON.</p> <p>On 2/25/19 at 10:01 AM, Resident #31 said she had not had a shower for three weeks. She said CNAs came and told her they were going to give her a shower and then they never came back. She said she did not want to get any staff in</p>	F 677	<p>plucked as instructed by the resident.</p> <p>2) Resident #14's wheelchair cushion was immediately replaced with a fresh replacement and her wheelchair was cleaned.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>1) Residents were interviewed and assessed regarding their grooming needs. Any resident that needed assistance with grooming, and specifically the removal of facial hair were assisted.</p> <p>2) All resident wheelchair cushions and wheelchairs were audited for cleanliness and order. Any dirty wheelchair was cleaned and cushions were replaced.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>1) CNAs and shower aids were inserviced on following resident care plans, regarding personal care and grooming, and specifically the removal of facial hair.</p> <p>2) Licensed staff were inserviced on the need to document incontinence care and on wheelchair and wheelchair cushion cleaning.</p>		

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F 677	<p>Continued From page 16</p> <p>trouble, but she wanted a shower. She said she was told she was getting a shower that day. Resident #31's hair was unkempt and was greasy. Her chin also had multiple hairs on it which ranged from one-to-two inches in length.</p> <p>On 2/25/19 at 3:10 PM, Resident #31's hair was washed and groomed, and she still had multiple hairs on her chin. Resident #31 said she had just received a shower and felt "wonderful." She said staff did not have time to pluck her chin hairs and said it was difficult for her to grasp her tweezers and pluck them. She said she preferred her hairs to be plucked instead of shaved.</p> <p>On 2/27/19 at 3:25 PM, CNA #4 said she was not sure if Resident #31 had received a shower the previous week.</p> <p>On 2/27/19 at 4:08 PM, the DON said Resident #31 was cognitively intact and said if the resident said she had not received a shower in weeks, then it was probably true. The DON said the ADON had documented Resident #31's showers on 2/14/19, 2/18/19, and 2/21/19, based on verbal reports from the CNAs. The DON said she and the ADON were calling CNAs when there was incomplete shower documentation. She said they called them anywhere from a day to several days after the fact. She said she and the ADON were trying to get the CNAs to document at the time the showers were completed or at the end of their shifts. The DON said it was expected for the CNAs to document before they left for the day. At 4:12 PM, the DON visualized Resident #31's chin and said she was going to ensure staff helped with plucking her hairs as she requested.</p>	F 677	<p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>• CNA Task Flow Sheets will be audited weekly X 6 weeks by Nurse Case Manager (or designee), to ensure that CNAs are adhering to resident care plans regarding personal grooming. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.</p> <p>Wheelchairs and wheelchair cushions will be audited weekly x 4 weeks to ensure that wheelchairs are being cleaned or replaced in a timely manner. All negative findings will be reported to the DON, and reported in the monthly QAPI meeting.</p>		

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F 677	<p>Continued From page 17</p> <p>2. The facility's Incontinent Care policy, revised 5/2007, documented staff were to remove urine or feces from residents' skin, cleanse and lubricate the skin, and "Provide dry, odor free perennial [sic] care system." Staff were directed to check the resident frequently for soiled briefs.</p> <p>Resident #14 was admitted to the facility on 10/18/14, with multiple diagnoses including retention of urine and dementia with behavioral disturbance.</p> <p>Resident #14's care plan, initiated on 12/13/18, documented she required one staff for toileting, staff were directed to check as required for incontinence, and change clothing PRN after incontinence episodes. Staff were also to offer toileting after lunch, initiated on 2/7/19.</p> <p>Resident #14's quarterly MDS assessment, dated 1/2/19, documented she required extensive assistance of two persons with toileting and she was always incontinent of bladder and bowel.</p> <p>On 2/26/19 at 9:23 AM, Resident #14 was not in her room. A smell of urine was noted near her bed, and her bed smelled of urine.</p> <p>On 2/26/19 at 10:17 AM, Resident #14 was in her wheelchair outside her room, and a smell of urine was noted near her. Approximately six minutes later, Resident #14 was assisted into her room, and two CNAs assisted her into bed and provided incontinence care.</p> <p>On 2/26/19 at 3:09 PM, Resident #14's room smelled strongly of urine. Two CNAs had provided incontinence care and repositioned her</p>	F 677		

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F 677	<p>Continued From page 18</p> <p>in bed. Resident #14's wheelchair was in her room adjacent to her bed, and her wheelchair cushion had a strong urine odor.</p> <p>On 2/27/19 at 10:29 AM, two CNAs provided incontinence care for Resident #14 while she was in bed. CNA #1 said Resident #14 was last changed before breakfast, at approximately 8:00 AM. Resident #14's wheelchair cushion had a strong urine odor.</p> <p>On 2/27/19 at 10:35 AM, CNA #1 said Resident #14's wheelchair had an odor and it needed to be wiped down. CNA #1 said the wheelchair should be wiped down daily, and night shift was supposed to do that. CNA #1 said Resident #14's wheelchair was not wiped down because she had just gone to the bathroom, and it should be wiped off.</p> <p>On 2/27/19 at 10:44 AM, LPN #1 said residents should have incontinence care whenever an episode of incontinence occurred and as ordered. LPN #1 said Resident #14 was incontinent and sometimes used the bedpan. LPN #1 said Resident #14 should be checked/changed for incontinence at least every 2 hours: before breakfast, after breakfast, before lunch, after lunch, and whenever needed. LPN #1 said night shift staff were responsible for cleaning Resident #14's wheelchair, but whenever an odor was noticed it should be taken care of.</p> <p>On 2/27/19 at 11:24 AM, the DON said incontinence care should be provided if a resident smelled of urine, and staff should shower or change the resident and give good</p>	F 677			

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F 677	Continued From page 19 perineal care. The DON said Resident #14 just finished antibiotics for a urinary tract infection, and staff should give incontinence care on rounds and as needed. The DON said it was not documented in Resident #14's clinical record each time she was checked for incontinence. The DON said residents' wheelchairs were cleaned according to the schedule in each hall. She said staff cleaned the wheelchairs for 3 rooms each night, and it should be done as needed. On 3/1/19 at 8:50 AM, the DON said it was an ongoing battle to get CNAs to document, and she was sure they were providing incontinence care more often and were not documenting it. The DON said incontinence care should be done on rounds, about every two hours. She said staff should be cleaning three wheelchairs and beds per night, and mattresses should be cleaned every time the resident got a shower. The DON said it was not documented anywhere how often residents were checked for incontinence, and if there was an odor coming from a resident she expected staff to investigate and find where it was coming from and change the resident if needed.	F 677			
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of	F 679		4/5/19	

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F 679	<p>Continued From page 20</p> <p>each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, family member interview, and staff interview, it was determined the facility failed to ensure there was an ongoing activity program to meet individual and social needs for residents. This was true for 2 of 3 residents (#27 and #76) reviewed for activities. This failure created the potential for harm if residents experienced boredom and lacked meaningful engagement throughout the day. Findings include:</p> <p>The facility's Activity policy, dated 7/2007, documented the Activity Director was to consult with nursing staff to develop suitable activity plans, be informed of residents' changes, and for nursing to use the resident's care plan, and encourage them to participate in appropriate activities.</p> <p>1. Resident #27 was admitted to the facility on 9/22/15, with multiple diagnoses including anxiety, major depression, dementia, and stroke affecting the left side.</p> <p>Resident #27's annual MDS assessment, dated 6/15/18, documented she was severely cognitively impaired, required one-to-two-person assistance for all ADLs, and music was very important to her.</p> <p>Resident #27's quarterly Activity assessment, dated 9/15/18, documented she liked to listen to music and watch TV.</p>	F 679	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>1) A new activity assessment was performed on Resident #27 and Resident #76, and confirmed their preferences regarding the use of radio and TV. Staff confirmed that both residents had access to a working radio and TV in their rooms.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>1) Resident care plans were reviewed by activities staff and an audit was conducted to ensure that the care plans were being followed. Any adverse findings were reported to DON and immediate action was taken to resolve the adverse findings.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>1) Licensed staff were inserviced on following resident care plans associated with activity preferences.</p> <p>Measures that will be implemented to</p>		

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F 679	<p>Continued From page 21</p> <p>Resident #27's care plan, dated 11/14/18, documented she enjoyed listening to music in her room.</p> <p>Resident #27's February 2019 Activity Participation record, documented she was involved in a passive music program each day from 2/1/19 to 2/27/19.</p> <p>Resident #27 was observed as follows:</p> <p>* On 2/25/19 at 10:52 AM, 2:39 PM, and 3:04 PM, Resident #27 was either in her wheelchair in her room or in bed and awake. There was no radio visible in the room and there was no music on and the TV was turned off. At 3:05 PM, the Administrator was in Resident #27's room and gave her a sandwich she had requested and left the room without offering to turn on the TV or music.</p> <p>* On 2/26/19 at 9:01 AM, an unidentified staff member brought Resident #27 back to her room and did not offer to play music or turn on the TV.</p> <p>* On 2/26/19 at 12:55 PM, Resident #27 was awake in bed and there was no music playing and the TV was not on in the room.</p> <p>* On 2/27/19 at 11:01 AM and 2:56 PM, Resident #27 was awake in her wheelchair in her room. There was no music playing and the TV was not on in the room.</p> <p>* On 2/27/19 at 3:50 PM, CNA #4 and another CNA had just changed Resident #27's incontinent brief. CNA #4 was the last one in the room and did not offer to turn on music or the TV</p>	F 679	<p>monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>¿</p> <p>Activities staff or designee will audit care plans weekly X 6 weeks, to ensure that staff are following the resident care plan preferences. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.</p>		

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F 679	<p>Continued From page 22 before leaving.</p> <p>* On 2/27/19 at 5:55 PM, Resident #27 was awake in her bed in her room. There was no music playing and the TV was not on in the room.</p> <p>* On 2/28/19 at 9:27 AM, CNA #4 and Activity Director #1 (AD), who was also a CNA, transferred Resident #27 from her wheelchair to her bed with a Hoyer lift (a mechanical lift) and changed her incontinent brief. Neither CNA #4 nor AD #1 offered music or TV to Resident #27 before leaving.</p> <p>On 2/26/19 at 4:00 PM, LPN #3 said Resident #27 liked to spend a lot of time in her room and said she enjoyed music.</p> <p>On 2/27/19 at 3:29 PM, CNA #4 said Resident #27 generally liked to be by herself in her room and liked to watch TV. CNA #4 said she was not sure if she had a radio in her room.</p> <p>On 2/28/19 at 10:25 AM, AD #2 said Resident #27 liked music but could not handle large groups and so that was why she had a radio in her room for staff to turn on. AD #2 said the music documented on the Activity Participation records was for the music played in the dining room before and during meals and not necessarily for the music in her room, which nursing staff were directed to provide. AD #2 was not aware nursing staff were not providing TV or music for Resident #27 while in her room and she said that needed to be addressed.</p> <p>On 2/28/19 at 12:24 PM, the DON said she expected her staff to follow Resident #27's care</p>	F 679			

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F 679	<p>Continued From page 23 plan and turn on music and/or the TV.</p> <p>2. Resident #76 was admitted to the facility on 11/15/18, with multiple diagnoses including Alzheimer's disease and major depression.</p> <p>Resident #76's admission MDS assessment, dated 11/22/18, documented she was severely cognitively impaired, required one-to-two-person assistance for all ADLs, and music was very important to her.</p> <p>Resident #76's quarterly Activity assessment, dated 12/10/18, documented she liked listening to music in a language she understood.</p> <p>Resident #76's care plan, dated 12/4/18, documented she enjoyed listening to music and had a personal stereo.</p> <p>Resident #76's February 2019 Activity Participation record, documented she was involved in an active music program each day from 2/1/19 to 2/25/19, and used a DVD player 13 out of 27 days from 2/1/19 to 2/27/19.</p> <p>Resident #76 was observed as follows:</p> <p>* On 2/25/19 at 10:57 AM, 2:35 PM, and 4:00 PM, Resident #76 was awake on her bed in her room. There was no music playing and there was not a radio, stereo, or TV in the room. A portable DVD player was in her room on a tray table six-feet away from Resident #76 next to the sink and it was not on.</p> <p>* On 2/26/19 at 2:50 PM, Resident #76 was awake on her bed in her room. There was no</p>	F 679			

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F 679	<p>Continued From page 24</p> <p>music and her DVD player was not on. LPN #3, LPN #1, and CNA #5 were all in Resident #76's room to re-adjust her in bed and to take off her shoes. The three staff members did not ask Resident #76 about participating in an in-room activity. At 3:41 PM, Resident #76 was still awake on her bed and looking around the room and up at the wall. There was no music and the DVD player was not on.</p> <p>* On 2/27/19 at 10:22 AM and 2:42 PM, Resident #76 was awake on her bed in her room, staring up at the wall, and playing with her light cord against the wall. There was no music and no radio, stereo, or TV in the room, and the DVD player was not on.</p> <p>* On 2/28/19 at 1:43 PM, Resident #76 was in bed in her room attempting to sleep. The DVD player was on and played a disc without sound.</p> <p>On 2/26/19 at 3:54 PM, LPN #3 said Resident #76 often watched the DVD player in a language she understood. LPN #3 said she was not sure if there was a stereo in her room.</p> <p>On 2/27/19 at 3:20 PM, CNA #4 said Resident #76 used to have a radio she listened to but two or three weeks ago some family members took it to replace the battery and had not brought it back.</p> <p>On 2/27/19 at 4:40 PM, Resident #76 was in her wheelchair in her room and was watching the DVD player without any sound. LPN #2 said Resident #76 used to have a radio she listened to, but she had not seen it and thought her daughter had taken it home. LPN #2 said besides</p>	F 679			

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F 679	Continued From page 25 the radio, Resident #76 also enjoyed watching the DVD player in her room with DVDs in a language she understood. LPN #2 said there was something wrong with the sound either to the DVD player or the disc that was playing. On 2/28/19 at 10:41 AM, AD #2 said the music documented on Resident #76's Activity Participation records was for the music either played in the dining room before and during meals, and/or music played in her room which nursing staff were directed to provide. AD #2 said Resident #76 had a radio in her room and was not aware the radio was no longer in the room. On 2/28/19 at 1:49 PM, Resident #76's family member said the staff had not informed her Resident #76's blue tooth stereo was taken home by another family member until that day. She said her family was taking turns charging the battery, so facility staff did not have to do that. The family member said she was going to contact her family to bring it back. She said the DVD player audio was not working well and she was replacing that soon because Resident #76 enjoyed watching the DVDs. On 2/28/19 at 3:51 PM, the DON said her staff or activity staff should have provided music to Resident #76 and/or contacted her family when they discovered the stereo was not returned.	F 679			
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	F 684		4/5/19	

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F 684	<p>Continued From page 26</p> <p>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:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure neurological assessments were performed after a fall with trauma to the resident's head. This was true for 1 of 7 residents (Resident #56) reviewed for falls. These failures created the potential for harm should residents experience undetected changes in neurological status due to lack of appropriate assessment. Findings include:</p> <p>The facility's policy for Neurological Evaluation, dated 5/2007, documented the following:</p> <ul style="list-style-type: none"> * All incidents that involved trauma to the head would have a comprehensive neurological assessment for a minimum of 72 hours. * The neurological evaluation would be performed by a licensed nurse. * Any resident who experienced an injury involving their head or an unobserved fall would have neurological assessments and vital signs taken at least every 8 hours for 24 hours, "or per specific facility policy, or physician's order." * Comprehensive neurological assessments would be done as follows: Every 15 minutes for one hour, every 30 minutes for two hours, every hour for 4 hours, and every shift for 72 hours. * On the Nurse's Notes/Neurological Assessment Form, document vital signs, pupil signs, motor strength, assessment of responsiveness, 	F 684	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>1) Resident #56 was assessed and neurological assessment was completed.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>1) All residents with falls in the past week were audited to ensure that neurological assessments was completed. If neurological assessment was missing, a neurological assessment was completed.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>1) Neurological assessment will be documented electronically in PCC and the paper form will be discontinued. All licensed staff were inserviced on completing neurological assessments post fall and how to document the neurological assessments electronically in PCC.</p>		

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F 684	<p>Continued From page 27 changes in status, and "any other pertinent observations."</p> <p>Resident #56 was admitted to the facility on 1/16/19, with multiple diagnoses including Parkinson's disease, dementia, and repeated falls. Resident #56 was on hospice services.</p> <p>Resident #56's admission MDS assessment, dated 1/23/19, documented he had severe cognitive impairment, required extensive assistance of two persons with bed mobility and total dependence of two persons for transfers, he was not steady, only able to stabilize with human assistance when moving from seated to standing and when transferring from surface to surface, and had fallen in the previous one to six months prior to admission to the facility.</p> <p>Resident #56's care plan documented he was at risk for falls related to limited mobility, weakness, Parkinson's disease, and history of falling. Interventions included the following:</p> <p>* Initiated on 2/7/19 and revised on 2/27/19: Steri-Strips (a type of adhesive wound closure strip) to the head laceration and dressing as ordered, monitor/document/report to the physician signs/symptoms of pain, bruises, change in mental status, new onset of confusion, drowsiness, inability to maintain posture, or agitation. Neurological assessments and vital signs as ordered.</p> <p>* Initiated on 2/22/19: Increased supervision with neurological assessments.</p> <p>Resident #56 had two falls documented as</p>	F 684	<p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>¿ DON or designee will audit weekly x 6 weeks all recent falls to ensure that neurological assessments are being completed timely. All negative findings will be reported to the DON, a neurological assessment will be done immediately, and reported in the monthly QAPI meeting.</p>		

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F 684	<p>Continued From page 28 follows:</p> <p>* An Incident Report, dated 2/6/19 at 7:54 PM, documented Resident #56 fell when attempting to self-ambulate, and he sustained a laceration to his scalp. Actions taken included cleansing the laceration, applying Steri-Strips, and the nurse practitioner and hospice were notified.</p> <p>A Progress Note, dated 2/6/19 at 8:02 PM, documented Resident #56 was found by another resident "laying face down in a small pool of blood." A laceration was noted on his right scalp. Resident #56 said he was trying to ambulate.</p> <p>* A Progress Note, dated 2/22/19 at 1:07 PM, documented Resident #56 was found on the floor by a caregiver, and he stated he lost his balance.</p> <p>An Incident Report, dated 2/22/19 at 2:45 PM, documented Resident #56 fell when he attempted to self-ambulate. Action taken included range of motion was completed, he was assisted back to bed, staff were to monitor for injuries, hospice and his family member were notified, and neurological assessments were initiated.</p> <p>There was no documentation in Resident #56's record of neurological assessments after the unwitnessed falls on 2/6/19 and 2/22/19.</p> <p>On 2/25/19 at 12:30 PM, Resident #56 was observed in the dining room with a large scabbed area to his right scalp covered by Steri-Strips.</p> <p>On 2/28/19 at 4:26 PM, the DON said there were no neurological assessments found for Resident #56.</p>	F 684			

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F 684	Continued From page 29 On 3/1/19 at 8:23 AM, LPN #5 said neurological assessments should be done with every fall, especially when the resident hit their head. On 3/1/19 at 8:27 AM, the RN supervisor said neurological assessments should be done immediately after an unwitnessed fall, and it should be done every 15 minutes, every 30 minutes, then every hour.	F 684			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents received appropriate care to prevent skin breakdown. This was true for 1 of 5 residents (Resident #76) reviewed for skin breakdown. This failure created the potential for harm if residents developed pressure ulcers. Findings include:	F 686	Corrective actions taken for those residents who may have been affected by this deficiency: 1) Resident #76 heel's were assessed and her heel's were floated as care planned. The resident's care plan was updated to indicate clear terminology.	4/5/19	

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F 686	<p>Continued From page 30</p> <p>The facility's Care and Treatment policy, dated 5/2007, documented a resident who enters the facility without pressure sores does not develop them and to implement appropriate resident care.</p> <p>Resident #76 was admitted to the facility on 11/15/18, with multiple diagnoses including Alzheimer's disease, pain in both knees, and repeated falls.</p> <p>Resident #76's admission and quarterly MDS assessment, dated 11/22/18 and 12/19/18 respectively, documented she did not have pressure ulcers and required extensive assistance of one-person for bed mobility.</p> <p>Resident #76's physician orders, dated 11/15/18, documented to "Bridge heels while in bed."</p> <p>Resident #76's care plan directed staff to float her heels on 12/27/18. On 1/2/19 the care plan was updated and stated "brody heels while in bed." The care plan did not have clarification regarding this intervention.</p> <p>Resident #76's January 2019 and February 2019 TARs, documented her heels were "bridged" as ordered for 103 out of 112 opportunities. The TARs documented Resident #76 refused 8 times and 1 was left blank, with no staff initials, for January and February 2019.</p> <p>On 2/25/19 at 9:10 AM, 10:57 AM, 2:35 PM, and 4:00 PM, and on 2/26/19 at 9:38 AM, 10:26 AM, and 3:41 PM, Resident #76 was observed on her bed in her room with socks on and her heels were not "bridged" or floated (the heels are positioned so they were not touching the bed).</p>	F 686	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>1) All residents with orders for their heels to floated, were assessed and their care plans were audited to ensure clear terminology and that the POC match the care plane.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>1) Licensed staff and CNAs were educated on modes of heel skin care and the need to indicate clear terminology on resident care plans. Licensed staff were educated on the need to ask for clarification if they don't understand and order.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>¿ DON or designee will audit 3 times a week for 4 weeks, any resident orders to float heels to ensure that order is being followed and the care plan has clear terminology. All negative findings will be reported to the DON and reported in the monthly QAPI meeting.</p>		

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F 686	<p>Continued From page 31</p> <p>On 2/26/19 from 2:36 PM to 2:50 PM, LPN #3 assisted Resident #76 to transfer from her wheelchair to her bed. LPN #3 did not remove her shoes and did not attempt to float her heels. A few minutes later, LPN #1 and CNA #5 came into the room and LPN #1 assisted LPN #3 to re-adjust Resident #76 farther up on the bed and CNA #5 took off Resident #76's shoes but did not float her heels.</p> <p>On 2/27/19 at 10:22 AM and 2:42 PM, Resident #76 was awake in her bed on her back. Her feet had socks on and her heels were not floated.</p> <p>On 2/26/19 at 3:54 PM, LPN #3 said Resident #76's heels were to be floated at night, so her heels did not get boggy (mushy to touch). LPN #3 said she was not sure what "bridge" or "brody" heels were and said they might be some sort of foam support to keep her feet off of the bed.</p> <p>On 2/27/19 at 4:40 PM, LPN #2 said staff were supposed to float Resident #76's heels and her skin integrity was good. LPN #2 said she did not know what the order meant by "bridge" heel and she said different devices went by different names. LPN #2 looked around Resident #76's room and did not find a device or support to bridge the heels. At 6:10 PM, LPN #2 reviewed Resident #76's TAR and said she was signing off on the bridge heels order because she assumed that they were there.</p> <p>On 2/27/19 at 6:59 PM, LPN #4 said she signed Resident #76's TAR as refusals because she did not always allow staff to float or bridge her heels.</p>	F 686			

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F 686	Continued From page 32 On 2/28/19 at 10:05 AM, CNA #4 said staff used pillows to float Resident #76's heels but she often removed them. On 2/28/19 at 3:56 PM, the DON said she did not know what brody heels were and said she meant for the care plan to document bridge or float Resident #76's heels. She said the order to bridge heels was not a device but rather an order to prop up or float her heels to prevent pressure ulcers. The DON said if staff were not clear on what was in her care plan or on an order, then she expected them to ask what it meant. The DON was informed of the observations and she said staff should have floated her heels anytime she was in bed.	F 686			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		4/5/19	

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F 688	<p>Continued From page 33</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure residents received treatment and services to prevent decrease in Range of Motion (ROM). This was true for 1 of 3 residents (Resident #27) reviewed for treatment and services related to ROM. This failure created the potential for harm when a therapy carrot (an orthotic device used to gently open the hand) was not implemented as ordered to prevent deterioration of existing contractures of the hand. Findings include:</p> <p>The facility's Restorative Care Program policy, undated, documented staff were to apply devices and splints according to therapy direction.</p> <p>Resident #27 was admitted to the facility on 9/22/15, with multiple diagnoses including stroke affecting the left side.</p> <p>Resident #27's quarterly MDS assessments, dated 11/14/18 and 2/14/19, documented she had an impairment to her upper extremity, required one-to-two staff with physical assistance for all ADLs, and was severely cognitively impaired.</p> <p>Resident #27's physician orders, dated 1/31/19 and revised on 2/7/19, documented to place a carrot splint to her left hand every shift for contractures (12-hour shifts). A physician order, dated 2/12/19, documented for therapy to evaluate and treat her contractures.</p> <p>Resident #27's care plan, dated 1/31/19, directed</p>	F 688	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>1) Resident #27 was assessed by therapy and order was changed for the carrot splint to be on in the am and off at night. The resident's care plan was updated.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>1) All residents with contractures and orders for the use of a carrot splint were assessed, orders and care plans were updated.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>1) All licensed staff were inserviced on the management of contractures and the importance of following the resident's care plan.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>↳ DON or designee will audit 3 times a week for 4 weeks, that the carrot splint is</p>		

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F 688	<p>Continued From page 34 staff to place the carrot splint to the left hand.</p> <p>Resident #27's Occupational Therapy (OT) evaluation, dated 2/4/19, documented goals for her to receive passive range of motion to maintain joint integrity. OT progress notes, dated 2/21/19 and 2/26/19, documented Resident #27 tolerated the carrot orthotic for 6 hours and she continued using the carrot orthotic.</p> <p>Resident #27 was observed as follows:</p> <ul style="list-style-type: none"> * On 2/25/19 at 10:52 AM, 2:39 PM, and 3:04 PM, Resident #27 did not have the therapy carrot in her left hand, it was on her bedside table. * On 2/26/19 at 9:01 AM, a staff member brought her back to her room and did not offer one of two therapy carrots on her bedside table. * On 2/26/19 at 9:42 AM, 12:55 PM, 3:05 PM, and 4:04 PM, Resident #27 was in bed and did not have a therapy carrot in her left hand. * On 2/27/19 at 11:01 AM, 12:09 PM, and 2:56 PM, Resident #27 did not have a therapy carrot in her left hand. <p>On 2/26/19 at 4:26 PM, LPN #3 said Resident #27 had contractures to her left hand due to her stroke and a therapy carrot was used to prevent further contractures of the hand.</p> <p>On 2/27/19 at 3:29 PM, CNA #4 said Resident #27 used a therapy carrot at all times to help with her contractures. At 3:50 PM, CNA #4 finished assisting Resident #27 with personal cares and then applied a therapy carrot to her left hand.</p>	F 688	<p>in place as care planned. All negative findings will be reported to the DON and reported in the monthly QAPI meeting.</p>		

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F 688	Continued From page 35 Resident #27 accepted the therapy carrot. On 2/28/19 at 11:19 AM, the Director of Therapy said Resident #27 was currently in therapy and she was working with Resident #27, which included using the therapy carrot to the left hand. She said Resident #27 used a therapy carrot in the past with mixed results due to her taking it out of her hand, but she was trialing it again to help with the contractures. The Director of Therapy said she was trialing to have the therapy carrot on only in the daytime and off at night. She said she was not aware nursing staff already implemented the therapy carrot to be in her left hand at all times or had received an order. On 2/28/19 at 11:47 AM, LPN #2 said when Resident #27's therapy carrot was applied she often tossed it out of her hand. On 2/28/19 at 12:11 PM, the DON said Resident #27 had used a therapy carrot in the past and the current order and care plan were implemented again to help with her contractures. The DON said Resident #27 should be using the therapy carrot at all times.	F 688			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		4/5/19	

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F 689	<p>Continued From page 36</p> <p>by: Based on observation, record review, policy review, resident interview, and staff interview, it was determined the facility failed to ensure fall prevention interventions were implemented as ordered following a fall. This was true for 1 of 7 residents (Resident #56) reviewed for falls. This failure had the potential for harm if residents sustained injuries from falling. Findings include:</p> <p>The facility's policy Fall Prevention, dated 5/2007, documented the following:</p> <p>* The facility would implement measures to decrease the incidence of additional falls and minimize the potential for injury. * If a resident experienced a fall, the care plan would be created or the existing care plan would be updated.</p> <p>Resident #56 was admitted to the facility on 1/16/19, with multiple diagnoses including Parkinson's disease, dementia, and repeated falls. Resident #56 received hospice services.</p> <p>A Fall Risk Evaluation, dated 1/16/19 at 5:35 PM, documented Resident #56 was at medium risk for falling.</p> <p>Resident #56's admission MDS assessment, dated 1/23/19, documented he had severe cognitive impairment, he required extensive assistance of two persons with bed mobility and total dependence of two persons for transfers, he was not steady and only able to stabilize with human assistance when moving from seated to standing and when transferring from surface to surface, and he had fallen in the previous one to</p>	F 689	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>1) The fall mat and non-skid rug was immediately placed by the bed of Resident #56 as indicated on the care plan.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>1) All residents with care plans indicating the use fall prevention measures, were audited to ensure that the prevention measures were in place. All negative findings were corrected immediately.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>1) All licensed staff were inserviced on the importance of following care plans and the use of fall prevention measures.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>↳ DON or designee will audit 3 times a week for 4 weeks, that all residents with care plans indicating the use fall prevention measures, have their fall</p>		

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F 689	<p>Continued From page 37 six months.</p> <p>Resident #56's care plan documented he was at risk for falls related to limited mobility, weakness, Parkinson's disease, and a history of falling. Interventions included the following:</p> <p>* Initiated on 1/16/19 and revised on 1/17/19: Avoid rearranging the furniture, ensure call light is within reach and encourage to use the call light for assistance, fall mats to the bedside, keep needed items within reach, maintain a clear pathway, and ensure a safe environment, including floors free from spills and/or clutter, adequate glare-free lighting, call light within reach and working, bed in low position at night, side rails as ordered, handrails on walls, and personal items within reach.</p> <p>* Initiated on 2/24/19: Non-skid rug at the bedside for safety.</p> <p>* Initiated on 2/7/19 and revised on 2/27/19: Steri-Strips (a type of adhesive wound closure strip) to the head laceration and dressing as ordered, monitor/document/report to the physician signs/symptoms of pain, bruises, change in mental status, new onset of confusion, drowsiness, inability to maintain posture, or agitation. Neurological assessments as ordered, Resident #56 to be up in the wheelchair and to the dining room for every meal, and vital signs as ordered.</p> <p>Resident #56's physician orders included a fall mat at bedside for safety every shift and a non-skid rug at bedside for safety every shift, dated 2/24/19.</p>	F 689	<p>prevention measures in place as care planned. All negative findings will be corrected immediately. All negative findings will be reported to the DON and reported in the monthly QAPI meeting.</p>		

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F 689	Continued From page 38 Resident #56's Fall Risk Evaluations, dated 2/6/19 at 7:54 PM, 2/22/19 at 2:45 PM, and 2/27/19 at 11:43 PM, documented he was at high risk for falling. Resident #56 had two falls documented as follows: * An Incident Report, dated 2/6/19 at 7:54 PM, documented Resident #56 fell when attempting to self-ambulate, and he sustained a laceration to his scalp. Actions taken included cleansing the laceration, applying Steri-Strips, and the nurse practitioner and hospice were notified. A Progress Note, dated 2/6/19 at 8:02 PM, documented Resident #56 was found by another resident "laying face down in a small pool of blood." A laceration was noted on his right scalp. Resident #56 said he was trying to ambulate. * A Progress Note, dated 2/22/19 at 1:07 PM, documented Resident #56 was found on the floor by a caregiver, and he stated he lost his balance. An Incident Report, dated 2/22/19 at 2:45 PM, documented Resident #56 fell when he attempted to self-ambulate. Action taken included range of motion was completed, he was assisted back to bed, staff were to monitor for injuries, hospice and his family member were notified, and neurological assessments were initiated. Resident #56's February 2019 TAR included the orders for the fall mat and non-skid rug at the bedside, starting on 2/24/19 at 1:53 PM. The fall mat and non-skid rug were documented as	F 689			

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F 689	Continued From page 39 placed at his bedside on night shift on 2/24/19 and on day and night shift on 2/25/19 through 2/27/19. On 2/26/19 at 9:03 AM, 2/28/19 at 2:38 PM, and 2/28/19 at 3:04 PM, Resident #56 did not have a fall mat and non-skid rug placed by his bed. On 2/28/19 at 3:01 PM, the Clinical Resource Nurse said a non-skid rug was added after Resident #56's fall on 2/22/19. The DON said Resident #56 should have had fall mats and a non-skid rug by his bed. On 2/28/19 at 3:04 PM, the DON said if Resident #56 was in bed, the fall mat should be in place. The DON said a non-skid rug should be in place and was not there.	F 689			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents received oxygen therapy per physician orders. This was true for 2 of 4 residents (#14 and #15) reviewed for oxygen therapy. This failure created the potential for	F 695	Corrective actions taken for those residents who may have been affected by this deficiency: Resident #14's oxygen was immediately	4/5/19	

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F 695	<p>Continued From page 40</p> <p>harm if residents' respiratory needs were not met. Findings include:</p> <p>The facility's oxygen administration policy, revised 5/2007, documented staff were to administer oxygen therapy as ordered by the physician, reassess oxygen flowmeter for appropriate flow and document all appropriate information in the medical record.</p> <p>1. Resident #15 was admitted to the facility on 11/26/18, with multiple diagnoses including chronic respiratory failure with hypoxia (low oxygen supply in body tissue).</p> <p>A physician order, dated 11/14/18, documented Resident #15 was to receive oxygen therapy continuously via nasal cannula at 2 LPM and staff were to monitor Resident #15 for signs and symptoms of respiratory distress.</p> <p>A quarterly MDS assessment, dated 12/23/18, documented Resident #15 was cognitively intact and she received oxygen therapy.</p> <p>A care plan, revised on 1/2/18, documented Resident #15 received oxygen therapy related to chronic respiratory failure with congestive heart failure (weakness of heart leading to a buildup of fluid) and staff were directed to provide oxygen therapy via nasal cannula as ordered by the physician.</p> <p>Resident #15 was observed in her room receiving oxygen therapy via nasal cannula at a liter flow rate as follows:</p> <p>*On 2/25/19 at 10:20 AM, 3 LPM per oxygen</p>	F 695	<p>adjusted to the correct LPM as indicated on the orders, and the resident's care plan was corrected to reflect the orders.</p> <p>Resident #15's oxygen was immediately adjusted to the correct LPM as indicated on the orders and care plan.</p> <p>¿¿</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All resident with orders for the use of oxygen were checked to ensure that they were receiving the correct LPM as ordered. All care plans for residents with oxygen orders were audited to ensure that their care plans included the oxygen as ordered.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>All licensed nursing staff were educated on the need to ensure that the care plan for resident's with oxygen orders, contain the oxygen as ordered.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>¿</p> <p>The care plan for residents with oxygen orders will be audited weekly x 8 weeks,</p>		

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F 695	<p>Continued From page 41</p> <p>concentrator, *On 2/26/19 at 11:01 PM, 2 LPM per oxygen concentrator, *On 2/27/19 at 10:49 AM, 3 LPM per oxygen concentrator.</p> <p>On 2/27/19 at 10:56 AM, RN #1 reviewed the physician's order and said Resident #15 was to receive oxygen therapy at 2 LPM continuously. RN #1 then went to Resident #15's room and checked her oxygen flow rate and it was at 3 LPM.</p> <p>2. Resident #14 was admitted to the facility on 10/18/14, with multiple diagnoses including chronic obstructive pulmonary disease (a lung disease making it difficult to breathe).</p> <p>Resident #14's quarterly MDS assessment, dated 1/2/19, documented she was cognitively intact and required oxygen therapy.</p> <p>Resident #14's care plan, revised on 12/13/18, documented she required oxygen at 2 LPM continuously by nasal cannula related to congestive heart failure.</p> <p>Resident #14's physician orders, dated 10/25/18, documented oxygen was ordered at 3 LPM continuously.</p> <p>Resident #14's MAR included the order for oxygen at 3 LPM by nasal cannula continuously. Staff documented this was completed each day from 2/1/19 through 2/28/19.</p> <p>On 2/26/19 at 9:55 AM and at 10:38 AM, Resident #14 was in the community TV area with</p>	F 695	<p>to ensure that the care plan matches the oxygen orders and check to ensure that the resident is receiving oxygen at the correct LPM as ordered. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.</p>		

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F 695	Continued From page 42 oxygen on at 2 LPM by nasal cannula. On 2/27/19 at 10:35 AM, CNA #1 said Resident #14's oxygen was on at 2 LPM and it should have been at 3 LPM. On 2/27/19 at 10:42 AM, LPN #1 said Resident #14's oxygen should be on at 3 LPM, and she was responsible for adjusting the oxygen. On 2/27/19 at 11:22 AM, the DON said the nurse was responsible to see oxygen flow was set correctly. The DON said Resident #14's oxygen was supposed to be on at 3 LPM.	F 695			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, policy review, and record review, it was determined the facility failed to ensure adequate communication was provided to a dialysis center. This was true for 1 of 1 resident (Resident #49) reviewed for dialysis. The failure created the potential for harm when the facility failed to communicate the resident's current care, access site, and vital signs to the dialysis center. Findings include: The facility's Dialysis policy, revised 5/2007, documented staff were to assess a resident's blood pressure (in the non-shunt arm) prior to	F 698	Corrective actions taken for those residents who may have been affected by this deficiency: DON confirmed that the hemodialysis communication record was being completed on resident #49 prior to being sent to dialysis.¿¿ How the facility will identify other residents having the potential to be affected by the same deficient practice	4/5/19	

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F 698	<p>Continued From page 43 being transported to the dialysis center.</p> <p>Resident #49 was admitted to the facility on 7/11/18, with multiple diagnoses including end stage renal disease.</p> <p>Resident #49's annual MDS assessment, dated 11/28/18, documented he was cognitively intact and received dialysis.</p> <p>Resident #49's care plan, dated 11/28/18, documented he received hemodialysis related to end stage renal disease and he had an arteriovenous (AV) fistula/graft (a surgically created passageway between the vein and artery used for dialysis) on his left and right upper extremities, and staff were directed to not take his blood pressure in either upper extremity.</p> <p>On 2/25/19 at 11:42 AM, Resident #49 said he had dialysis every Monday, Wednesday and Friday.</p> <p>Resident #49's record included Hemodialysis Communication Records which included a section for the licensed nurse to complete prior to dialysis treatment, and a section for the dialysis nurse to complete after dialysis and prior to the resident's return to the facility. The pre and post-dialysis sections included areas to document vital signs (blood pressure, temperature, pulse), time of last meal, diet, condition of the access site, patient's general condition, and signature of the person completing each section.</p> <p>The pre-dialysis section, which is filled out by facility staff, of the Hemodialysis Communication</p>	F 698	<p>and what corrective action will be taken:</p> <p>DON audited hemodialysis communication records to identify any documentation issues.¿¿</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>All licensed nursing staff were educated on the facilities policy regarding the use of the hemodialysis communication record and the need to complete the record prior to sending a resident to dialysis treatment.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>¿ The DON or designee will audit weekly x 6 all hemodialysis communication records to ensure they are completed per facility policy. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.</p>		

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F 698	Continued From page 44 Records for Resident #49 was blank on the following dates 1/9/19, 1/14/19, 1/16/19, 1/21/19, 1/23/19, 1/28/19, 1/30/19, 2/4/19, 2/6/19, 2/11/19, 2/13/19, 2/18/18, 2/20/19, 2/22/19 and 2/25/19. On 2/26/19 at 3:51 PM, the RN Supervisor said the dialysis form should be completed by the nurse prior to sending Resident #49 to the dialysis center. The RN Supervisor said the nurse might have taken the vital signs and other needed information but forgot to complete the dialysis form.	F 698			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, family interview, Resident Group interview, test tray evaluation, and staff interview, it was determined the facility failed to ensure palatable food was served. This affected 3 of 5 residents (#25, #31, and #50) who were reviewed for dietary concerns. This failed practice created the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include:	F 804	Corrective actions taken for those residents who may have been affected by this deficiency: Administrator surveyed residents on food palatability of vegetables and provided feedback to Dietary Manager. How the facility will identify other residents having the potential to be affected by the same deficient practice	4/5/19	

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F 804	<p>Continued From page 45</p> <p>Residents and family were interviewed regarding the food. Examples include:</p> <p>* On 2/25/19 at 10:03 AM, Resident #31 said the food did not always taste good, the hot items were cold, the cold items were not cold, and the vegetables were "mushy."</p> <p>* On 2/25/19 at 11:34 AM, Resident #50's daughter said she was a very picky eater and frequently complained about the food.</p> <p>* On 2/26/19 at 10:02 AM, during the Resident Group Interview, Resident #25 said the food did not taste good sometimes and could be cold, like the oatmeal served that morning.</p> <p>* On 2/28/19 at 10:28 AM, when asked about the facility's food, Resident #50 made an unpleasant face, said the food was "fair" and the hot foods were not always hot.</p> <p>The tray line was observed on 2/27/19 beginning at 11:56 AM. Cook #1 took five plates at a time out of the plate warmer and stacked them on the counter next to him. Cook #1 then plated the food and placed them on the counter where Dietary Aide #1 placed them on a warming pellet with a lid to cover the food. On at least two occasions, there were two plated meals on top of the counter side-by-side and Cook #1 placed another plated meal to the right of the two meals. Dietary Aide #1 then placed the meal to the right, which was recently plated, on a warming pellet with a lid prior to the two previous plated meals which sat on the counter. Dietary Aide #1 then placed the two plates, which had sat on the counter for a longer time, on warming pellets and covered</p>	F 804	<p>and what corrective action will be taken:</p> <p>Residents were asked in resident council how they would like their vegetables cooked. The resident feedback was provided to the kitchen staff.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>The kitchen tray line and food serving procedures will be modified to ensure that warming pallets are being utilized as intended and that food is being served timely. The facility will also utilize insulated food carts for the distribution of food to the resident hallways to ensure proper food temperatures. All kitchen staff will be in seviced on the facilities food handling procedures related to palatable food.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>¿</p> <p>The dietary manager or designee will provide resident surveys 3 times a week x6 weeks to evaluate food palatability. All negative findings will be reported to the administrator, and reported in the monthly QAPI meeting.</p> <p>The Administrator or designee will request a food tray daily for 6 weeks, to ensure proper food temperatures and palatability</p>		

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F 804	Continued From page 46 them. On 2/27/19 at 12:48 PM, two test tray lunch meals were requested for the regular and alternative meals. At 12:54 PM, Cook #1 plated both meals and Dietary Aide #1 informed staff there were no more warming pellets left for the alternative meal or for the last few resident meals that came into the kitchen at that time. The alternate meal was then covered with a lid. After a few minutes, several warming pellets were washed, and the alternative meal was placed on a warming pellet. At 12:58 PM, the two test tray meals were placed on a non-insulated tray cart and transported to the 200 hallway. On 2/27/19 at 1:08 PM, the test trays were evaluated by two surveyors along with the Certified Dietary Manager (CDM) and the Manager-in-Training. The alternate meal included zucchini and onions which had a temperature of 122 degrees F (Fahrenheit), white rice which was 122 degrees F, and canned peaches which were 58 degrees F. The zucchini was mushy and not hot. The CDM said the zucchini was not crunchy and it was hard to keep previously frozen zucchini from getting soft. The rice was not hot. The CDM said the peaches were supposed to be colder and confirmed with the Manager-in-Training the facility had run out of cold canned peaches for several residents and for the test tray, and staff had not tried to cool them prior to serving.	F 804	of the food. All negative findings will be reported to the dietary manager, and reported in the monthly QAPI meeting.		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		4/5/19	

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F 842	<p>Continued From page 47</p> <p>resident-identifiable to the public.</p> <p>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized</p> <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p>	F 842			

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F 842	Continued From page 48 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. 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' medical records were accurately documented and documented in a timely manner after care and/or services were provided. This was true for 4 of 19 residents (#24, #31, #49 and #76) whose records were reviewed. This deficient practice created the potential for harm should inappropriate care and/or treatment be provided based on inaccurate information. Findings include:	F 842	Corrective actions taken for those residents who may have been affected by this deficiency: 1) Resident #24 was assessed and a shower was given and documented. Resident #24's PASARR was updated and the resident was seen by the facilities contracted phycologist.¿¿ 2) Resident #31 was assessed and a		

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F 842	<p>Continued From page 49</p> <p>The facility's Health Information policy, dated 2016, documented:</p> <ul style="list-style-type: none"> * Clinical health records are maintained in accordance with regulations and professional practice standards to provide complete and accurate information on each resident for continuity of care. * Avoid assuming the responsibilities of the other health care professionals in the facility. * The purpose of the clinical record is to document the course of the resident's plan of care and to provide a medium of communication among health care professionals involved in this care. <p>1. Resident #49 was admitted to the facility on 7/11/18, with multiple diagnoses including end stage renal disease.</p> <p>The facility's Dialysis policy, revised 5/2007, documented staff were to assess the resident's blood pressure (in the non-shunt arm) prior to being transported to the dialysis center.</p> <p>Resident #49's record included Hemodialysis Communication Records which included a section for the licensed nurse to complete prior to dialysis treatment, and a section for the dialysis nurse to complete after dialysis and prior to the resident's return to the facility. The pre and post-dialysis sections included areas to document vital signs (blood pressure, temperature, pulse), time of last meal, diet, condition of the access site, patient's general</p>	F 842	<p>shower was given and facial hair was plucked as instructed by the resident. Care provided to resident was documented.</p> <p>3) Resident #49 was interviewed regarding his desire to continue use of his CPAP. The resident indicated that he doesn't intend to use the CPAP, even if it is cleaned on a regular basis. The CPAP order was discontinued and the CPAP was removed from the resident's care plan. DON confirmed that the hemodialysis communication record was being completed on resident #49 prior to being sent to dialysis.</p> <p>4) Resident #76's code status on their care plan was updated to match the code status on the resident's POST.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>1) CNA flow task sheets were audited and compared to resident shower schedule. In cases a shower was not provided, the resident was asked if they would like a shower and if confirmed, a shower was provided.</p> <p>2) All resident PASARR were audited and compared to current medication list to ensure resident PASARRs were current.</p> <p>3) Residents were interviewed and</p>		

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F 842	<p>Continued From page 50 condition, and signature of the person completing each section.</p> <p>The pre-dialysis section, which was filled out by facility staff, was blank on the following dates 1/9/19, 1/14/19, 1/16/19, 1/21/19,1/23/19, 1/28/19, 1/30/19, 2/4/19, 2/6/19, 2/11/19, 2/13/19, 2/18/18, 2/20/19, 2/22/19 and 2/25/19. Copies of the Hemodialysis Communication Record were requested from the Clinical Resource Nurse.</p> <p>On 2/26/19 at 3:51 PM, the RN Supervisor said the dialysis form should be completed by the nurse prior to sending Resident #49 to the dialysis center. The RN Supervisor said the nurse might have taken the vital signs and other needed information but forgot to complete the dialysis form.</p> <p>On 2/26/19 at 4:45 PM, the Clinical Resource Nurse provided copies of the requested documents for Resident #49.</p> <p>On 2/27/19 at 2:53 PM, the Clinical Resource Nurse said she made copies of Resident #49's record and thought she copied the correct Hemodialysis Communication Records as requested. The Clinical Resource Nurse said she was going to make another set of copies of Resident #49's Hemodialysis Records. The Hemodialysis Communication Records dated 1/9/19, 1/14/19, 1/16/19, 1/21/19,1/23/19, 1/28/19, 1/30/19, 2/4/19, 2/6/19, 2/11/19, 2/13/19, 2/18/18, 2/20/19, 2/22/19 and 2/25/19, were reviewed with the Clinical Resource Nurse. Where the pre-dialysis sections were all filled with the necessary information on the copies provided by the Clinical Resource Nurse, they</p>	F 842	<p>assessed regarding their grooming needs and documentation was audited.</p> <p>4) All residents currently using a CPAP were audited to determine accuracy of their care plan to their written orders.</p> <p>5) DON audited hemodialysis communication records to identify any documentation issues.</p> <p>6) All resident care plans were audited to ensure that the resident's code status on their care plan, matched each resident's code status on their POST.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>1) CNAs were in-serviced on proper and timely documentation care.</p> <p>2) Nurse Managers and Social Workers will be educated on maintaining an updated PASARR for all residents.</p> <p>3) All licensed nursing staff were educated on the facilities policy regarding the use of the hemodialysis communication record and the need to complete the record prior to sending a resident to dialysis treatment.</p> <p>4) All licensed nursing staff were educated on the need to ensure that every resident's code status on their care plan, match the code status on the resident POST.</p>		

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NAME OF PROVIDER OR SUPPLIER CREEKSIDE TRANSITIONAL CARE AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642		
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F 842	<p>Continued From page 51</p> <p>were blank with no information documented the previous day. The Clinical Resource Nurse said the vital signs came from Resident #49's EMR (electronic medical record). The Clinical Resource Nurse compared the vital signs written on the Hemodialysis Communication Record with those documented in the EMR and they were not the same.</p> <p>On 2/27/19 at 3:33 PM, the Administrator and DON said it was not a practice of the facility to alter medical records. The DON said they brought it to the nurse's attention for not completing the hemodialysis record in timely manner, but they were not aware the nurse entered the missing information in the Hemodialysis Communication Records after it was discussed.</p> <p>2. Resident #24 was admitted to the facility on 1/30/19, with multiple diagnoses including Alzheimer's disease, generalized muscle weakness, and anxiety disorders.</p> <p>Resident #24's CNA task flowsheet for bathing, dated 3/1/19 at 8:42 AM, documented he received a shower on 2/4/19, 2/7/19, 2/11/19, and 2/14/19, which were initialed as completed by the ADON.</p> <p>On 3/1/19 at 8:30 AM, the RN Supervisor said he was not aware of any other place to document showers besides the EMR. The RN Supervisor said he heard the day before there may have been some problems with the documentation, and he completed an audit and the facility was behind on documenting some of the residents' showers.</p>	F 842	<p>5) All licensed nursing staff were educated on proper documentation, including only documenting on care personally provided and not the care of another staff member, or presumed care, how to perform late entry documentation and that late entry documentation can only be performed by the staff member who provided care, asking for help/assistance when not understanding orders, care plans, instructions and resident documentation.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>↳</p> <p>1) CNA Task Flow Sheets will be audited randomly (30 residents) weekly X 6 weeks by Nurse Case Manager (or designee), to ensure that CNAs are adhering to resident care plans and documenting care. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.</p> <p>2) The DON or designee will audit CPAP equipment weekly x 6 weeks, to ensure equipment is being cleaned according to the TAR and properly documented and care planned. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.</p> <p>3) The DON or designee will audit weekly</p>		

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F 842	<p>Continued From page 52</p> <p>On 3/1/19 at 8:39 AM, the DON said the RN Supervisor completed an audit on the previous day to see if showers were documented. The DON said she and the ADON were keeping track of shower documentation, and if they found the documentation of a shower was missing they called the CNA to verify whether the shower was given and the ADON entered the missing documentation in the resident record.</p> <p>3. Resident #31 was admitted to the facility on 5/8/18, with multiple diagnoses including muscle weakness and difficulty in walking.</p> <p>Resident #31's ADL flowsheet for February 2019, documented she received a shower on 2/11/19 and 2/25/19, 14 days apart. The flowsheet also documented she received showers on 2/14/19, 2/18/19, and 2/21/19, which was signed by the ADON.</p> <p>On 2/25/19 at 10:01 AM, Resident #31 said she had not had a shower for three weeks. She said CNAs came and told her they were going to give her a shower and then they never came back. She said she did not want to get any staff in trouble, but she wanted a shower.</p> <p>On 2/27/19 at 3:25 PM, CNA #4 said she was not sure if Resident #31 had received a shower the previous week.</p> <p>On 2/27/19 at 4:08 PM, the DON said Resident #31 was cognitively intact and said if she said she had not received a shower in weeks, then it was probably true. The DON said the ADON had documented Resident #31's showers on 2/14/19,</p>	F 842	<p>x 6 all hemodialysis communication records to ensure they are completed per facility policy. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.</p> <p>4) Resident care plan will be audited weekly x 8 weeks by DON or designee, to ensure that the code status for every resident's care plan, matches the code status on the POST. All negative findings will be reported to DON, and reported in the monthly QAPI meeting.</p> <p>DON or designee will audit 3 times a week for 4 weeks, that the carrot splint is in place as care planned. All negative findings will be reported to the DON and reported in the monthly QAPI meeting.</p>		

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F 842	<p>Continued From page 53</p> <p>2/18/19, and 2/21/19, based on verbal reports from the CNAs. The DON said she and the ADON were calling CNAs when there was incomplete shower documentation. She said they called them anywhere from a day to several days after the fact. She said she and the ADON were trying to get the CNAs to document at the time the showers were completed or at the end of their shifts. The DON said it was expected for the CNAs to document before they left for the day.</p> <p>The facility failed to ensure records were completed at the time care was delivered or to correct the record using late entry documentation. A late entry, an addendum or a correction to the medical record, bears the current date of that entry and is signed by the person making the addition or change.</p> <p>4. Resident #76 was admitted to the facility on 11/15/18, with multiple diagnoses including Alzheimer's disease, pain in both knees, and repeated falls.</p> <p>Resident #76's physician orders, dated 11/15/18, documented to "Bridge heels while in bed."</p> <p>Resident #76's January 2019 and February 2019 TARs, documented her heels were "bridged" as ordered for 103 out of 112 opportunities. The TARs documented Resident #76 refused 8 times and 1 was left blank, with no staff initials.</p> <p>Resident #76's care plan directed staff to float her heels on 12/27/18. On 1/2/19 the care plan was updated and stated "brody heels while in bed." The care plan did not have clarification regarding this intervention.</p>	F 842			

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F 842	<p>Continued From page 54</p> <p>On 2/26/19 at 3:54 PM, LPN #3 said Resident #76's heels were to be floated at night, so her heels did not get boggy. LPN #3 said she was not sure what 'Bridge heels' or 'brody heels' were and said they might be some sort of foam heel to keep her feet off of the bed.</p> <p>On 2/27/19 at 4:40 PM, LPN #2 said staff were supposed to float Resident #76's heels and her skin integrity was good. LPN #2 said she did not know what a bridge heel was and said different devices went by different names. LPN #2 looked around the resident's room and did not find a bridge heel device. At 6:10 PM, LPN #2 reviewed Resident #76's TAR and said she had been signing off on the bridge heels order because she assumed that they were there and said that they were not there because she had checked earlier with the surveyor present.</p> <p>On 2/28/19 at 3:56 PM, the DON said she did not know what brody heels were and said she meant for the care plan to document bridge or float Resident #76's heels. She said that the bridge heels order was not a device but rather an order to prop up or float her heels to prevent pressure ulcers. The DON said if staff were not clear on what was in her care plan or on an order, then she expected them to ask her or someone who knew what it meant.</p>	F 842			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER CREEKSIDE TRANSITIONAL CARE AND REHA	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 WEST PINE AVENUE MERIDIAN, ID 83642
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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey of your facility from February 25, 2019 to March 1, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Cecilia Stockdill, RN, Team Coordinator Presie Billington, RN Brad Perry, LSW</p>	C 000		
C 666	<p>02.150,02,c Quarterly Committee Meetings</p> <p>c. Meet as a group no less often than quarterly with documented minutes of meetings maintained showing members present, business addressed and signed and dated by the chairperson. This Rule is not met as evidenced by: Based on review of the facility's Infection Control Program policies and staff interview, it was determined the facility failed to ensure a quarterly Infection Control Meeting was held. This failure had the potential to affect all residents who resided in the facility. Findings include:</p> <p>The facility's Infection Control policy, dated 5/2007, documented the Infection Control Committee would meet quarterly as part of the Quality Assurance Committee.</p> <p>On 2/27/19 at 5:23 PM, RN (Registered Nurse) #2 said there was no Infection Control meeting since 11/1/18. He said there was supposed to be a meeting in January and it was re-scheduled due to the physician being unable to attend the meeting.</p>	C 666	<p>Corrective actions taken for those residents who may have been affected by this deficiency:</p> <p>IDT met and reviewed all residents for any infection control issue and reviewed infection control trends.</p> <p>∩∩ How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>IDT met and reviewed all residents for any infection control issue and reviewed infection control trends.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p>	4/5/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/25/19
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C 666	Continued From page 1	C 666	<p>Facility will hold the Infection Control Meeting in conjunction with the monthly QAPI meeting. All Infection control issues will be reviewed in the QAPI meeting. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>∩ Administrator will audit montly x 6 months that an Infection Control meeting is being done at least quarterly and findings are reviewed in the QAPI meeting. All negative findings will be reported in the monthly QAPI meeting.</p>	
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