



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

March 26, 2020  
Joan Martellucci, Administrator  
Ivy Court  
2200 Ironwood Place,  
Coeur D'Alene, ID 83814-2610

Corrected letter  
replaces letter of March 17, 2020

Provider #: 135053

Dear Ms. Martellucci:

On **March 6, 2020**, a survey was conducted at Ivy Court by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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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 **April 3, 2020**. Failure to submit an acceptable PoC by **April 3, 2020**, may result in the imposition of civil monetary penalties by **April 22, 2020**.

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

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

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

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

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

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

**Denial of payment for new admissions effective June 4, 2020**

A 'per instance' civil money penalty

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 2, 2020**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, LTC Supervisors Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **April 3, 2020**. If your request for informal dispute resolution is received after **April 3, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any

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questions, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208) 334-6626, option #2.

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor  
Long Term Care Program

bd/  
Enclosures

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

PRINTED: 06/17/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/06/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>IVY COURT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814</b>		
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F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from March 2, 2020 to March 6, 2020.  The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Kim Saccomando, RN Janet Kubisiak, RN  Survey Abbreviations: ADL = Activities of Daily Living CDM = Certified Dietary Manager CNA = Certified Nursing Assistant DON = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = milligram ml = milliliter PRN = As Needed RCM = Resident Care Manager RD = Registered Dietician	F 000			
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3)  §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type,	F 553		4/29/20	

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

TITLE

(X6) DATE

Electronically Signed

04/03/2020

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

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F 553	<p>Continued From page 1</p> <p>amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.</p> <p>(iii) The right to be informed, in advance, of changes to the plan of care.</p> <p>(iv) The right to receive the services and/or items included in the plan of care.</p> <p>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.</p> <p>§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-</p> <p>(i) Facilitate the inclusion of the resident and/or resident representative.</p> <p>(ii) Include an assessment of the resident's strengths and needs.</p> <p>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on policy review, record review, and resident and staff interview, it was determined the facility failed to include a resident or their representative to participate in their care planning. This was true for 1 of 19 residents (Resident #10) reviewed for care plans. This failure created the potential for harm if a resident experienced a decline in physical, mental, or psychosocial functioning due to lack of their input toward their goals. Findings include:</p> <p>The facility's Care Plan policy, undated, documented the following:</p> <p>* Care plans addressed issues to provide for a</p>	F 553	<p>This plan of correction constitutes the facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of, or agreement with, the deficiencies or conclusions contained in the department's inspection report.</p> <p>Deficiencies related to F 553 1. Correction/s as it relates to the resident/s: Resident #10 invited to Care</p>		

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F 553	<p>Continued From page 2</p> <p>resident's highest practicable level of wellbeing and were re-evaluated and updated quarterly, annually, and when a significant change in status occurred.</p> <p>* Care plans reflected the resident/resident's representative input and goals for health care.</p> <p>* Care plans involved the resident/resident's representative and other representatives as appropriate.</p> <p>This policy was not followed.</p> <p>Resident #10 was admitted into the facility on 9/2/16, with diagnoses of cerebral infarction (stroke), Hemiplegia (paralysis of one side of the body) and repeated falls.</p> <p>An MDS assessment dated 12/6/19, stated Resident #10 was cognitively intact.</p> <p>A Care Conference Note, dated 6/18/19, documented a self care conference was conducted about Resident #10. There was no documentation Resident #10 was asked to participate.</p> <p>A Care Conference Note dated 9/18/19, documented a self care conference was conducted about Resident #10 and no concerns were voiced from Resident #10. It was unclear when Resident #10 was asked for his concerns as it was documented he was not in attendance at the meeting.</p> <p>On 3/3/20 at 10:57 AM, Resident #10 stated he did not know what a care plan was. The care</p>	F 553	<p>Conference with explanation of purpose of care conference with copy of care plan given to resident.</p> <p>2. Action/s taken to protect residents in similar situations: Social Services has reviewed all planned quarterly care conferences and will assure documentation reflects invitations put forth and presence of residents.</p> <p>3. Measures taken or systems altered to ensure that solutions are sustained: Social Services staff reviewed process to assure residents and/or responsible parties are invited and in attendance if they choose.</p> <p>4. Plans to monitor performance to ensure solutions are sustained and person responsible: Social Services Director will randomly audit documentation of 10 care conferences monthly for 3 months and report compliance to the QAPI Committee with recommendations.</p> <p>5. Who will be responsible for ensuring compliance: SSD and ED.</p>		

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F 553	Continued From page 3 plan and care plan conference were defined for Resident #10 and he was asked if he ever attended one, or if anyone asked him for input for one. He replied no. When asked if he would like to go to his care plan meetings, he replied yes.  On 3/5/2020 at 3:43 PM, the DON said he expected all care plans to be followed. He said he expected all care conferences were offered to residents.	F 553			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)  §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.  §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.  §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		4/29/20	

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F 583	<p>Continued From page 4</p> <p>of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure a resident's privacy in their room. This was true for 1 of 18 residents (Resident #27) reviewed for privacy when a resident's room had private health information hanging on the wall in view of any person who entered the room. This deficient practice had the potential for psychosocial harm if the resident felt embarrassed with the placement of the sign. Findings include:</p> <p>The facility's privacy and confidentiality policy, dated 12/1/17, documented residents had the right to personal privacy in their accommodations.</p> <p>This policy was not followed.</p> <p>Resident #27 was readmitted to the facility on 12/20/18, with multiple diagnoses including dysphagia (difficulty swallowing).</p> <p>Resident #27's care plan, dated 4/12/18 and 8/2/18; respectively, directed staff to provide him with a homelike environment and to elevate the head of his bed at least 30 degrees related to tube feeding and his preference.</p>	F 583	<p>F583 <input type="checkbox"/> Personal Privacy/Confidentiality of Records</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Sign removed from above resident #27's bed.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>Residents residing in the facility have the potential to be affected by this deficient practice. Resident rooms were inspected for any violations in personal privacy or confidentiality of records with no negative findings.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>Daily monitoring of resident rooms for any violations in personal privacy or confidentiality of records by nursing staff and caring partners.</p> <p>Staff will be educated to facility policy/procedure on Personal Privacy/Confidentiality of Records to</p>		

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F 583	Continued From page 5  Resident #27's physician orders, dated 1/23/20, directed staff to keep the head of his bed elevated at least 30 degrees related to his gastrostomy tube (a tube inserted through the abdomen that brings nutrition directly to the stomach).  On 3/2/20 at 9:55 AM, 3/3/20 at 8:41 AM, and 3/4/20 at 9:56 AM and 4:28 PM, a wall to the left of Resident #27's bed had a sign posted that documented, "HOB [head of bed](greater than) 30 (degrees) AT ALL TIMES."  On 3/5/20 at 1:08 PM, the DON observed the sign on the wall in Resident #27's room and said he was not sure who put the sign up. He said the sign was not needed because his orders and his care plan documented the same thing. The DON said he expected staff to follow privacy guidelines.	F 583	include the appropriate use of signs in resident rooms by DON/designee. How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained: Audits of resident's rooms will be done by the DON/RCM's daily Monday through Friday x 4 weeks then weekly x 6 weeks to ensure compliance. Findings will be reviewed at QAPI monthly x3 months for further educational opportunities. DON/designee is responsible for compliance.		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		4/29/20	

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F 600	<p>Continued From page 6 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, policy review, review of facility Incident and Accident reports, resident interview and staff interview, it was determined the facility failed to ensure residents were free from intimidation when reporting abuse for 1 of 18 residents (#176). This failure resulted in psychosocial harm due to fear of intimidation and retaliation by the facility in reporting abuse and neglect by staff. Findings include:</p> <p>The facility's policy, Prevention and Reporting: Abuse, Neglect and Mistreatment, dated February 2018, defined abuse as the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It further defined mental abuse as verbal or non-verbal and included humiliation, harassment, and threats of punishment or deprivation. The policy stated residents had the right to be free from abuse, neglect, and exploitation.</p> <p>This policy was not followed.</p> <p>Resident #176 was admitted to the facility on 8/29/18, with diagnoses which included ankylosing spondylitis of the spine (an inflammatory arthritis affecting the spine and large joints), COPD (Chronic Obstructive Pulmonary Disease, a lung disease that interferes with normal breathing by obstructing airflow from the lungs), heart failure, muscle contractures, and dementia.</p> <p>A quarterly MDS assessment, dated 12/10/19, stated Resident #176 was cognitively intact.</p>	F 600	<p>F600 <input type="checkbox"/> Free from Abuse and Neglect What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #176 no longer resides in the facility.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents residing in the facility have the potential to be affected by this deficient practice. The past 3 months of abuse/neglect reports will be reviewed to ensure all reports are thoroughly investigated. Residents still residing in the facility will be interviewed by SS for concerns related to the incident and evidence of residual psychosocial harm.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Daily monitoring of the 24 hour report, risk management, clinical dashboard and grievances will occur to identify any possible instances of abuse or neglect with immediate follow up as indicated. Staff will be educated to facilities policy/procedure on identifying and reporting abuse and neglect by DON/designee.</p> <p>How the facility plans to monitor</p>		

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F 600	<p>Continued From page 7</p> <p>An Incident and Accident Report, dated 8/25/19, documented on 8/24/19, Resident #176 reported to an unnamed CNA that Staff Member A was "rough during cares." Resident #176 stated Staff Member A smacked his forehead against the side rails of the bed and smacked and pinched his scrotum with the urinal. It was documented in the report Resident #176 stated he did not want to say anything, because he was worried it would make things worse for him in the facility.</p> <p>Resident #176's care plan, dated 8/26/20, stated Resident#176 had a potential concern for psychosocial well-being related to accusations of abuse. The interventions documented were as follows:</p> <ul style="list-style-type: none"> <li>* allow Resident #176 to verbalize perceptions and fears</li> <li>* protect Resident #176</li> <li>* offer reassurance</li> <li>* use positive conversation</li> <li>* rule out abuse/pain</li> <li>* report allegation</li> </ul> <p>An undated follow up interview in the Incident and Accident Report documented Resident #176 stated he had a verbal disagreement with Staff Member A. It documented Staff Member A turned Resident #176 and bumped his head on the siderail unintentionally. The report also documented when Staff Memer A was providing cares, the urinal also unintentionally pinched Resident #176's thigh. The report documented Resident #176 stated during the undated follow up interview he felt safe in the facility and denied any abuse.</p> <p>On 3/2/20 at 10:50 AM, Resident #176 stated</p>	F 600	<p>performance to ensure the corrective actions are effective and compliance is sustained:Audits of the 24 hour report, risk management, clinical dashboard and grievance log will be done by the DON/RCM's daily Monday through Friday x 12 weeks to ensure compliance. Findings will be reviewed at QAPI monthly x3 for further educational opportunities. DON/designee is responsible for compliance.</p>		

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F 600	<p>Continued From page 8</p> <p>"There is a lot going on here that is just not good." Resident #176 stated he had a copy of the investigation report and "They minimized what I said." Resident #176 stated there was a staff member, Staff Member A, "that was just really, really, bad." He stated Staff Member A went to turn him and "banged his head against the rails over and over." Resident #176 stated Staff Member A then took the urinal and "smashed it against his genitals over and over." Resident #176 stated he got "thumped up pretty good" by Staff Member A and the facility sent Staff Member A to another hall to work. Resident #176 stated what Staff Member A was doing was not right and he only felt safe once Staff Member A left the facility. Resident #176 stated the facility fired Staff Member A after another resident complained of abuse. Resident #176 stated he contacted the local Ombudsman at the time, but then changed his mind about discussing the incident when the local Ombudsman asked for information because he was afraid of repercussions from staff.</p> <p>On 3/5/20 at 9:44AM, Resident #176 reported he thought the abuse started because he was telling Staff Member A he shot the biggest bear in Idaho and he called "BS on me." Resident #176 stated a couple of days later Staff Member A was turning him in bed and Staff Member A hit his head on the siderail really hard. Resident #176 stated Staff Member A then grabbed his shoulders and hit his head against the siderails over and over, "really hard", an unknown amount of times. Resident #176 stated he later asked for the urinal and Staff Member A took the urinal and forcefully slammed it into his groin area over and over an unknown amount of times. Resident</p>	F 600			

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F 600	<p>Continued From page 9</p> <p>#176 stated he felt unsafe around Staff Member A so he reported the incident to the nurse.</p> <p>Resident #176 was asked about his statement in the follow up interview. Resident #176 denied he made the statement that he felt safe in the facility and denied he stated the abuse did not happen. He stated the facility was "sweeping things under the rug." Resident #176 stated he currently was not comfortable about his safety "at all" in the facility. Resident #176 stated regarding his denial the abuse happened, "I'm not stupid and I never said that. I am afraid of retaliation in here." Resident #176 stated he was currently concerned about retaliation for "talking to the state" and worried he will be "starved out," for talking to state surveyors. When asked to clarify, he stated he was not afraid of physical abuse but worried about things staff control, such as his medications being late, his call light not being answered, and not getting food served to him. Resident#176 was tearful during the interview and when describing the allegation he hung his head down and was tearful.</p> <p>On 3/5/20 at 10:08 AM, Resident #176 called a family friend in the surveyor's presence and asked the surveyor to listen to the call. Resident #176 asked the family friend if she remembered the interview about the allegation and she stated "yes." She then stated she was with Resident #176 during the staff interview for the Incident and Accident follow up report and Resident #176 never stated during the interview he felt safe in the facility and denied any abuse. She stated she did not remember the facility staff asking those questions in her presence.</p>	F 600			

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F 600	Continued From page 10 On 3/5/20 at 10:35 AM, the Administrator was interviewed about the Incident and Accident report regarding Resident #176. She stated the person who conducted the Incident and Accident investigation on Resident #176 no longer worked at the facility.	F 600			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, review of incident reports, and resident and staff interview, it was determined the facility failed to conduct complete and thorough investigations for 1 of 4 residents (#65) reviewed for abuse allegations. This failure had the potential for harm if staff failed to conduct a thorough and credible investigation of abuse if staff failed to recognize when abuse occurred, and for the inability to	F 610	F610 <input type="checkbox"/> Investigate/Prevent/Correct Alleged Violation  What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #65 will be assessed for safety and potential psychosocial harm related to the incident.	4/29/20	

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F 610	<p>Continued From page 11</p> <p>protect the residents from further abuse. Findings include:</p> <p>The facility's Abuse policy, dated February 2018, documented, "When allegations that meet the definition of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property are received, the center shall...thoroughly investigate all alleged violations and retain documents showing that all alleged violations are thoroughly investigated."</p> <p>This policy was not followed.</p> <p>Resident #65 was admitted to the facility on 2/8/18, with diagnoses which included high blood pressure, diabetes mellitus, and depression.</p> <p>An incident report of alleged abuse, dated 8/8/19, documented two CNAs reported to the RCM Resident #65 slapped them both in the arm while they were trying to assist another resident in his wheelchair. The report documented Resident #65 said, "I slapped them, because they slapped me first."</p> <p>The incident report, dated 8/8/19, stated the incident occurred in the dining room and two CNAs, one LPN, and one RCM were interviewed as witnesses to the incident. Resident #65 was interviewed and stated she "slapped" the CNAs when they were trying to assist another resident and she was holding on to the resident's wheelchair. Resident #65 stated she slapped them because the CNAs would not allow her to assist the resident to his room, she then stated later it was because they grabbed her hands to</p>	F 610	<p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents residing in the facility have the potential to be affected by this deficient practice. The past 3 months of Abuse and Neglect reports will be reviewed to ensure all reports are thoroughly investigated.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Daily monitoring of the 24 hour report, risk management, clinical dashboard and grievances will occur to identify any possible instances of abuse or neglect. Staff will be educated to facilities policy/procedure on identifying and reporting abuse and neglect by DON/designee. Managers educated on fully investigating all events thoroughly. ED/Don will review all A&amp;I reports to ensure proper investigation was completed.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained: Audits of the 24 hour report, risk management, clinical dashboard and grievance log will be done by the DON/RCM's daily Monday through Friday x 12 weeks to ensure compliance. Findings will be reviewed at QAPI monthly x3 for further educational opportunities. DON/designee is</p>		

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F 610	Continued From page 12 attempt to remove them from the wheelchair. There were no other residents interviewed concerning the incident or potential alleged abuse.  On 3/5/20 at 10:55 AM, the DON said as part of investigations, the facility suspended people involved, and interviewed staff and other residents. He said he thought since there were enough staff that witnessed the event for Resident #65 they did not think they needed to interview other residents. The DON said residents should have been interviewed regarding abuse concerns as part of the investigation.	F 610	responsible for compliance.		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on policy review, record review and staff interview, it was determined the facility failed to ensure an MDS assessment was completed. This was true for 1 of 19 residents (Resident #1) whose MDS assessments were reviewed for accuracy. This failure created the potential for harm should residents receive inappropriate care related to discrepancies in the MDS assessments. Findings include:  The facility's MDS policy, dated 10/2019, documented a discharge MDS assessment must be completed no later than 14 days after a resident discharged from the facility.	F 641	Deficiencies related to F 641 1. Correction/s as it relates to the resident/s: Discharge MDS for Resident #1 was completed and transmitted on 3/6/2020 2. Action/s taken to protect residents in similar situations: Audit was conducted of all discharge residents for the past 60 days to assure a completed and transmitted discharge MDS is available. 3. Measures taken or systems altered to ensure that solutions are sustained: Resident Assessment Coordinator will	4/29/20	

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F 641	Continued From page 13 This policy was not followed.  Resident #1 was admitted to the facility on 9/5/19, with multiple diagnoses including epilepsy. He was discharged from the facility on 10/7/19.  Resident #1's record documented the most recent MDS assessment was a 14-day MDS assessment completed on 9/19/19. His record did not include a discharge MDS assessment.  Resident #1's nurse progress notes, dated 10/7/19, documented he discharged to a different facility that day.  On 3/5/20 at 3:54 PM, MDS Coordinator #1 said a discharge MDS assessment was not completed for Resident #1. She said she was not sure why the MDS assessment was missed.	F 641	generate a weekly discharge report to assure completion and transmittal of previous weeks discharge MDSs for the next 90 days. RAC and MDS nurse reviewed requirement for accurate understanding. 4. Plans to monitor performance to ensure solutions are sustained and person responsible: Resident Assessment Coordinator will conduct random MDS audits to include discharge resident MDS completion and report findings to the QAPI Committee with recommendations for ongoing 5. Who will be responsible for ensuring compliance: Resident Assessment Coordinator and Executive Director.		
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, policy review, record review, and resident and staff interview, it was determined the facility failed to ensure a resident was provided daily oral care. This was true for 1 of 3 residents (Resident #10) reviewed for activities of daily living relating to oral care and hygiene. This failure created the potential for harm if residents experienced weight loss, increased mouth pain from poor fitting dentures,	F 677	F677 <input type="checkbox"/> ADL care provided for Dependent Residents  What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #10 had oral assessment completed, he is receiving assistance with dental care and has	4/29/20	

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F 677	<p>Continued From page 14 or mouth sores related to poor fitting dentures. Findings include:</p> <p>The facility's Activities of Daily Living policy, undated, stated brushing teeth was a grooming procedure.</p> <p>Resident #10 was admitted into the facility on 9/2/16, with diagnoses of cerebral infarction (stroke), Hemiplegia (paralysis of one side of the body), and aphasia (loss of ability to understand or express speech).</p> <p>An admission MDS assessment dated 9/9/16, documented Resident #10 had no natural teeth and he was cognitively intact.</p> <p>Resident #10's care plan, dated 6/12/18, stated Resident #10 had upper and lower dentures and mouth inspections should occur daily and concerns were reported to the nurse. Resident #10's record did not include documentation of daily mouth inspections.</p> <p>On 3/3/20 at 10:53 AM, Resident #10 shook his head side to side indicating no, when asked if anyone helped him with dental care. When asked if he would like someone to help him with dental care Resident #10 stated yes. When asked if anyone took his dentures out or provided dental care supplies so he could clean his dentures and mouth he shook his head side to side, indicating no.</p> <p>On 3/3/20 at 10:57 AM, no dental care supplies were on Resident #10's side table or in his bathroom.</p>	F 677	<p>supplies available.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents residing in the facility have the potential to be affected by this deficient practice. Residents will be assessed for dental care needs with follow up as indicated.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Daily monitoring of the 24 hour report, risk management, clinical dashboard and grievances will occur to identify any possible need in ADL care. Staff will be educated to facilities policy/procedure on providing ADL care, including assistance with oral hygiene to dependent residents by DON/designee.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained: Audits of the grievance log and caring partner rounds will be done by the DON/RCM's daily Monday through Friday x 12 weeks to ensure compliance. Findings will be reviewed at QAPI monthly x3 for further educational opportunities. DON/designee is responsible for compliance.</p>		

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F 677	Continued From page 15 On 3/5/20 at 4:03 PM, the DON stated there was no documentation for oral care for Resident #10. The DON stated oral care was not a scheduled task for the CNAs on the computer, so it was not getting charted in Resident #10's record. He stated if a task was not in the CNA charting, they were instructed to tell the nurse and the nurse made a progress note and started a task in the chart.	F 677			
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure staff followed professional standards of practice for disposition of controlled medications. This was true for 2 of 6 residents (#178 and #179) whose records were reviewed for controlled substances (narcotics) and had the potential to affect each of the 72 residents residing in the facility if controlled medications were diverted and residents did not receive medications as ordered for pain. Findings include:  The facility's Destruction of Controlled Drugs policy, undated, stated all controlled substances	F 684	F684 ☐ Quality of Care  What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #178 and 179 are no longer at the facility.  How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents discharging from the facility have the potential to be affected by this deficient practice. Residents discharging	4/29/20	

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F 684	<p>Continued From page 16</p> <p>were destroyed in the presence of two licensed nurses designated by the Director of Nursing or according to the local, State, and Federal regulations. It stated when controlled drugs needed to be stored, the proof of use inventory page [for disposition of unused medication] required the signature of two licensed nurses at the bottom, and they were transferred to the DON. The policy stated record keeping for destruction of controlled drugs was logged into the DON's Controlled Substance Record book, which was completed by the DON. The policy stated at the time of destruction, the DON and another licensed nurse must document destruction at the bottom of the DON's controlled substance record book.</p> <p>This policy was not followed.</p> <p>An email, dated 2/26/20, from the facility pharmacist to the DON, stated she had a concern about the release of narcotics to residents without the correct documentation. In the e-mail the pharmacist documented it appeared there was only a signature of who the controlled medication was released to and did not include the signatures of licensed nurses for verification and reconciliation.</p> <p>On 3/6/20 at 12:30 PM, three resident narcotic books were reviewed and the following residents' narcotic medication sheets were not signed off as the facility's policy directed for the reconciliation of narcotics, as follows:</p> <p>*Resident #178's record included three reconciliation logs for her unused oxycodone, 5mg each, dated 1/1/20, 1/3/20, and 1/15/20,</p>	F 684	<p>from the center will be reviewed to ensure narcotics sent with them have the logs completed with name, address, and phone number of resident /responsible party and that two licensed nurses sign for verification and reconciliation of meds before releasing.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Daily monitoring of facility discharges to ensure staff are properly documenting the disposition of narcotics. Staff will be educated to Professional standards of practice related to disposition policy/procedure on the destruction of and documenting the disposition of narcotics by DON/designee.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained: Audits of the 24 hour report, discharge log, and narcotic reconciliation log will be done by the DON/RCM's daily Monday through Friday x 12 weeks to ensure compliance. Findings will be reviewed at QAPI monthly x3 for further educational opportunities. DON/designee is responsible for compliance.</p>		

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F 684	<p>Continued From page 17</p> <p>which totaled 43 pills. At the bottom of each log was a section which stated "Disposition of Unused Medication" which included an area for the date of the disposition, the quantity of unused medication, an area for the method of disposition, an area for the staff to write the resident's name, address and telephone if the medications were released to the resident or their responsible party. The three logs documented the remaining oxycodone was released to the resident and had Resident #178's signature. The logs did not include Resident #178's complete name, address, and phone number. The logs were not signed by two licensed nurses for verification the narcotics were verified and reconciled.</p> <p>*Resident #179's record include one reconciliation log for his unused hydrocodone, 5/325 mg each, dated 2/12/20. At the bottom of the log was a section which stated "Disposition of Unused Medication" which included an area for the date of the disposition, the quantity of unused medication, an area for the method of disposition, an area for the staff to write the resident's name, address and telephone if the medications were released to the resident or their responsible party. The log had a line through it and was signed by one person, it was unclear if the signature was by a nurse or Resident #179. The log documented the remaining medication was released to Resident #179. There was no date of disposition documented on the bottom of the log.</p> <p>On 3/6/20 at 10:11 AM, LPN #1 stated he reviewed the narcotic book with the DON and they counted the narcotics, signed them off in the narcotic book, and then they both put them in the drug buster. He stated when there was a concern</p>	F 684			

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

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F 684	Continued From page 18 about a narcotic count being incorrect, they looked into it and assessed if the resident was in pain or if the resident stated they did not receive their medication.  On 3/6/20 at 11:32 AM, The DON stated when a resident was discharged, the medications were taken out of the narcotic medication cart locker and if there were any narcotics left, two nurses destroyed the medications themselves. When asked if the floor nurses destroyed narcotics, the DON said they could, but it was usually him and two RCMs. The DON was asked if the facility had a drug destruction book [as referenced in the policy], he stated there was no requirement for one and he did not have one. When asked where the staff nurses documented their narcotic destruction, he stated they log them in the narcotic log book and both sign to note the destruction on the resident's individual narcotic page. The DON was asked if the narcotics were taken out of the medication cart and held somewhere before destruction. He stated no, the narcotics stayed in the carts until they were destroyed.  On 3/6/20 at 2:30 PM, the Pharmacist said she did a 10% storage audit monthly to check documentation for controlled substances. She said she talked to the DON last month about incomplete documentation for narcotics. She said if there was only 1 nurse's signature on the log, she informed the DON, Administrator, or a charge nurse.	F 684			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)  §483.25(c) Mobility.	F 688		4/29/20	

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F 688	<p>Continued From page 19</p> <p>§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</p> <p>§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.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.</p> <p>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 a resident received restorative services through the restorative nursing program as needed. This was true for 1 of 2 residents (Resident #55) reviewed for the restorative nursing program. This failure created the potential for residents to experience a decline in Range of Motion (ROM). Findings include:</p> <p>The facility's Restorative Nursing Program policy, undated, documented the restorative program was to enable residents to attain or maintain their highest practicable level of physical functioning, and to provide restorative interventions as indicated. This policy was not followed.</p> <p>Resident #55 was readmitted to the facility on</p>	F 688	<p>F688 <input type="checkbox"/> Increase/Prevent Disease in ROM/Mobility</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #55 is receiving restorative services as indicated.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents receiving restorative therapy have the potential to be affected by this deficient practice. Past 30 days of restorative therapy referrals were reviewed for accuracy with any negative findings</p>		

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F 688	<p>Continued From page 20</p> <p>1/30/20, with multiple diagnoses including infective tenosynovitis of the left ankle and foot (an infection of a tendon and its protective sheath).</p> <p>Resident #55's physician orders, dated 1/30/20, included an order for therapy to evaluate and treat him.</p> <p>Resident #55's therapy assessment, dated 1/31/20, documented he was at a similar level of function prior to his hospital stay and he was referred to the restorative nursing aide (RNA) program to work on arm strength and using a sit-to-stand with parallel bars.</p> <p>Resident #55's therapy referral to the RNA program, dated 1/31/20, documented he was to receive upper extremity strengthening exercises with weights and therabands five days a week. The referral did not include the use of a sit-to-stand with parallel bars.</p> <p>A 5-day MDS assessment, dated 2/5/20, documented Resident #55 had limited ROM impairments in both his upper and lower extremities.</p> <p>A care conference note, dated 2/3/20, documented Resident #55 would participate in the restorative exercise program.</p> <p>An RNA progress note, dated 2/14/20, documented Resident #55 was appropriate for the RNA program.</p> <p>Resident #55's care plan, dated 2/14/20, documented he received upper extremity</p>	F 688	<p>addressed.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Daily monitoring of restorative therapy referrals to ensure residents are receiving their scheduled ROM/therapy activities. Staff will be educated to facilities policy/procedure on the Restorative Therapy program by DON/designee.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained: Audits of the Restorative Therapy Program log will be done by the Restorative Therapy Supervisor daily Monday through Friday x 12 weeks to ensure compliance. Findings will be reviewed at QAPI monthly x3 for further educational opportunities. DON/designee is responsible for compliance.</p>		

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F 688	<p>Continued From page 21</p> <p>strengthening exercises with weights and therabands five days a week.</p> <p>Resident #55's ROM activity records, dated 1/31/20 to 2/24/20, documented he was to receive upper extremity strengthening exercises with weights and therabands five days a week, Tuesday through Saturday. The referral did not include the use of a sit-to-stand with parallel bars. The record documented he received upper extremity exercises on 2/16/20 and 2/19/20. Resident #55 did not receive RNA services on 15 out of 17 opportunities.</p> <p>Resident #55's physician orders, dated 2/24/20, included an order for physical therapy.</p> <p>A therapy assessment, dated 2/24/20, documented Resident #55 was referred to therapy because he wanted to transition from the RNA program to physical therapy.</p> <p>On 3/3/20 at 11:20 AM, Resident #55 said a month prior he was on the "light" therapy program. He said he was frustrated because he had not received the therapy for two-to-three weeks. He said he complained about the lack of exercises and was working with therapy since he complained.</p> <p>On 3/6/20 at 9:57 AM, the Director of Therapy said Resident #55 was referred to the RNA program on 1/31/20. She said the referral form did not include the use of a sit-to-stand with parallel bars and said she expected it to be on the referral form. She said she expected nursing staff to follow-up on the therapy referrals and start the RNA program in a timely manner. The</p>	F 688			

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F 688	Continued From page 22 Director of Therapy said Resident #55 spoke with her and said he was not getting enough RNA services and she placed him back on the therapy program the following day (2/24/20).  On 3/6/20 at 10:13 AM, the RNA program manager said Resident #55 was added to the RNA case load on 2/14/20 from a referral from therapy and it did not document to assist him with sit-to-stand with parallel bars. She said she did not know why the referral was delayed. She said she expected RNA staff to provide ROM services as directed by therapy.	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 by: Based on record review, observation, and staff interview, it was determined the facility failed to ensure residents were provided with adequate supervision regarding the level of supervision necessary to prevent falls. This was true for 1 of 4 residents (Resident #10) reviewed for falls. This failure placed Resident #10 at risk of pain, bone fracture, brain damage and other life changing injuries as a result of falls. Findings include:  Resident #10 was admitted into the facility on	F 689	F689 <input type="checkbox"/> Free of Accident Hazards/Supervision/Devices  What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #10 is receiving adequate supervision. Care plan was reviewed for accuracy and effectiveness of fall interventions with updates made as indicated.	4/29/20	

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F 689	<p>Continued From page 23</p> <p>9/2/16, with diagnoses of cerebral infarction (stroke), hemiplegia (paralysis of one side of the body) and repeated falls.</p> <p>Resident #10's care plan, dated 9/22/17, stated interventions for falls included bilateral assist rails and a lipped mattress, keep furniture in locked position, keep needed items within reach, and he would wear appropriate non-slip shoes and/or socks at all times.</p> <p>An admission MDS assessment dated 12/6/19, documented Resident #10 was cognitively intact.</p> <p>Incident and Accident reports documented Resident #10 fell in the facility three times.</p> <p>An Incident and Accident Report, dated 9/7/19, stated Resident #10 was found on the floor next to his bed. The report stated he was attempting to self-transfer from his bed to his wheelchair. The brakes were not locked on his wheelchair and he was wearing regular socks. A fall risk evaluation, dated 9/7/19, stated Resident #10's care plan interventions to prevent falls were bilateral assist rails and a lipped mattress on his bed, ensure he was wearing appropriate footwear, non-skid socks or well-fitting shoes when ambulating or mobilizing in his wheelchair, and keep his needed items in reach. There were no changes documented in the care plan related to the 9/7/19 fall.</p> <p>An Incident and Accident Report dated 9/9/19, stated Resident # 10 was found by staff on the floor on his knees and his wheelchair was moving. The report stated Resident #10 kept pointing to the table with his books. His</p>	F 689	<p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents residing in the facility have the potential to be affected by this deficient practice. Past 30 days of accident/incident reports concerning falls were reviewed for correct, consistent, and effective fall interventions with care plan updates as indicated.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Resident falls will be reviewed daily M-F ongoing for effective interventions to assist with prevention of falls. Staff will be educated by DON/designee to facilities policy/procedure on following care plan interventions related to the level of supervision, safety devices and keeping residents free from accidents.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained: The care plan review team will review 10% of the facility care plans weekly until completed to ensure compliance. Findings will be reviewed at QAPI monthly x3 for further educational opportunities. DON/designee is responsible for compliance.</p>		

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

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F 689	Continued From page 24 wheelchair was unlocked. Resident #10's care plan interventions regarding falls were unchanged from 9/22/17.  An Incident and Accident Report dated 12/15/19, stated Resident #10 was found lying on the floor between his bed and his wheelchair. He was wearing regular socks and no shoes. The care plan interventions were unchanged from 9/22/17.  Three falls occurred after the Care Plan noted fall interventions were initiated on 9/22/17. These interventions were not implemented as follows:  * On 9/7/19 Resident #10's wheelchair was not locked and he did not have grip socks or shoes on.  * On 9/9/19, Resident #10's wheelchair was witnessed moving while he was on the floor pointing to books on his side table  * On 12/15/19 Resident #10 was found wearing regular socks without shoes.  These interventions were not implemented correctly and consistently per the fall incident documentation nor were they evaluated for effectiveness or modified for prevention of further falls.  On 3/5/2020 at 3:43 PM, the DON was asked if he expected care plans to be followed, he stated "I do, yes."	F 689			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)  §483.25(g)(4)-(5) Enteral Nutrition	F 693		4/29/20	

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F 693	<p>Continued From page 25 (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and</p> <p>§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. 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 adequate care and treatment was provided to 1 of 1 resident (Resident #27) reviewed for feeding tube use. This created the potential for harm if complications developed from improper tube feeding practices. Findings include:  The facility's Enteral Tubes policy, undated, documented staff were to follow physician orders.  This policy was not followed.  Resident #27 was readmitted to the facility on</p>	F 693	<p>F693 <input type="checkbox"/> Tube Feeding Mgmt/Restore Eating Skills</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #27 is receiving adequate care and treatment, his PEG tube was replaced by physician and placement confirmed.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents</p>		

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F 693	<p>Continued From page 26 12/20/18, with multiple diagnoses including dysphagia (difficulty swallowing).</p> <p>The manufacturer's operating manual for Resident #27's Enteral Feed and Flush Pump, revised 1/2016, documented the feed error screen appeared when the enteral formula was no longer delivered because the bag was empty or there was a clog in the line.</p> <p>Resident #27's care plan, dated 12/26/18, directed staff to administer tube feedings, and water flushes as ordered to supplement his oral intake and to monitor his tube for dysfunction or malfunction.</p> <p>Resident #27's significant change MDS assessment, dated 2/23/20, documented he was severely cognitively impaired and dependent on staff for all ADLs.</p> <p>Resident #27's physician orders, dated 2/26/20, included an order for 2 Cal nutrition formula at 35 ml per hour continuously, for a total of 340 ml in a 24 hour period.</p> <p>Resident #27's February and March 2020 MARs, documented he received 2 Cal nutrition formula 35 ml per hour continuously for a total of 840 ml to start at 5:00 PM.</p> <p>On 3/2/20 at 9:55 AM, Resident #27 was asleep in his bed in his room. The Enteral Feed and Flush Pump displayed "feed error, clog in line, valve not loaded." There was formula in the tube feed line with an empty 1,000 ml bottle of 2 Cal nutritional formula hung next to the bed. The bottle had a hand written date and time of</p>	F 693	<p>receiving enteral nutrition in the facility have the potential to be affected by this deficient practice. Residents receiving enteral nutrition were reviewed to validate physician orders are followed, and that proper tube feeding practices occur.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Daily monitoring of enteral feeding to ensure residents are receiving proper nutrition. Staff will be educated by the DON/designee to facilities policy/procedure on the monitoring of enteral feeding, dating of the bottles, what to do if the alarm sounds and proper flushing of the tube.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained: Audits of the residents receiving enteral feeding will be done by the DON/RCM□s daily Monday through Friday x 12 weeks to ensure compliance. Findings will be reviewed at QAPI monthly x3 for further educational opportunities. DON/designee is responsible for compliance.</p>		

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F 693	Continued From page 27 2/29/20 at 7:30 PM on it, almost 39 hours after the date written on the bottle.  On 3/2/20 at 10:11 AM, the surveyor alerted LPN #2 to come to Resident #27's room to assess his tube feeding pump. LPN #2 said the pump had stopped. She said the date and time on the bottle documented when it was started. She said due to the date, time, and the empty bottle, it appeared he had not received a new bottle of formula the evening of 3/1/20. LPN #2 filled up a 60 ml syringe half-way, disconnected the tube feeding, and connected the syringe to the gastrostomy tube port and attempted to complete a gravity flush without success. She then used the plunger on the syringe and attempted to push water through and it was unsuccessful. LPN #2 said only a scant amount of water went through the port and she would notify the RCM or the DON about the clogged tube.  On 3/2/20 at 12:06 PM, LPN #2 said her shift started at 6:00 AM that morning and had not been in Resident #27's room prior to being alerted by the surveyor.  On 3/6/20 at 9:17 AM, RCM #1 said she expected nurses to check on Resident #27's feeding pump every two hours and expected nurses to follow physician orders regarding his free water flushes to his feeding tube.	F 693			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)  §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:	F 732		4/29/20	

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F 732	<p>Continued From page 28</p> <p>(i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of daily staffing records, and staff interview, it was determined the facility failed to ensure nurse staffing information was posted daily, at the beginning of</p>	F 732	<p>Deficiencies related to F 732 1. Correction/s as it relates to the resident/s:</p>		

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F 732	<p>Continued From page 29</p> <p>each shift, and was complete. This failed practice had the potential to affect the 72 residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include:</p> <p>On 3/4/20 at 9:04 AM, the daily nurse staffing information was observed in the hallway near the nurses' station. The posted information was for the night, day, and evening shift, and documented the following:</p> <ul style="list-style-type: none"> <li>* Night Shift: CNAs - 4 for a total of 30 hours, LPNs - 2 for a total of 16 hours</li> <li>* Day Shift: CNAs - 9 and transportation driver - 1 for a total of 75 hours, LPNs - 3 for a total of 24 hours, and RNs - 1 for a total of 8 hours</li> <li>* Evening Shift: CNAs - 7 for a total of 52.5 hours, LPNs - 2 for a total of 16 hours, and RNs - 1 for a total of 8 hours</li> <li>* The facility's census was 69</li> </ul> <p>On 3/6/20 at 2:17 PM, the daily nurse staffing information was observed in the hallway near the nurses' station. The posted information was for the night, day, and evening shift, and documented the following:</p> <ul style="list-style-type: none"> <li>* Night Shift: CNAs - 3 for a total of 22.5 hours and LPNs - 2 for a total of 16 hours</li> <li>* Day Shift: CNAs - 9 and transportation driver - 1 for a total of 75 hours, LPNs - 3 for a total of 24 hours, and RNs - 1 for a total of 8 hours</li> <li>* Evening Shift: CNAs - 8 for 60 hours, LPNs - 3 for 24 hours, and RNs - 1 for 8 hours</li> <li>* The facility's census was 68</li> </ul> <p>The Nurse Staffing postings were not posted at</p>	F 732	<p>No specific resident was identified.</p> <p>2. Action/s taken to protect residents in similar situations: All current residents have the potential to be affected by this deficient practice.</p> <p>3. Measures taken or systems altered to ensure that solutions are sustained: The Executive Director/Designee has educated the Staffing Coordinator, Director of Nursing and Licensed Nurses on the appropriate completion of the Nurse Staff Postings.</p> <p>4. Plans to monitor performance to ensure solutions are sustained and person responsible: The Executive Director or Staffing Coordinator will audit weekly for 12 weeks to assure on-going compliance and report findings and recommendations to the QAPI committee monthly.</p> <p>5. Who will be responsible for ensuring compliance: ED</p>		

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F 732	Continued From page 30 the beginning of each shift and the van driver was included under the CNA section for total hours.  The Nurse Staffing postings from 2/1/20 to 3/6/20 were reviewed. The postings included the transportation driver for 2/1/20 to 2/6/20, 2/11/20, 2/12/20, 2/17/20, 2/25/20 to 2/28/20, and 3/3/20.  On 3/6/20 at 2:22 PM, the Staffing Coordinator said she was told she could post the van driver on the nurse posting because that person was a CNA. She said the van driver did not work as a CNA on the floor on the days she was listed as transportation. She said on the night shift the nurse posted all of the shifts for the day.  On 3/6/20 at 2:42 PM, the Administrator and the Regional Vice-President said they thought the van driver could be counted on the posting because that person was a CNA and provided cares to residents she transported. They said they thought all of the shifts could be posted at the same time.	F 732			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(2) For excessive duration; or  §483.45(d)(3) Without adequate monitoring; or	F 757		4/29/20	

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F 757	<p>Continued From page 31</p> <p>§483.45(d)(4) Without adequate indications for its use; or</p> <p>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents were free from unnecessary drugs. This was true for 1 of 5 residents (Resident #50) reviewed for unnecessary medications. This deficient practice created the potential for adverse consequences if residents received duplicate medications and were not monitored for harmful side effects. Findings include:</p> <p>Resident #50 was admitted to the facility on 8/31/17, with multiple diagnoses including Parkinson's Disease (a progressive disease of the nervous system that affects movement) and depression.</p> <p>A quarterly MDS assessment, dated 1/30/20, documented Resident #50 had moderate cognitive impairment.</p> <p>A consultation report from the pharmacy, dated 1/22/20, stated Resident #50 had orders for duplicate therapy for the medications Oxybutynin ER (a medication used to relax bladder smooth muscle) and Myrbetriq (a medication used to</p>	F 757	<p>F757 <input type="checkbox"/> Drug Regimen is Free from Unnecessary Drugs</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Medication review completed for resident #50.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents residing in the facility have the potential to be affected by this deficient practice. Orders will be reviewed for accuracy and timely completion. DNS will educate RCMs on triaging timely response to pharmacy recommendations with focus on those recommendations regarding duplicate therapy and or dosing.</p> <p>Measures in place and what systemic changes will be made to ensure that the</p>		

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F 757	Continued From page 32 relax bladder smooth muscle). The consult stated a follow up with the nephrologist was needed to determine which of these medications Resident #50 should take.  A fax, dated 1/23/20 at 11:37 AM, was sent from the facility to Resident #50's nephrologist requesting clarification on the Oxybutynin ER and Myrbetriq orders. On 2/5/20 the nephrologist replied to stop both medications. The facility received the order on 2/6/20 and the medication was stopped on 2/6/20, 11 days after the consultation report from the pharmacy requesting clarification.  On 3/6/20 at 3:36 PM, the DON stated when the clarification from the pharmacist was requested he expected the nurse to call the physician to follow-up before the end of the week.	F 757	deficient practice does not recur: Daily monitoring of physician orders to ensure all orders are being completed accurately and without delay. Staff will be educated to facilities policy/procedure on the processing of physician orders. DNS will educate the RCMs on the appropriate triaging of pharmacy recommendations to assure those related to dosing or duplicate issues are resolved within 24 hours.  How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained: Audits of the physician's orders/pharmacy recommendations be done by the DON/RCMs daily Monday through Friday x 12 weeks to ensure compliance. Findings will be reviewed at QAPI monthly x3 for further educational opportunities. DON/designee is responsible for compliance.		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)  The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure insulin was administered as ordered and at the appropriate time for 3 of 6 residents (#39, #63, and #65) who were reviewed for diabetic management. This failure placed the residents at risk of their insulin being less effective and the	F 760	Deficiencies related to F 760 1. Correction/s as it relates to the resident/s: Unable to correct for Residents #39, #63 and #65 as events occurred in the past. No negative outcomes were	4/29/20	

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F 760	<p>Continued From page 33</p> <p>therapeutic dose at low or high levels which may increase the risk of high or low blood sugar. Findings include:</p> <p>The facility's Medication Administration policy, undated, stated the licensed nurse checked the following to administer medication: Right medication, Right dose, Right route, Right resident, and Right time.</p> <p>The Food and Drug Administration website, accessed on 3/17/20, documented the following: * Rapid-acting insulin starts working within 15 minutes after use. It is mostly out of the body after a few hours and should be taken just before or just after eating. * Long-acting insulin starts working within 2 to 4 hours after use and it could last in the body for up to 24 hours. It is often used in the morning or at bedtime to help control blood sugar throughout the day.</p> <p>The facility's Flexible Medication Pass Policy, undated, documented the following guidelines for medication administration, unless otherwise indicated by the nature of the medication: * AM (morning) - Medications were to be administered between 6:00 AM and 10:00 AM * HS (bedtime) - Medications were to be administered between 8:00 PM and 10:00 PM</p> <p>1. Resident #39 was admitted to the facility on 5/4/18, with multiple diagnoses including Type 2 diabetes mellitus with diabetic nerve damage, and long-term use of insulin.</p> <p>Resident #39's annual MDS assessment, dated 1/2/20, documented he was moderately</p>	F 760	<p>identified as a result of the untimely insulin administration documentation.</p> <p>2. Action/s taken to protect residents in similar situations: All other residents with insulin orders have the potential for the deficient practice and MAR were reviewed to determine compliance and no negative outcomes were identified.</p> <p>3. Measures taken or systems altered to ensure that solutions are sustained: DNS/designee reviewed process of medication administration with all Licensed Nurses to assure insulin is administered and documented within the prescribed timeframes.</p> <p>4. Plans to monitor performance to ensure solutions are sustained and person responsible: DNS/designee will review insulin administration daily 5 times a week for 4 weeks then weekly for 4 weeks then monthly for 3 months and report findings/recommendations to the QAPI committee for ongoing compliance.</p> <p>5. Who will be responsible for ensuring compliance: DNS</p>		

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F 760	<p>Continued From page 34</p> <p>cognitively impaired and received insulin.</p> <p>Resident #39's Medication Orders, as of 3/6/20, documented:</p> <ul style="list-style-type: none"> <li>* Lantus Solution (long-acting insulin) 30 units to be given via injection at bedtime.</li> <li>* Lantus Solution 40 units to be given via injection in the morning.</li> </ul> <p>The MARs for January and February 2020 documented Resident #39's Lantus was not given between 6:00 AM and 10:00 AM and between 8:00 PM and 10:00 PM. Examples include:</p> <ul style="list-style-type: none"> <li>* The MAR for January 2020 documented the Lantus scheduled to be given in the morning was administered at the following times: <ul style="list-style-type: none"> <li>- On 1/3/20, administered at 11:45 AM</li> <li>- On 1/6/20, administered at 11:36 AM</li> <li>- On 1/7/20, administered at 11:21 AM</li> <li>- On 1/9/20, administered at 12:14 PM</li> <li>- On 1/16/20, administered at 12:31 PM</li> <li>- On 1/17/20, administered at 12:13 PM</li> <li>- On 1/23/20, administered at 1:11 PM</li> <li>- On 1/31/20, administered at 12:16 PM</li> </ul> </li> <li>* The MAR for January 2020 documented the Lantus scheduled to be given at bedtime was administered at the following times: <ul style="list-style-type: none"> <li>- On 1/11/20, administered at 10:28 PM</li> <li>- On 1/12/20, administered at 10:21 PM</li> <li>- On 1/18/20, administered at 10:37 PM</li> <li>- On 1/22/20, administered at 10:34 PM</li> <li>- On 1/26/20, administered at 10:17 PM</li> <li>- On 1/27/20, administered at 10:59 PM</li> <li>- On 1/28/20, administered at 10:22 PM</li> </ul> </li> </ul>	F 760			

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F 760	<p>Continued From page 35</p> <p>- On 1/29/20, administered at 10:42 PM</p> <p>* The MAR for February 2020 documented the Lantus scheduled to be given at bedtime was administered at the following times:</p> <p>- On 2/5/20, administered at 10:52 PM</p> <p>- On 2/8/20, administered at 11:05 PM</p> <p>On 3/4/20 at 2:42 PM, LPN #2 reviewed Resident #39's MARs. LPN #2 said she documented the insulin for Resident #39 at the end of the day. LPN #2 said she had to document at the end of the day on several occasions because she "runs out of time."</p> <p>2. Resident #63 was readmitted to the facility on 8/2/19, with multiple diagnoses including Type 2 diabetes mellitus with diabetic nerve damage on one side.</p> <p>Resident #63's quarterly MDS assessment, dated 2/9/20, documented he was cognitively intact and received insulin.</p> <p>Resident #63's record included an order for Insulin Glargine (long-acting insulin) 60 units to be given via injection at bedtime.</p> <p>Resident #63's January 2020 MAR documented his Insulin Glargine was not administered as ordered at bedtime. On 1/18/20, the Glargine was scheduled for 7:00 PM and was administered at 11:00 PM</p> <p>Resident #63's February 2020 MAR documented his Insulin Glargine was not administered at bedtime, as follows:</p> <p>- On 2/3/20, administered at 11:01 PM</p>	F 760			

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F 760	<p>Continued From page 36</p> <ul style="list-style-type: none"> <li>- On 2/19/20, administered at 10:38 PM</li> <li>- On 2/26/20, administered at 10:31 PM</li> </ul> <p>Resident #63's March 2020 MAR documented his Insulin Glargine was not administered as ordered at bedtime. On 3/3/20, the Glargine was scheduled for 7:00 PM and was administered at 10:06 PM</p> <p>3. Resident #65 was admitted to the facility on 2/8/19, with multiple diagnoses including Type 2 diabetes mellitus with diabetic nerve damage and heart disease.</p> <p>Resident #65's annual MDS assessment, dated 2/19/20, documented she was cognitively intact and received insulin.</p> <p>Resident #65's Medication Orders documented:</p> <ul style="list-style-type: none"> <li>* Bydureon (a non-insulin medicine that helps to stabilize blood sugar) 2 mg to be given via injection in the morning every Friday.</li> <li>* Novolog (rapid-acting insulin) to be given via injection per sliding scale before meals and at bedtime for diabetes.</li> <li>* Basaglar (long-acting insulin) 75 units to be given via injection at bedtime.</li> </ul> <p>Resident #65's January 2020 MAR documented she received two doses of Novolog within a minute of each other on 1/7/20 at 1:22 PM and 1:23 PM. The MAR documented the breakfast dose was administered at 1:23 PM after the lunch dose, which was documented as given at 1:22 PM.</p>	F 760			

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F 760	Continued From page 37  The January 2020 and February 2020 MARs documented Bydureon was not administered each Friday between 6:00 AM and 10:00 AM as ordered. On 1/24/20 it was administered at 11:46 AM, on 2/7/20 it was administered at 2:39 PM, and on 2/28/20 it was administered at 12:04 PM.  On 3/3/20 at 1:53 PM, LPN #1 reviewed Resident #65's MARs. LPN #1 said he documented the insulin when he had time during or at the end of his shift. He said he should document when he administered the medication.  On 3/4/20 at 2:50 PM, the DON said he expected staff to document at the time of insulin administration. He reviewed Resident #39's, Resident #63's, and Resident #65's MARs for January, February, and March and said the insulin administration times were documented later than what the physician orders stated. He said the documented administration times of several hours late was not acceptable.  On 3/6/20 at 9:56 AM, the facility's Physician's Assistant said he expected the insulin to be given as ordered in a specific time frame otherwise it could cause false blood sugar readings and inaccurate dosing of insulin which can lead to low or high blood sugar.  On 3/6/20 at 2:27 PM, the Pharmacist said she expected Lantus and Levemir (long-acting insulin) to be consistently given at the same time. The Pharmacist said that if the insulin was not documented accurately it could lead to medication being omitted or given twice.	F 760			
F 790	Routine/Emergency Dental Srvcs in SNFs	F 790		4/29/20	

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F 790 SS=D	Continued From page 38 CFR(s): 483.55(a)(1)-(5)  §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care.  §483.55(a) Skilled Nursing Facilities A facility-  §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;  §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;  §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;  §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and  §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental	F 790			

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F 790	<p>Continued From page 39</p> <p>services and the extenuating circumstances that led to the delay.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on policy review, record review, and resident and staff interview, it was determined the facility failed to ensure a resident was provided dental services. This was true for 1 of 2 residents (Resident #10) reviewed for dental services. This failure created the potential for harm if residents experienced weight loss due to inability to chew food or increased mouth pain from poor fitting dentures. Findings include:</p> <p>The facility's dental services referral policy, undated, documented the Social Service department worked to assist residents with routine dental services, appointments, and arranging transportation. The policy stated all dental interventions were documented in the medical record.</p> <p>Resident #10 was admitted into the facility on 9/2/16, with diagnoses of cerebral infarction (stroke), hemiplegia (paralysis of one side of the body) and aphasia (loss of ability to understand or express speech).</p> <p>An admission MDS assessment, dated 9/9/16, documented Resident #10 had no natural teeth and he was cognitively intact.</p> <p>Resident #10's care plan, revised on 12/3/19, documented he was able to clean his dentures after set up with one person assist and he was to receive complete mouth inspections daily. The care plan also documented the facility would coordinate arrangements for dental care, and</p>	F 790	<p>Deficiencies related to F 790</p> <ol style="list-style-type: none"> <li>Correction/s as it relates to the resident/s: Resident #10 interviewed to determine dental needs as resident currently is edentulous and wears dentures.</li> <li>Action/s taken to protect residents in similar situations: Social Services will interview residents for dental needs and coordinate dental appointments as identified for all current residents.</li> <li>Measures taken or systems altered to ensure that solutions are sustained: Social Services will interview resident regarding dental needs during quarterly care conferences and coordinate appointments/care as identified and document efforts in the medical record. Director of Nursing Services/Designee to conduct education re: dental needs and services.</li> <li>Plans to monitor performance to ensure solutions are sustained and person responsible: Social Services will randomly audit 10% of the population for dental inquiries and coordination on a monthly basis for 3 months and report to the QAPI Committee for ongoing compliance and recommendations.</li> <li>Who will be responsible for</li> </ol>		

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F 790	Continued From page 40 transportation to dental appointments as needed.  Resident #10's record documented he had no dental appointments from 2016 to present. No dental visits were documented in his progress notes since admission. There was also no documentation in Resident #10's record from a dentist.  Resident #10's transportation documentation had no record of transportation to a dental appointment.  On 3/3/20 at 10:53 AM, Resident #10 was asked if he wanted to see a dentist for care and he stated "yes."  On 3/5/20 at 4:03 PM, the DON stated the staff documented dental concerns and if there was a recommendation from the physician or provider the facility sent residents to the dentist.	F 790	ensuring compliance: SSD		
F 804 SS=F	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 policy review, test tray evaluation, and resident and staff interview, it was determined the facility failed to ensure palatable food was	F 804	Deficiencies related to F 804 1. Correction/s as it relates to the	4/29/20	

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F 804	<p>Continued From page 41</p> <p>served. This was true for 13 of 16 residents (#4, #8, #10, #15, #23, #42, #45, #48, #51, #63, #65, #70, and #176) reviewed for food and nutrition, and had the potential to affect all residents in the facility. This created the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include:</p> <p>The facility's Food Quality and Palatability policy, dated 9/2017, documented food was to be palatable and served at an appetizing temperature.</p> <p>This policy was not followed.</p> <p>Residents were interviewed individually regarding the food served at the facility, and they responded as follows:</p> <p>* On 3/2/20 at 11:20 AM, Resident #45 said she thought a new contractor took over managing the kitchen and since then the food quality and taste had gotten bad.</p> <p>* On 3/2/20 at 11:55 AM, Resident #176 said the quality of food was bad.</p> <p>* On 3/2/20 at 2:45 PM, Resident #51 said the food was cold and tasted bad. He said sometimes there was too much garlic and other times the food was bland.</p> <p>* On 3/3/20 at 10:55 AM, Resident #10 said the food was not good.</p> <p>* On 3/3/20 at 11:39 AM, Resident #65 said the food was "awful" most of the time and sometimes had to ask for an alternate because the meat was tough.</p> <p>* On 3/3/20 at 2:54 PM, Resident #70 said the food was "gross."</p>	F 804	<p>resident/s:</p> <p>Resident #51 and 176 no longer resides at facility. Residents # 45, 10, 65, 70, 4, 8, 15, 42 and 63 will be interviewed by the Nutrition Services Manager for specific concerns re: palatability and preferences.</p> <p>2. Action/s taken to protect residents in similar situations: Over the next 30 days the Account Manager will conduct food satisfaction surveys with all other interviewable residents to determine areas for improvement not already identified.</p> <p>3. Measures taken or systems altered to ensure that solutions are sustained: Dietary educated re: palatability issues and importance of maintaining food temps through the delivery process. Nursing staff educated re: timely delivery of meals with focus on impact on food temps. This education conducted by the Account Manager, for dietary services.</p> <p>4. Plans to monitor performance to ensure solutions are sustained and person responsible: Account Manager/RD will conduct test trays 3 x weekly for 3 weeks, then 2 x weekly for 2 weekly and then weekly thereafter- ongoing.</p> <p>5. Who will be responsible for ensuring compliance: Account Manager</p>		

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F 804	Continued From page 42 On 3/3/20 at 2:58 PM, during the Resident Group interview, Residents #4, #8, #15, #23, #42, #48, #63, #65, and #176 said they did not like the food and it was often served cold.  On 3/4/20 at 12:07 PM, the test tray was evaluated by two surveyors along with the CDM and the RD. The turkey was 134.6 degrees Fahrenheit (F), the green beans were 111.9 degrees F, and the sweet potato souffle was 120 degrees F. The CDM said the turkey was palatable with the cranberry sauce. The surveyors determined the turkey was flavorless without the cranberry sauce. The CDM and RD said the green beans were warm. The surveyors determined the green beans were crunchy and not hot enough. The surveyors determined the sweet potato souffle was not hot enough.	F 804			
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2)  §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician.  §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. 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 a physician ordered diet was served to a resident. This was true for 1 of 6 residents (Resident #68) reviewed for altered diets. This failure created the	F 808	Deficiencies related to F 808 1. Correction/s as it relates to the resident/s: Resident 68 no longer resides in the facility.	4/29/20	

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F 808	<p>Continued From page 43</p> <p>potential for harm if residents did not receive adequate nutritional intake due to incorrect diets. Findings include:</p> <p>The facility's meal policy, dated 9/2017, documented meals were to be served according to the individualized diet order and nursing staff were responsible for verifying meal accuracy.</p> <p>This policy was not followed.</p> <p>Resident #68 was admitted to the facility on 2/14/20, with multiple diagnoses including end stage renal disease.</p> <p>Resident #68's care plan, dated 2/18/20, directed staff to serve his diet as ordered for adequate nutritional intake.</p> <p>Resident #68's nutrition evaluation, dated 2/22/20, documented he required a high protein diet for hemodialysis.</p> <p>Resident #68's physician orders, dated 3/2/20, documented he was to receive a renal diet with double protein.</p> <p>Resident #68's tray tickets, dated 3/2/20 and 3/4/20, documented he was to receive a renal diet with double protein.</p> <p>On 3/2/20 at 11:10 AM, Resident #68 said he was on dialysis and needed extra protein. He said "it's been a battle" to receive the correct diet because the kitchen was not reading his tray tickets and he had to send food back for the correct renal diet.</p>	F 808	<p>2. Action/s taken to protect residents in similar situations: Account Manager reviewed current therapeutics diets ordered with dietary staff members to assure understanding of diet requirements.</p> <p>3. Measures taken or systems altered to ensure that solutions are sustained: Account Manager educated dietary team on therapeutic diets and tray accuracy at point of service for all residents.</p> <p>4. Plans to monitor performance to ensure solutions are sustained and person responsible: RD or Account Manager will conduct tray accuracy audits daily Monday thru Friday for 3 weeks then 3 x weekly for two weeks, and continue weekly audits ongoing. Account Manager will report findings monthly to the QAPI Committee for ongoing compliance.</p> <p>5. Who will be responsible for ensuring compliance: Account Manager</p>		

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F 808	Continued From page 44 On 3/4/20 at 8:17 AM, Resident #68's tray was observed with two empty plates with remnants of eaten food. His tray ticket documented the protein was scrambled eggs. He said he had not received a double portion of eggs that morning and had to request additional eggs which was why he had the additional plate.  On 3/4/20 at 11:55 AM, Resident #68 was in his room when his lunch tray was delivered. His tray ticket documented a renal diet with double protein. The documented protein was turkey. On his plate were two small slices of turkey. Each slice was approximately 1/4 to 1/2-inches thick, 2-inches wide, and 3-inches long.  On 3/4/20 at 12:15 PM, a test tray evaluation was conducted with the CDM and RD present. The test tray had the double protein diet of two slices of turkey. The CDM and RD said each turkey slice was approximately 1/4 to 1/2-inches thick, 3-inches wide, and 4-inches long. The RD said residents with double protein should have received two pieces of turkey that were the same size as the test tray (Resident #68 received two-thirds of the recommended portion of protein).  On 3/4/20 at 3:14 PM, the CDM said she expected staff to serve Resident #68's diet as ordered.	F 808			
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4)  §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services	F 849		4/29/20	

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F 849	<p>Continued From page 45</p> <p>through an agreement with one or more Medicare-certified hospices.</p> <p>(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.</p> <p>§483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:</p> <p>(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.</p> <p>(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:</p> <p>(A) The services the hospice will provide.</p> <p>(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.</p> <p>(C) The services the LTC facility will continue to provide based on each resident's plan of care.</p> <p>(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.</p> <p>(E) A provision that the LTC facility immediately notifies the hospice about the following:</p> <p>(1) A significant change in the resident's physical,</p>	F 849			

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F 849	Continued From page 46 mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.	F 849			

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F 849	<p>Continued From page 47</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.</p> <p>The designated interdisciplinary team member is responsible for the following:</p> <p>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.</p> <p>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.</p> <p>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's</p>	F 849			

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F 849	<p>Continued From page 48</p> <p>attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.</p> <p>(iv) Obtaining the following information from the hospice:</p> <p>(A) The most recent hospice plan of care specific to each patient.</p> <p>(B) Hospice election form.</p> <p>(C) Physician certification and recertification of the terminal illness specific to each patient.</p> <p>(D) Names and contact information for hospice personnel involved in hospice care of each patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to</p>	F 849	Deficiencies related to F 849		

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F 849	<p>Continued From page 49</p> <p>ensure there were orders for hospice care, that care was coordinated with a hospice provider, and duties of the hospice provider and the facility were delineated. This was true for 1 of 2 residents (Resident #27) reviewed for hospice care and services. This failure placed residents at risk of receiving inadequate and inappropriate care and services. Findings include:</p> <p>The facility's Hospice policy, undated, documented the facility was to coordinate the plan of care with the hospice agency, to coordinate the provision of medications as needed to manage terminal illness and related conditions, and to delineate what services hospice provided and what services the facility provided.</p> <p>This policy was not followed.</p> <p>Resident #27 was readmitted to the facility on 12/20/18, with multiple diagnoses including convulsions.</p> <p>The hospice service agreement for Resident #27's hospice provider, dated 6/7/18, documented the facility and hospice provider would develop a coordinated plan of care.</p> <p>Resident #27's hospice election form for a local hospice provider was signed by his guardian on 2/11/20.</p> <p>Resident #27's record did not include a physician order for hospice or a delineation of care and services provided.</p> <p>Resident #27's hospice plan of care, dated</p>	F 849	<ol style="list-style-type: none"> <li>Correction/s as it relates to the resident/s: Resident #27 medical record was updated to include hospice orders /delineation of duties and care plan update.</li> <li>Action/s taken to protect residents in similar situations: No other residents are currently accessing their hospice benefit.</li> <li>Measures taken or systems altered to ensure that solutions are sustained: Social Services, Resident Care Coordinators and LN educated by the Director of Nursing Services/Designee regarding hospice services with focus on orders/delineation and care plan review.</li> <li>Plans to monitor performance to ensure solutions are sustained and person responsible: DNS/designee will conduct audit of each new hospice record to assure all components are within compliance and report monthly x 3 months to the QAPI Committee with results and recommendations.</li> <li>Who will be responsible for ensuring compliance: DNS</li> </ol>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135053</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/06/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>IVY COURT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814</b>		
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F 849	<p>Continued From page 50</p> <p>2/11/20, documented medications were obtained through the hospice pharmacy.</p> <p>Resident #27's care plan, dated 2/12/20, directed staff to obtain orders through hospice, alert the hospice provider for resident changes, and provide end of life care. The care plan did not include documentation of the detailed responsibilities or care provided between the facility and the hospice agency.</p> <p>Resident #27's significant change MDS assessment, dated 2/23/20, documented he received hospice services.</p> <p>On 3/4/20 at 4:44 PM, LPN #2 said the hospice pharmacy provided some of Resident #27's medications.</p> <p>On 3/4/20 at 4:56 PM, LPN #3 said hospice staff came to the facility one-to-two times a week to provide cares for Resident #27 and the coordinated information could be found in his record. She said his hospice physician was responsible for his medications related to hospice and were filled by the hospice pharmacy.</p> <p>On 3/5/20 at 1:19 PM, the DON said he could not find physician orders to admit Resident #27 into hospice and expected staff to obtain an order for hospice.</p> <p>On 3/5/20 at 1:30 PM, the Regional Nurse said there was not a delineation of duties in Resident #27's record. She said she expected more information regarding who was responsible for his care and his medications in his record.</p>	F 849			
F 867	QAPI/QAA Improvement Activities	F 867			4/29/20

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F 867 SS=F	<p>Continued From page 51 CFR(s): 483.75(g)(2)(ii)</p> <p>§483.75(g) Quality assessment and assurance.</p> <p>§483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the QAPI (Quality Assessment Performance Improvement) plan, review of allegations of abuse, review of the QAPI meeting minutes, and resident and staff interviews, it was determined the facility failed to take actions to identify, track performance, and to resolve systemic problems. These failed practices directly impacted 9 out of 23 residents (#27, #39, #63, #65, #176, #177, #178, and #179), and had the potential to affect all residents residing in the facility. As a result, the facility failed to implement improvement actions to resolve identified insufficient quality control measures regarding diabetic management, narcotic medication controls, abuse investigations, and infection control outcomes. Findings include:</p> <p>The facility's QAPI plan, dated 2/2019, directed the QAPI committee to do the following:</p> <ul style="list-style-type: none"> <li>* Take a proactive approach to improve resident care.</li> <li>* Incorporate QAPI principles to achieve performance improvement goals.</li> <li>* Establish goals that are specific, measurable, attainable, relevant, and time bound.</li> <li>* Monitor care and services, drawing data from</li> </ul>	F 867	<p>Deficiencies related to F867</p> <ol style="list-style-type: none"> <li>1. Correction/s as it relates to the resident/s: No specific resident was identified.</li> <li>2. Action/s taken to protect residents in similar situations: All residents have potential to be effected by this deficient practice.</li> <li>3. Measures taken or systems altered to ensure that solutions are sustained: Facility Managers educated on expectations of the QAA and QAPI process, specifically to include the development of appropriate plans of action to correct quality deficiencies.</li> <li>4. Plans to monitor performance to ensure solutions are sustained and person responsible: Regional staff will review monthly minutes of the QAPI Committee for 3 months to assure the QAPI is being followed according to the QAPI plan.</li> <li>5. Who will be responsible for ensuring compliance: Executive Director</li> </ol>		

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F 867	<p>Continued From page 52 multiple sources.</p> <ul style="list-style-type: none"> <li>* Demonstrate proficiency using root cause analysis.</li> <li>* Conduct on-going evaluations or assessments of its performance improvement efforts to determine achievement of intended goals.</li> <li>* Revise goals if benchmarks were not achieved, attained or sustained.</li> </ul> <p>This plan was not followed.</p> <p>The facility's QAPI minutes from 5/30/19 to 2/27/20 were reviewed.</p> <p>a. The QAPI meeting minutes, dated 5/30/19, documented, "F610 100% of accidents and incidents in April were completed within 5-day parameter." The QAPI minutes from 6/27/19, 7/25/19, 8/22/19, 9/29/19, 10/24/19, 11/21/19, 12/19/19, 1/22/20, and 2/27/20 did not include F610 or abuse reporting and investigations as a QAPI item. The facility was cited for F610 on 1/10/19.</p> <p>Please refer to F610 where the facility failed to ensure a resident's (#65) allegation of abuse was thoroughly investigated and F600 where the facility failed to ensure a resident was free from intimidation when reporting abuse (Resident #176).</p> <p>b. The QAPI meeting minutes, dated 11/21/19, documented under infection control, "Process identified and being resolved." The minutes did not document what was identified, what was being resolved, and/or what goals were in place that were specific, measurable, attainable, relevant, and time bound.</p>	F 867			

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F 867	<p>Continued From page 53</p> <p>The QAPI meeting minutes, dated 12/19/19, documented an infection control summary which included different types of infections in the facility and where they were located. There was no action plan to address the infection control concerns or identify a root cause analysis for the infections.</p> <p>Please refer to F880 where the facility failed to ensure nursing staff followed hand hygiene practices which affected Resident #27 and had the potential to affect other residents in the facility.</p> <p>c. The QAPI meeting minutes, dated 1/22/20, documented a QAPI plan for blood glucose management. The concern was identified and dated 1/9/20. The issue documented staff were failing to complete physician notification with documentation of blood glucose outside of parameters. The root cause was attributed to staff knowledge deficits. The action plan was to educate nurses and review orders for necessity and completeness. The minutes documented the completion date was 1/14/20. The plan did not identify what monitors were put into place and what measurable efforts would be assessed to attain and maintain compliance.</p> <p>The 2/27/20 minutes did not include blood glucose as a QAPI item or documentation of follow through.</p> <p>Please refer to F760 where nursing staff failed to document the administration of insulin within 60 minutes of the prescribed time and/or following a blood glucose reading requiring insulin for</p>	F 867			

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F 867	<p>Continued From page 54 residents (#39, #63, and #65).</p> <p>d. An email from the pharmacist to the DON, dated 2/26/20, documented the pharmacist identified a concern with narcotics that were sent home with residents. The pharmacist documented the narcotic ledger should include the contact information of who the medications were released to and not just a signature of the person receiving them which was the process at that time.</p> <p>The QAPI minutes from 5/30/19, 6/27/19, 7/25/19, 8/22/19, 9/29/19, 10/24/19, 11/21/19, 12/19/19, 1/22/20, and 2/27/20 did not include medications which were sent home with residents or narcotic destruction procedures were identified as concerns.</p> <p>Please refer to F684 where the facility failed to keep accurate narcotics records for 3 residents (#177 and #179) and failed to follow the facility's protocol related to destruction of narcotics.</p> <p>On 3/6/20 at 3:35 PM, the Administrator said the QAPI committee focused on F610 related to making sure the facility had abuse allegations completed within 5-days and had three people reviewing each investigation. She said she thought the facility was in compliance based on the process that was in place. The Administrator said the QAPI process had not identified a lack of thorough abuse investigations. She said infection control concerns were reviewed in QAPI and said hand hygiene had not been discussed as an agenda item. The Administrator said she was aware clinical staff discussed missed medications in their daily meeting and said</p>	F 867			

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F 867	Continued From page 55 medication administration and insulin concerns were not being discussed or followed-up in QAPI. She said narcotic medication controls had not been brought up until the end of February.	F 867		
F 880 SS=E	The facility failed to ensure an effective QAPI program was implemented and maintained to address identified concern areas.  Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		4/29/20

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F 880	<p>Continued From page 56</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p>	F 880			

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F 880	<p>Continued From page 57</p> <p>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 appropriate hand hygiene was performed. This was true for 1 of 18 residents (Resident #27) reviewed for infection control practices and 3 staff members (CNA #3, CNA #4, and LPN #2) and had the potential to affect all residents in the facility. This deficient practice created the potential for harm if residents experienced infections from cross contamination. Findings include:</p> <p>The facility's policy for Hand Hygiene, revised 1/2017, directed staff to wash hands with soap and water when visibly soiled and to use an alcohol-based hand rub for routine decontamination of hands when not visibly soiled, including:</p> <ul style="list-style-type: none"> <li>* Before having direct contact with residents.</li> <li>* After touching body fluids.</li> <li>* During resident care if moving from a contaminated-body site to a clean-body site.</li> <li>* After removal of gloves.</li> </ul> <p>This policy was not followed.</p> <p>1. Resident #27 was readmitted to the facility on 12/20/18, with multiple diagnoses including dysphagia (difficulty swallowing).</p> <p>On 3/2/20 at 10:11 AM, LPN #2 was observed while attempting to flush Resident #27's gastrostomy tube (a tube inserted through the abdomen that brings nutrition directly to the stomach). LPN #2 sanitized her hands and</p>	F 880	<p>F880 <input type="checkbox"/> Infection Prevention &amp; Control</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #27 assessed for any adverse effects with none noted.</p> <p>How you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken: Residents residing in the facility have the potential to be affected by this deficient practice. Hand washing audits and education provided to staff. Licensed Nurses also trained regarding needed hand hygiene through out the enteral feeding process by the DNS/designee.</p> <p>Measures in place and what systemic changes will be made to ensure that the deficient practice does not recur: Daily monitoring of hand washing to ensure staff is cleaning and sanitizing hands per policy and random monitoring during the enteral feeding process.</p> <p>How the facility plans to monitor performance to ensure the corrective actions are effective and compliance is sustained: Hand washing audits will be done daily Monday through Friday x 12 weeks to ensure compliance. Findings will be reviewed at QAPI monthly x3 for further educational opportunities.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	<p>Continued From page 58</p> <p>donned gloves as she entered Resident #27's room. With her gloved right hand, she pulled on the light cord for the light at the head of the bed. LPN #2 then touched Resident #27's tube feed bottle with both hands without changing her gloves or performing hand hygiene. She then picked up the call light off of the floor using both hands and laid it on the bed. LPN #2 next picked up the water flush container off of the bedside table went to the sink and turned it on with her left gloved hand to fill the container. LPN #2 did not change her gloves or perform hand hygiene. She brought the container back to the table and opened a package containing a clean 60 ml syringe. With the same gloved hands, LPN #2 disconnected Resident #27's tube feeding catheter from the gastrostomy tube and connected the syringe to the tube using her left gloved hand to handle the port and her right gloved hand to handle the syringe and then attempted to flush the gastrostomy tube using gravity. LPN #2 then retrieved more water from the sink without changing her gloves or performing hand hygiene. She then reconnected the syringe to the gastrostomy tube and attempted to flush the tube using the syringe plunger. LPN #2 said the tube was clogged and reconnected the tube feed to Resident #27's gastrostomy tube.</p> <p>On 3/2/20 at 10:33 AM, LPN #2 said she should have changed her gloves and sanitized her hands after handling Resident #27's call light cord and before she performed the care of the gastrostomy tube.</p> <p>On 3/5/20 at 2:00 PM, the DON said he expected staff to change gloves and sanitize their hands</p>	F 880	DON/designee is responsible for compliance.		

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F 880	<p>Continued From page 59</p> <p>after touching potentially contaminated surfaces and prior to handling Resident #27's gastrostomy tube.</p> <p>2. On 3/3/20 at 11:18 AM, CNA #3 was observed without wearing gloves as she walked down the hall carrying trash to the dirty utility room. After delivery she sanitized her hands. When asked about not having gloves while carrying trash she stated the staff were instructed not to wear gloves in the hallway.</p> <p>3. On 3/3/20 at 2:33 PM, CNA #4 was observed as she came out of a resident's room wrapping up a trash bag with her bare hands. She threw the trash away in the dirty utility room and went into room #29 to answer a call light, without performing hand hygiene prior to entering the room. From room #29 she went into room #30 to answer the call light without performing hand hygiene when she exited room #29 or prior to entering room #30.</p> <p>On 3/5/20 at 2:41 PM, the Infection Control Preventionist said she expected staff to sanitize their hands after touching things from the floor, before and after personal cares, and when leaving residents' rooms.</p>	F 880			



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

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

June 17, 2020

Joan Martellucci, Administrator  
Ivy Court  
2200 Ironwood Place  
Coeur d'Alene, ID 83814-2610

Provider #: 135053

Dear Ms. Martellucci:

On **March 2, 2020** through **March 6, 2020**, an unannounced on-site complaint survey was conducted at Ivy Court. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008184**

**ALLEGATION:**

Staff Nurses were not checking vital signs prior to administering blood pressure medication as directed.

**FINDINGS:**

During the investigation, four residents were observed and their records were reviewed for vital signs, medication administration and quality of care.

Staff were observed taking vital signs on 4 residents immediately before medication administration by the staff nurse throughout the survey.

The medication and vital signs sheets were reviewed to correlate times between medication administration and vital sign recording. There was no discrepancy in time noted. One medication was held during the survey time because the resident's blood pressure did not meet blood pressure parameters for the medication to be administered.

Joan Martellucci, Administrator  
June 17, 2020  
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Two nurses were interviewed about timing of blood pressure medications and vital signs. Both stated they were aware of timing of blood pressure medication and the need for current vital signs. One nurse stated the CNA (certified nursing assistant) would take residents' vital signs before medication administration or she would do it herself. One nurse stated he always takes the blood pressure himself before giving blood pressure medication.

Residents were interviewed at various times during the survey and voiced no concerns about timing of blood pressure readings and when they got their blood pressure medication. They all stated their needs were being met regarding medication administration and the quality of care by nurses and CNAs in the facility.

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

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj



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HEALTH & WELFARE

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DAVE JEPPESEN – Director

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

June 16, 2020

Joan Martellucci, Administrator  
Ivy Court  
2200 Ironwood Place  
Coeur d'Alene, ID 83814-2610

Provider #: 135053

Dear Ms. Martellucci:

On **March 2, 2020** through **March 6, 2020**, an unannounced on-site complaint survey was conducted at Ivy Court. During the survey, observations, staff and resident interviews were conducted and records were reviewed. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008203**

**ALLEGATION #1:**

The facility failed to ensure residents were provided with adequate amounts of hot water.

**FINDINGS #1:**

Four interviews were conducted with residents and three resident representatives. No concerns were voiced. Nine residents were interviewed during the Resident Group meeting and no concerns were voiced about adequate amounts of hot water provided to residents by the facility..

Facility reported incidents documented on 7/16/19 the facility's Administrator was notified the hot water heater had a leak. The facility maintenance staff were unable to repair the hot water heater. The facility developed an action plan to provide residents with hot water and developed a "camp shower" system for each shower room.

Water was heated to 120 degrees prior to being delivered to the shower rooms. The dish washer and laundry system were both low temperature systems and sanitizing softener was added to the wash cycle. Residents and families were notified of the hot water outage. Review of the bidding contracts documented it would take three weeks to obtain the hot water replacement and have it installed.

Review of the infection control and surveillance for July 2019, August 2019, and September 2019, documented no concerns related to the spread of infections.

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

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #2:**

The facility failed to ensure residents did not experience offensive odors when opening their window due to smokers outside the window.

**FINDINGS #2:**

The facility is a non-smoking facility, with one resident grand-fathered into the program as the only smoking resident.

Observations and interviews with the resident revealed the resident was evaluated as being independent to smoke. The area outside where the resident smokes was located on the side of the facility, outside of the dining room. There were no resident rooms located near the area where the resident smoked.

Staff who smoked were observed going outside to the back of the facility to a designated smoking area at the back of the parking area. This area was not located near resident rooms. Staff were not observed smoking near resident rooms.

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

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #3:**

Facility failed to ensure meal items were served at appropriate temperatures.

**FINDINGS #3:**

Meal observations were conducted, residents were interviewed and a test tray was sampled.

Six residents were interviewed and said the taste or quality of the food was bad. During a Resident Group interview, residents said they did not like the food and it was often served cold.

A test tray was evaluated by two surveyors with the Certified Dietary Manager and the Registered Dietitian. The turkey lacked flavor, the green beans were cool and chewy, and the sweet potato souffle was cool to taste.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F804, as it relates to food for nutritive value, appearance, and palatability.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

**ALLEGATION #4:**

Facility failed to ensure therapeutic diets were served as ordered.

**FINDINGS #4:**

Three surveyors conducted observations and interviews from 3/2/20 through 3/6/20, that included meal observations and a test tray. A review of the dietary menu and recipes indicated the residents were receiving therapeutic diets and observations of the tray line and meal pass confirmed that diabetic diets were being served.

**CONCLUSIONS:**

Unsubstantiated. Lack of sufficient evidence.

**ALLEGATION #5:**

The facility failed to ensure allegations of abuse were thoroughly investigated and appropriate measures instituted for substantiated allegations.

Joan Martellucci, Administrator  
June 16, 2020  
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**FINDINGS #5:**

Records and the facility's incident reports were reviewed and residents and staff were interviewed.

An incident report for one resident who was admitted to the facility on 2/8/18, had an incident report dated 8/8/19, which documented the resident slapped two CNAs in the arm when they were trying to assist another resident in his wheelchair. The report documented the resident said she slapped them because they slapped her first. The facility interviewed the resident, but there were no other residents interviewed concerning the incident or potential alleged abuse.

In an interview, the DON said as part of investigations, the facility suspended people involved, and interviewed staff and other residents. He said he thought since there were enough staff that witnessed the event, they did not think they needed to interview other residents. The DON said residents should have been interviewed regarding abuse concerns as part of the investigation.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F610, as it relates to investigations to prevent and correct alleged violations of abuse or neglect.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj

Joan Martellucci, Administrator  
June 16, 2020  
Page 5 of 4



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

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

June 16, 2020

Joan Martellucci, Administrator  
Ivy Court  
2200 Ironwood Place  
Coeur d'Alene, ID 83814-2610

Provider #: 135053

Dear Ms. Martellucci:

On March 2, 2020 through **March 6, 2020**, an unannounced on-site complaint survey was conducted at Ivy Court. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008251**

**ALLEGATION #1:**

**Residents were not supervised and kept falling.**

**FINDINGS #1:**

During the survey, multiple observations were conducted for three residents reviewed for falls and supervision. 15 residents and 5 residents' representatives were interviewed regarding falls. Four residents' records were reviewed for falls and supervision, including Incident and Accident (I&A) reports.

A resident was admitted into the facility on 9/2/16, with diagnoses of cerebral infarction (stroke), hemiplegia (paralysis of one side of the body) and repeated falls.

The resident's care plan, dated 9/22/17, stated interventions for falls included bilateral assist rails and a lipped mattress, to keep furniture in a locked position, keep needed items within reach, and he would wear appropriate non-slip shoes and/or socks at all times.

An admission Minimum Data Set assessment, dated 12/6/19, documented the resident was cognitively intact.

I&A reports documented the resident fell in the facility three times.

An I&A Report, dated 9/7/19, stated the resident was found on the floor next to their bed. The report stated the resident was attempting to self-transfer from the bed to the wheelchair. The brakes were not locked on the wheelchair and was wearing regular socks. A fall risk evaluation, dated 9/7/19, stated the resident's care plan interventions to prevent falls were bilateral assist rails and a lipped mattress on the bed, ensure they were wearing appropriate footwear, non-skid socks or well-fitting shoes when ambulating or mobilizing in the wheelchair, and keep the resident's needed items in reach. There were no changes documented in the care plan related to the 9/7/19 fall.

An I&A Report dated 9/9/19, stated the resident was found by staff on the floor on their knees and their wheelchair was moving. The report stated the resident kept pointing to the table with his books. The resident's wheelchair was unlocked. The care plan interventions regarding falls were unchanged from 9/22/17.

An I&A Report dated 12/15/19, stated the resident was found lying on the floor between the bed and the wheelchair. He was wearing regular socks and no shoes. The care plan interventions were unchanged from 9/22/17.

Three falls occurred after the Care Plan noted fall interventions were initiated on 9/22/17. These interventions were not implemented as follows:

- \* On 9/7/19, the resident's wheelchair was not locked and the he did not have grip socks or shoes on.
- \* On 9/9/19, the resident's wheelchair was witnessed moving while he was on the floor pointing to his books on the side table.
- \* On 12/15/19, the resident was found wearing regular socks without shoes.

These interventions were not implemented correctly and consistently per the fall incident documentation nor were they evaluated for effectiveness or modified for prevention of further falls.

Joan Martellucci, Administrator  
June 16, 2020  
Page 3 of 3

On 3/5/2020, the Director of Nursing said he expected care plans to be followed.

It was determined the facility failed to ensure the resident's were adequately supervised and were kept from falling. Therefore, the allegation was substantiated and deficient practice was cited at F689 as it relate to keeping residents free of accidents and hazards.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

June 17, 2020

Joan Martellucci, Administrator  
Ivy Court  
2200 Ironwood Place  
Coeur d'Alene, ID 83814-2610

Provider #: 135053

Dear Ms. Martellucci:

On **March 2, 2020** through **March 6, 2020**, an unannounced on-site complaint survey was conducted at Ivy Court. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

**Complaint #ID00008381**

**ALLEGATION #1:**

The facility failed to ensure a system was in place to prevent the falsification of resident records as relates to blood pressure and pulse before administering heart medications.

**FINDINGS #1:**

During the investigation 4 residents were observed and their records were reviewed for vital signs, medication administration and quality of care.

Staff were observed taking vital signs on 4 residents immediately before medication administration by the staff nurse throughout the survey.

The medication and vital signs sheets were reviewed to correlate times between medication administration and vital sign recording. There was no discrepancy in time noted. One medication was held during the survey time because the resident's blood pressure did not meet blood pressure parameters for the medication to be administered.

Two nurses were interviewed about timing of blood pressure medications and vital signs. Both stated they were aware of timing of blood pressure medication and the need for current vital signs. One nurse stated the CNA (certified nursing assistant) would take residents' vital signs before medication administration or she would do it herself. One nurse stated he always takes the blood pressure himself before giving blood pressure medication.

Residents were interviewed at various times during the survey and voiced no concerns about timing of blood pressure readings and when they got their blood pressure medication. They all stated their needs were being met regarding medication administration and the quality of care by nurses and CNAs in the facility.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The facility failed to ensure residents were supplied with appropriate medications in a timely manner.

#### FINDINGS #2:

Observations were conducted of medication being administered to residents, staff were interviewed, and medication administration records and policies were reviewed.

A review of three of six medication administration records documented that nursing did not administer residents' insulin during the time it was prescribed to be given. In interviews, the Director of Nursing and two staff nurses confirmed the insulin was not administered at the time it was prescribed.

Review of the facility's grievance reports included a grievance from a resident who said she did not receive her medications. The facility's investigation documented the medications were given, but were given later than the prescribed time.

Joan Martellucci, Administrator  
June 17, 2020  
Page 3 of 3

Based on the investigative findings, the allegation was substantiated and the facility was cited at F684 as it related to quality of care.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj