



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE- Governor
DAVE JEPPESEN- Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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3232 Elder Street
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March 29, 2019

Tyler Fackrell, Administrator
Promontory Point Rehabilitation
3909 South 25th East,
Ammon, ID 83406

Provider #: 135137

Dear Mr. Fackrell:

On **March 15, 2019**, a survey was conducted at Promontory Point Rehabilitation by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 8, 2019**. Failure to submit an acceptable PoC by **April 8, 2019**, may result in the imposition of civil monetary penalties by **May 1, 2019**.

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

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

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

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

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

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 15, 2019

A Civil money penalty

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 15, 2019**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Belinda Day RN, or Laura

Tyler Fackrell, Administrator
March 29, 2019
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Thompson, RN Co-Supervisors LTC, 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:

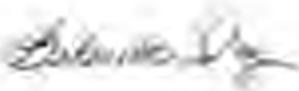
- BFS Letters (06/30/11)

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

This request must be received by **April 8, 2019**. If your request for informal dispute resolution is received after **April 8, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208) 334-6626, option #2.

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

bd/dr
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/15/2019
NAME OF PROVIDER OR SUPPLIER PROMONTORY POINT REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 3909 SOUTH 25TH EAST AMMON, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from March 11, 2019 to March 15, 2019.</p> <p>The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator Teresa Kobza, RD Kate Johnsrud, RN</p> <p>Survey Abbreviations: ADL = Activities of Daily Living cm = Centimeters CNA = Certified Nursing Assistant CPAP = Continuous Positive Airway Pressure CPR = cardiopulmonary resuscitation DON = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record mcg = microgram mg = milligrams MDS = Minimum Data Set MRR = Medication Regimen Review POST = Physician's Order for Scope of Treatment PRN = As Needed RN = Registered Nurse TAR = Treatment Administration Record</p>	F 000			
F 554 SS=D	<p>Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)</p> <p>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced</p>	F 554		4/15/19	

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

TITLE

(X6) DATE

Electronically Signed

04/08/2019

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

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F 554	<p>Continued From page 1</p> <p>by:</p> <p>Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure residents were assessed to determine if they were safe to self-administer medications. This was true for 1 of 1 resident (Resident #17) reviewed for self-administration of medications. The failure created the potential for adverse effects if Resident #17 self-administered medications inappropriately. Findings include:</p> <p>The facility's policy Self-Administration of Drugs (undated), documented staff and/or the practitioner would assess whether a resident was capable of self-administering medications. The findings of the assessment would be presented to the Interdisciplinary Team (IDT) for final decision on appropriateness, and the facility would periodically, such as during quarterly MDS reviews, reevaluate the resident's ability to continue to self-administer medications.</p> <p>Resident #17 was admitted on 2/8/19, with diagnoses which included joint replacement, high blood pressure, and glaucoma.</p> <p>The MDS admission assessment, dated 2/28/19, documented Resident #17's was cognitively intact.</p> <p>On 3/13/19 at 11:44 AM, eye drops were observed in Resident #17's bedside refrigerator.</p> <p>On 3/13/19 at 12:01 PM, LPN #2 stated Resident #17 self-administered her medicated eye drops at night, and the nurses' documented in the medical record the time it was self-administered.</p>	F 554	<p>This Plan of Correction Is prepared and submitted as required by law. By submitting this Plan of Correction, Promontory Point Rehabilitation does not admit that the deficiencies listed on the CMS 2567 exists, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies.</p> <ol style="list-style-type: none"> 1. Immediate action(s) taken for the resident(s) found to have been affected include: <ul style="list-style-type: none"> Resident #17 has discharged, and no further action is required 2. Identification of other residents having the potential to be affected was accomplished by: <ul style="list-style-type: none"> All residents and potential residents have the potential to be affected. A walk through of the resident's room was completed on 3/25/2019 to ensure no medications were present without a physician order and a self-administration assessment complete. The care plan was updated as indicated. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: <ul style="list-style-type: none"> The policy has been reviewed and found that no changes are necessary. Licensed staff were educated on the Self Administration Policy on 3/29/19. <p>The Interdisciplinary team will complete environmental rounds of the patient's</p>		

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F 554	Continued From page 2 On 3/13/19 at 12:05 PM, LPN #2 stated a self-administration assessment was not completed for Resident #17.	F 554	room during initial care conferences to ensure medications are identified. If identified, the unit manager or designee will review orders to ensure accuracy, assessments are complete, and update care plan as indicated. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DON/designee will complete a random audit weekly to ensure self-administration assessments, physician orders are obtained, and the care plan is up to date for those residents who wish to administer their own medications. The DON/designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of	F 577		4/15/19	

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F 577	<p>Continued From page 3</p> <p>the facility.</p> <p>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and</p> <p>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</p> <p>(iv) The facility shall not make available identifying information about complainants or residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure the results of the facility's most recent recertification survey was readily accessible for review. This failed practice impacted 12 of 12 sample residents (#1, #3, #8, #11, #13, #17, #19, #123, #125, #126, #129, and #173) residing in the facility and had the potential to impact the remaining 17 residents and/or their visitors who may want to review survey results. Findings include:</p> <p>The facility's undated policy for Availability of Survey Results documented a "Place readily accessible" meant a place where those who wished to examine survey results did not have to ask to see them. A representative of management was responsible to make weekly inspections of the survey binder to ensure the binder was readily accessible without having to ask for the information from staff.</p> <p>On 3/12/19 at 8:35 AM, a sign was posted in the facility's front lobby that indicated state survey</p>	F 577	<p>1. Immediate action(s) taken for the resident(s) found to have been affected include: The most recent standard survey was relocated to the front lobby when its inaccessibility was pointed out on 3/13/19. Resident #1, #3, #13, #123, #126, #129, and #173 were asked if they were aware of the survey results location, if they were unaware, they were provided education of the location of the survey results. Resident #8, #11, #17, and #19, #125 has discharged, and no further action is required.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: All residents and potential residents wishing to view the most recent survey have the potential to be affected. The survey results will remain in the front lobby.</p>		

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F 577	Continued From page 4 results were located in the library. The facility's "State Survey and Life Safety Inspection" binder was found in the library in a clear hard plastic holder on the wall next to the door. The binder holder was mounted greater than five feet from the floor, with a chair directly below. The surveyor was not able to reach the binder in its holder. On 3/13/19 at 8:25 AM, the survey results binder was located in the same position as previously described. The Administrator, present at the time, acknowledged the location of the binder and said he could see how it could be unreachable for some residents and it would be moved.	F 577	3. Actions taken/systems put into place to reduce the risk of future occurrence include: The administrator/designee will check the binder location weekly to ensure compliance and replace as indicated. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator/designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		4/15/19	

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F 578	<p>Continued From page 5</p> <p>facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure: a) residents were provided information regarding advance directives upon admission and were assisted to formulate an advance directive if necessary, and b) the residents' record included documentation of this process, a copy of the advance directive, or documentation the resident did not wish to formulate an advance directive. This was true for 9 of 12 residents (#1, #3, #11, #13, #17, #19, #123, #125, and #173) whose records were reviewed for advance directives. These failures created the potential for harm should residents not have their wishes documented and honored if they were unable to communicate their health care preferences.</p> <p>Findings include:</p>	F 578	<p>1. Immediate action(s) taken for the resident(s) found to have been affected include: The POST and Advanced directives were reviewed, updated as necessary, a progress note was made, and the care plan updated as indicated for resident #1 on 3/13 and 4/2; #3 on 3/13, #13 on 3/13, #123 on 3/20, and #173 on 3/13 and 4/3. Residents #11, #17, #125, and #19 has discharged, no further action is necessary.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined all residents are at risk. An audit of residents was</p>		

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F 578	Continued From page 6 The facility's undated policy for advance directives documented the facility would "support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an Advance Directive." Upon admission, the facility would determine whether the resident had an advance directive and would request a copy, place a copy in the clinical record, and communicate the advance directive information to staff. Decision making about the resident's choices would be documented in their record and communicated to the interdisciplinary team and staff involved in the resident's care. 1. Resident #19 was admitted to the facility on 2/7/19, with multiple diagnoses including aftercare following a joint replacement. Resident #19's admission MDS assessment, dated 2/14/19, documented he was cognitively intact. Resident #19's physician orders documented an order on 2/7/19 for "CPR." Resident #19's POST documented Resuscitate (Full Code) and was signed by him on 2/9/19. Resident #19's current care plan documented his code status was CPR, initiated on 2/7/19. Resident #19's clinical record did not include an Advance Directive or documentation he had been provided information regarding formulating an Advanced Directive and offered assistance to do so, and declined the offer.	F 578	completed to ensure the POST, advanced Directives, and Care plan were up to date. A progress note was made regarding the discussion with the residents/families. The Admission agreement was updated to ensure education is provided to residents upon admission regarding the formulation of an advanced directive. 3. Identification of other residents having the potential to be affected was accomplished by: The policy has been reviewed and found that no changes are necessary. The Admission Coordinator/designee will complete a random audit weekly to ensure the POST, advanced directives and care plans are up to date. 4. Actions taken/systems put into place to reduce the risk of future occurrence include: The Admissions Director/designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance, & PRN.		

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F 578	<p>Continued From page 7</p> <p>On 3/14/19 at 9:24 AM, the Admissions Director said he did not see documentation of an advance directive for Resident #19 or that it was requested.</p> <p>On 3/14/19 at 9:36 AM, the Admissions Director said Resident #19's POST did not indicate he had an advance directive, so he did not request one from him.</p> <p>2. Resident #125 was admitted to the facility on 3/8/19, with multiple diagnoses including aftercare following a joint replacement.</p> <p>Resident #125's physician orders documented an order on 3/13/19 for "DNR."</p> <p>Resident #125's POST documented Do Not Resuscitate and was signed by her on 3/11/19.</p> <p>Resident #125's current care plan documented her code status was DNR, initiated on 3/13/19.</p> <p>Resident #125's clinical record did not include an Advance Directive or documentation she had been provided information regarding formulating an Advanced Directive and offered assistance to do so, and declined the offer.</p> <p>On 3/15/19 at 9:15 AM, the Admissions Director said he did not see documentation of an advance directive for Resident #125, and he did not recall asking her about it or offering it to her. The Admissions Director said upon admission to the facility, Social Services did an assessment, asked residents about their advance directives, and helped them fill one out if the family asked for assistance.</p>	F 578			

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F 578	<p>Continued From page 8</p> <p>On 3/15/19 at 9:22 AM, the Social Services Director said when a resident first arrived at the facility she asked them if they had an Advance Directive. The Social Services Director said her documentation indicated Resident #125 had a living will at home, and she was not sure whether the facility ever obtained a copy. The Social Services Director said she documented whether a resident had an advance directive, and the Admissions Director usually asked residents if they had an advance directive and for a copy of it during completion of the admission paperwork.</p> <p>3. Resident #123 was admitted to the facility on 3/9/19, with multiple diagnoses including displaced bimalleolar (ankle) fracture and unspecified dementia without behavioral disturbance.</p> <p>Resident #123's physician orders documented an order for "CPR" on 3/9/19.</p> <p>Resident #123's POST documented "Resuscitate" and was signed by her on 6/14/13.</p> <p>Resident #123's clinical record did not include an Advance Directive or documentation she had been provided information regarding formulating an Advanced Directive and offered assistance to do so, and declined the offer.</p> <p>On 3/14/19 at 3:26 PM, the DON said there was no advanced directive documented for Resident #123.</p> <p>4. Resident #13 was readmitted to the facility on 2/4/19, with diagnoses which included fractured</p>	F 578			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 578	<p>Continued From page 9 prosthetic left hip joint, pain, and bacterial infection.</p> <p>Resident #13's physician's order, dated 2/4/19, documented her code status was Full Code and she wished to receive CPR.</p> <p>The care plan area addressing Resident #13's code status, initiated on 2/5/19, documented she wished to receive CPR.</p> <p>Resident #13's POST, dated 2/8/19, documented her code status was Full Code with limited interventions. The POST section C, regarding artificial fluids and nutrition, and antibiotic and blood product use, and section D, regarding advanced directives wishes, were not completed.</p> <p>An undated Social Services Initial Assessment documented Resident #13 had a living will and a POST.</p> <p>On 3/12/19 at 3:46 PM, the DON stated the advanced directives (living will) should be in the residents' records and she would attempt to locate them.</p> <p>5. Resident #173 was readmitted to the facility on 2/23/19, with diagnoses which included failure to thrive, muscle wasting, falling, heart disease, chronic obstructive pulmonary disease (chronic inflammatory lung disease that causes obstructed airflow from the lungs, making it hard to breathe), and pain.</p> <p>Resident #173's POST, dated 12/11/17, documented her code status was Full Code with comfort measures. The POST section D,</p>	F 578			

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F 578	<p>Continued From page 10 regarding advanced directives wishes, documented she had a living will.</p> <p>Resident #173's physician's order, dated 2/23/19, documented her code status was DNR.</p> <p>The care plan area addressing Resident #173's code status, initiated on 3/12/19, documented her wishes of DNR.</p> <p>Resident #173's physician orders and POST were inconsistent.</p> <p>An undated Social Services Initial Assessment documented Resident #173 had a living will and a POST.</p> <p>On 3/13/19 at 9:24 AM, the Administrator stated Resident #173's wishes were for Full code and Staff would correct the order and the care plan. The Administrator stated the facility was waiting for Resident #173's family to bring in a copy of her living will.</p> <p>6. Resident #3 was admitted to the facility on 12/18/18, with diagnoses which included pain and a fractured leg.</p> <p>Resident #3's physician's order, dated 12/18/18, documented his code status was Full Code and wished to receive CPR.</p> <p>The care plan area addressing Resident #3's code status, initiated on 12/18/18, documented he wished to receive CPR.</p> <p>Resident #3's POST, dated 12/18/18, documented his codes status was Full Code with</p>	F 578			

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F 578	<p>Continued From page 11</p> <p>comfort measures. The POST section C, regarding artificial fluids and nutrition, and antibiotic and blood product use, and section D, regarding advanced directives wishes, were not completed.</p> <p>An undated Social Services Initial Assessment documented Resident #3 had a living will and a POST.</p> <p>On 3/12/19 at 3:46 PM, the DON stated the advanced directives (living will) should be in the residents' records and she would attempt to locate them. The DON stated the POST should be filled out completely.</p> <p>7. Resident #1 was admitted to the facility on 2/27/19, with multiple diagnoses including fractures of the lumbar spine, diabetes, and hypertension (high blood pressure).</p> <p>Resident #1's admission MDS assessment, dated 3/5/19, documented he was cognitively intact.</p> <p>Resident #1's POST, dated 10/29/18, included a code status of Full Code. The Advanced Directive section was blank.</p> <p>The Medical Social Services Initial Comprehensive Assessment and Plan of Care, dated 2/27/19, included under the Advance Directives section a Living Will and POST were completed.</p> <p>Resident #1's record did not include a Living Will.</p> <p>On 3/14/19 at 11:03 AM, the DON was unable to</p>	F 578			

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F 578	<p>Continued From page 12 provide a copy of Resident #1's Living Will.</p> <p>8. Resident #11 was admitted to the facility on 2/14/19, with multiple diagnoses including hypertension (high blood pressure), anemia, and chronic renal disease (a gradual loss of kidney function over time).</p> <p>Resident #11's admission MDS assessment, dated 2/28/19, documented she was cognitively intact.</p> <p>Resident #11's POST, dated 2/15/18, documented her code status was DNR, and she had a Living Will.</p> <p>Resident #11's record did not include a Living Will.</p> <p>On 3/12/19 at 3:24 PM, the DON stated the Living Will was located; however, it was not included in Resident #11's record.</p> <p>9. Resident #17 was admitted to the facility on 2/8/19 with multiple diagnoses including joint replacement, hypertension (high blood pressure), and glaucoma.</p> <p>Resident #17's admission MDS assessment, dated 2/28/19, documented she was cognitively intact.</p> <p>Resident #17's POST, dated 2/19/19, documented her code status was DNR, and she had a Living Will. The POST section B, regarding medical interventions, and section C, regarding artificial fluids and nutrition, and antibiotic and blood products, were not completed.</p>	F 578			

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F 578	Continued From page 13 Resident #17's record did not include a Living Will. On 3/12/19 at 3:39 PM, the DON stated the Living Will was not in Resident #17's record.	F 578			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		4/15/19	

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F 655	Continued From page 14 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and policy review, it was determined the facility failed to ensure baseline care plans were developed to meet the needs of residents. This was true for 1 of 12 residents (Resident #1) reviewed for baseline care plans. The failure placed Resident #1 at risk of injury and/or medical complications due to the lack of information on his baseline care plan. Findings include: The facility's Baseline Care Plan policy (undated) documented the baseline care plan would be developed to properly care for the resident within 48 hours of a resident's admission. The baseline care plan would include the resident's stated goals and objectives and a copy of the baseline care plan summary provided to the resident. Resident #1 was admitted to the facility on 2/27/19, with multiple diagnoses including fractures of the lumbar spine, diabetes, and hypertension (high blood pressure), paroxysmal atrial fibrillation (a rapid, erratic heart rate begins	F 655	1. Immediate action(s) taken for the resident(s) found to have been affected include: Baseline care plan of resident #1 was reviewed and comprehensive assessment completed on 3/12/2019 and has been reviewed to ensure completion on 3/29/2019. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. An audit of current residents was completed on 3/25/19 to ensure each resident has a complete baseline care plan. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The interdisciplinary care plan team members responsible for writing care plans will be re-educated on the facility's		

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F 655	<p>Continued From page 15</p> <p>suddenly and then stops on its own within 7 days), and long-term use of anticoagulant (blood thinning) medication. Resident #1's baseline care plan, initiated on 2/27/19, documented he also had a non-operable left tibial plateau (top of the shin bone) fracture for which he wore a leg brace.</p> <p>Resident #1's admission MDS assessment, dated 3/5/19, documented he was cognitively intact.</p> <p>Resident #1's physician orders, dated 2/27/19, documented the following:</p> <ul style="list-style-type: none"> *2.5 mg of Apixaban (an anticoagulant used to reduce clot formation in the blood) twice daily *Humalog insulin KwikPen100 Unit/ML, inject per sliding scale for diabetes *Lantus insulin pen-injector 100 Unit/ML, inject 20 units subcutaneous two times a day *Monitor skin integrity under his knee brace *Non-weight bearing on his left lower extremity *Follow pressure sore prevention and/or care protocols *Resuscitation code status of Full Code, initiate CPR *Follow the bowel and bladder protocol *Complete an evaluation and initiate treatment for physical therapy, occupational therapy, and speech therapy *Fentanyl Patch for pain management, change every 72 hours *Hydrocodone-Acetaminophen 5-325 mg, 1-2 tablets every four hours, as needed, for pain *Ibuprofen 200 mg tablet every morning for inflammation 	F 655	<p>policy and procedure for developing Baseline Care Plans. Unit manager or designee will review patient's care plan within 48 hours to ensure completion.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator or designee. All care plans will be updated as indicated. A random audit will be completed weekly by the DON/designee. The baseline care plans will be updated as indicated. The DON/designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.</p>		

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F 655	Continued From page 16 Resident #1's baseline care plan did not include goals and interventions related to the following: *Insulin dependent diabetes *Fall prevention *Bowel and bladder care *Skin integrity and pressure sore prevention *Resuscitation code status *Pain management *Paroxysmal atrial fibrillation and use of anticoagulant medication *Therapy Services On 3/15/19 at 11:33 AM, the DON said the care plan was missing multiple components needed to care for Resident #1.	F 655			
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		4/15/19	

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F 656	Continued From page 17 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. 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 develop and implement comprehensive resident-centered care plans. This was true for 5 of 13 residents (#1, #8, #13, #19, and #173) whose care plans were reviewed. This failure created the potential for residents to receive inappropriate or inadequate care. Findings include: The facility's Comprehensive Care Plans policy, (no date, copyright 2018) documented a comprehensive person-centered care plan will be prepared by an interdisciplinary team for each resident within 7 days after the completion of the	F 656	1. Immediate action(s) taken for the resident(s) found to have been affected include: Care plan(s) of the resident #1 was reviewed and updated on 3/29/19 #13 was reviewed and updated on 3/29/19, #173 was reviewed and updated on 3/29/19, residents #8 and #19 have discharged and no further action is required. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be		

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F 656	<p>Continued From page 18</p> <p>comprehensive MDS assessment, and it would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.</p> <p>1. Resident #173 was readmitted to the facility on 2/23/19, with diagnoses which included failure to thrive, muscle wasting, falling, heart disease, chronic obstructive pulmonary disease (lung disease characterized by chronic obstruction of lung airflow that interferes with normal breathing and is not fully reversible), and pain.</p> <p>An admission MDS assessment, dated 3/1/19, documented Resident #173 was cognitively intact and required extensive assistance of 2 staff members for bed mobility and dressing, extensive assistance of one staff member for transfer and toilet use, and limited assistance of one with personal hygiene. The MDS documented she had broken or loose-fitting dentures.</p> <p>a. Resident #173's POST, dated 12/11/17, documented her code status was Full Code (resuscitate) with comfort measures.</p> <p>Resident #173's physician's order, dated 2/23/19, documented her code status was DNR (do not resuscitate).</p> <p>Resident #173's care plan, updated 3/12/19, documented her code status was DNR. Prior to 3/12/19 Resident #173's care plan did not include her code status.</p> <p>Resident #173's physician orders and care plan documented her code status as DNR. Her POST</p>	F 656	<p>affected. An audit of current patient's comprehensive care plans was completed on 3/29/19, care plans were updated as needed to ensure compliance.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: The interdisciplinary care plan team members responsible for writing care plans were re-educated on the facility's policy and procedure for developing Comprehensive Care Plans. A review of our initial care plan/conference process has been revamped to reflect patient's current orders, goals, prior level of function, and preferences. The Social Services Designee or other designee will be responsible for setting up the initial care plan conference within 14 days of admission.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator or designee. All care plans will be updated as indicated.</p> <p>The MDS Coordinator or designee will complete a random weekly audit of care plans to ensure that comprehensive care plans are developed for residents. The MDS Coordinator or designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.</p>		

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F 656	<p>Continued From page 19 documented her code status as Full Code.</p> <p>On 3/13/19 at 9:24 AM, the Administrator stated Resident #173's wishes were for Full code and staff would correct the order and the care plan.</p> <p>On 3/12/19 at 3:46 PM, the DON stated she was unaware Resident #173's care plan did not document a code status prior to 3/12/19.</p> <p>b. Resident #173's Nursing Admission Assessment, dated 2/23/19, documented she had full upper and lower dentures.</p> <p>Resident #173's Care Area Assessment (CAA), dated 3/8/19, documented Resident #173 had full dentures and she did not wear them because they were uncomfortable. The evaluation recommended Resident #173 visit a dentist and nursing to assess the fit of her dentures.</p> <p>Resident #173's care plan did not contain a care area for her dentures.</p> <p>c. Resident #173 did not have a care plan area for her ADL function until 3/12/19, which documented she "may require" 1-2 staff members assistance with transfers, toilet use, personal hygiene, bed mobility, dressing, and bathing. The care plan was not consistent with the 3/1/19 MDS assessment which documented she required extensive assistance of 2 staff members for bed mobility and dressing, extensive assistance of one staff member for transfer and toilet use, and limited assistance of one with personal hygiene.</p> <p>On 3/12/19 at 11:12 AM, Resident #173 stated</p>	F 656			

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F 656	<p>Continued From page 20</p> <p>she required assistance from staff with all her cares except eating.</p> <p>On 3/12/19 at 3:46 PM, the DON stated Resident #173's care plan should have more details. The DON stated she was missing multiple areas which were identified on her CAA.</p> <p>2. Resident #13 was readmitted to the facility on 2/4/19, with diagnoses which included fractured prosthetic left hip joint, pain, and bacterial infection.</p> <p>An admission MDS assessment, dated 2/11/19, documented Resident #13 was cognitively intact and had a surgical wound.</p> <p>Resident #13's Hospital History and Physical, dated 1/29/19, documented she had a pain pump in place on her left hip.</p> <p>The care plan area addressing Resident #13's pain, initiated 2/5/19, documented staff were to provide pain medications as ordered. The care plan did not document Resident #13 had a pain pump or address how staff were to manage the pain pump.</p> <p>On 3/12/19 at 9:58 AM, Resident #13 stated her incision was infected and started draining a few days ago. Resident #13 stated she had noticed increased pain in her hip as well.</p> <p>On 3/13/19 at 2:21 PM, the DON stated the care plan should contain information on Resident #13's pain pump.</p> <p>3. Resident #1 was admitted to the facility on</p>	F 656			

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F 656	<p>Continued From page 21 2/27/19, with multiple diagnoses including fractures of the lumbar spine, diabetes, and hypertension (high blood pressure).</p> <p>Resident #1's admission MDS assessment, dated 3/5/19, documented he was cognitively intact.</p> <p>Resident #1's POST, dated 10/29/18, documented a code status of Full Code.</p> <p>Resident #1's physician orders documented a code status of CPR, ordered on 2/27/19 .</p> <p>Resident #1's care plan, initiated on 2/28/19 through 3/11/19, did not contain documentation of his code status.</p> <p>On 3/12/19 at 3:29 PM, the DON stated there was not a code status addressed in Resident #1's care plan.</p> <p>4. Resident #8 was readmitted to the facility on 1/19/19, with multiple diagnoses including Type 2 diabetes mellitus and hypertension (high blood pressure).</p> <p>Resident #8's physician orders documented "CPR" was ordered on 12/19/18.</p> <p>Resident #8's POST documented Resuscitate (Full Code) and was signed by her daughter on 12/21/18.</p> <p>Resident #8's care plan did not document her code status.</p> <p>On 3/14/19 at 2:03 PM, the DON said she did not</p>	F 656			

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F 656	<p>Continued From page 22</p> <p>see Resident #8's code status on her care plan. The DON said Resident #8 went home and then came back to the facility, and normally when a resident returned to the facility they were asked if they wanted to keep the same POST or if they wanted to make any changes. The DON said the Admission Director obtained the POST and then it was documented on the care plan. The DON said it was overlooked and Resident #8's code status should have been on the care plan.</p> <p>5. Resident #19 was admitted to the facility on 2/7/19 with multiple diagnoses, including aftercare following a joint replacement and obstructive sleep apnea (periods of cessation of breathing).</p> <p>Resident #19's care plan documented he had altered respiratory status and difficulty breathing/shortness of breath related to sleep apnea, initiated on 2/13/19. The care plan interventions did not include or address the use of CPAP (a machine that is used to treat sleep apnea).</p> <p>Resident #19's Progress Notes, dated 2/27/19 at 12:24 PM, 2/28/19 at 6:14 PM, 3/5/19 at 9:20 AM, 3/9/19 at 12:46 PM, and 3/13/19 at 3:36 PM, documented he had shortness of breath on exertion and used a CPAP.</p> <p>On 3/13/19 at 11:20 AM, a CPAP machine, CPAP mask, and tubing were on Resident #19's bedside table. Resident #19 said he used the CPAP every night.</p> <p>On 3/13/19 at 11:36 AM, the DON said Resident #19's use of a CPAP machine should be on his</p>	F 656			

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F 656	Continued From page 23 care plan.	F 656			
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review, and policy review, it was determined the facility failed to ensure care plans were reviewed and revised after each comprehensive assessment, and as needed by, an	F 657		4/15/19	
			1. Immediate action(s) taken for the resident(s) found to have been affected include: Care plan(s) of the resident #13 was reviewed and updated on 3/29/19,		

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F 657	<p>Continued From page 24</p> <p>interdisciplinary team for 4 of 13 residents (#13, #17, #19, and #73) whose care plans were reviewed. The failure created the potential for harm if care and services were not provided to residents as needed. Findings include:</p> <p>The facility's Comprehensive Care Plans policy, (copyright 2018) documented a comprehensive person-centered care plan would be prepared by an interdisciplinary team for each resident within 7 days after the completion of the comprehensive MDS assessment, and reviewed and revised by the interdisciplinary team after each comprehensive, and quarterly, MDS assessment.</p> <p>1. Resident #17 was admitted to the facility on 2/8/19, with multiple diagnoses including joint replacement, hypertension (high blood pressure), and glaucoma.</p> <p>Resident #17's Admission MDS assessment, dated 2/28/19, documented she was cognitively intact.</p> <p>On 3/12/19 at 10:28 AM, Resident #17 stated she was not involved in care plan meetings.</p> <p>Resident #17's record did not include documentation of care plan meetings with Resident #17.</p> <p>On 3/13/19 at 9:59 AM, the Social Services Director said the process for setting up care plan meetings was to first check with the resident to coordinate the meeting with other disciplines. The Social Services Director stated the initial care plan meeting was completed within a week of the resident's admission. The Social Services</p>	F 657	<p>residents #17, #19, and #73 have discharged and no further action is required.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. An audit of current patient's comprehensive care plans was completed on 3/29/19, care plans were updated as needed to ensure compliance. A review of current patients was completed</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: The interdisciplinary care plan team members responsible for writing care plans were re-educated on the facility's policy and procedure for developing Comprehensive Care Plans. A review of our initial care plan/conference process has been revamped to reflect patient's current orders, goals, prior level of function, and preferences. The Social Services Designee or other designee will be responsible for setting up the initial care plan conference within 14 days of admission.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: Care plans and conferences will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator or designee. All care plans will be updated as indicated.</p>		

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F 657	<p>Continued From page 25</p> <p>Director said a form, titled Initial Care Plan Conference (ICPC), was used to document the meetings and the follow up care conferences were documented in the progress notes. She stated the initial ICPC was not scanned into the resident's record. The Social Services Director stated Resident #17 declined attending care conference meetings. The Social Services Director confirmed there was not documentation in Resident #17's record of her declining participation in the meetings. The Social Services Director reported there was no set time scheduled for the interdisciplinary care conferences, and usually the facility only did them as needed.</p> <p>On 3/13/19 10:24 AM, the Administrator stated the initial ICPC documentation was not included in the residents ' records. The Administrator said he kept the documentation in his office. Resident 17's ICPC form was provided by, and reviewed with, the Administrator. The form documented the care plan conference was completed on 2/15/19. The form included the signatures of the Social Service Director and an occupational therapist. Other signatures were not documented. A box was checked on the form indicating the "Patient" participated, although as mentioned previously, Resident #17 and the Social Services Director stated Resident #17 did not attend. The contents of the care plan conference was not documented. The Administrator stated the facility did not document items covered in the care plan conferences.</p> <p>2. Resident #19 was admitted to the facility on 2/7/19, with multiple diagnoses including aftercare following a joint replacement and</p>	F 657	<p>The MDS Coordinator or designee will complete a random weekly audit of care plans to ensure that comprehensive care plans are developed for residents. The MDS Coordinator or designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.</p>		

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F 657	<p>Continued From page 26</p> <p>obstructive sleep apnea (periods of cessation of breathing).</p> <p>Resident #19's record did not document a care plan conference occurred since his admission to the facility.</p> <p>On 3/11/19 at 3:08 PM, Resident #19 said he was not aware of a care plan conference being held since he was admitted to the facility.</p> <p>On 3/13/19 at 10:52 AM, the Social Services Director said documentation of care plan conferences were were kept in the Administrator's office. The Social Services Director said the initial care plan conference was done within a week of the resident's admission to the facility, and the Administrator, MDS nurse, Director of Therapy, and sometimes other staff attended the initial care plan conference.</p> <p>On 3/13/19 at 11:04 AM, the Administrator said he could not find the documentation of Resident #19's care plan conference.</p> <p>3. Resident #13 was readmitted to the facility on 2/4/19, with diagnoses which included fractured prosthetic left hip joint, pain, and bacterial infection.</p> <p>An admission MDS assessment, dated 2/11/19, documented Resident #13 was cognitively intact and had a surgical wound.</p> <p>Resident #13's physician order, dated 3/8/19, documented she received 500 mg of cephalexin (antibiotic) three times daily for an infection to her left surgical hip site, until 3/21/19.</p>	F 657			

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F 657	<p>Continued From page 27</p> <p>Resident #13's March 2019 MAR documented the cephalexin 500 mg was administered three times a day as ordered from 3/8/19 through 3/12/19.</p> <p>On 3/12/19 at 9:58 AM, Resident #13 stated her incision was infected and it started draining a few days ago.</p> <p>The care plan area addressing Resident #13's infection and antibiotic use, was not initiated until 5 days after treatment was initiated.</p> <p>On 3/13/19 at 2:21 PM, the DON stated Resident #13's care plan was reviewed after discussions with the surveyors and care areas were added. The DON stated the use of the antibiotic was not added to the care plan as soon as possible. The DON stated she expected the care plan to be updated as soon as possible. The DON stated after a nurse received an order for something that required extra care, the nurse should initiate a care plan or update the care plan.</p> <p>4. Resident #73 was admitted to the facility on 7/23/18, with diagnoses which included a fractured left femur (thigh bone), tobacco use, and cerebral infarction (stroke).</p> <p>An admission MDS assessment, dated 7/30/18, documented Resident #73 was cognitively intact and she required extensive assistance of two staff members for transfers, bed mobility, toilet use, and dressing. The MDS documented Resident #73 currently used tobacco.</p> <p>A Progress Note, dated 8/14/18, documented</p>	F 657			

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F 657	Continued From page 28 Resident #73 wanted to smoke, and the facility staff agreed to accommodate her request and assisted her with smoking at 10:00 AM and 4:00 PM. The care plan area addressing Resident #73's smoking, initiated on 7/27/18, did not document the agreed upon plan to assist her with smoking at 10:00 AM and 4:00 PM. On 3/15/19 at 8:45 AM, the Administrator stated Resident #73 was aware of the non-smoking policy upon admit, and the facility met with Resident #73 and her family to develop a plan to assist her with smoking. The Administrator stated he thought Resident #73's care plan included her smoking schedule. The care plan was not revised when changes occurred to Resident #73's care.	F 657			
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, policy review, and Activity Calendar	F 679	1. Immediate action(s) taken for the resident(s) found to have been affected	4/15/19	

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F 679	<p>Continued From page 29</p> <p>review, it was determined the facility failed to ensure there was a variety of activities, and the scheduled activities met the needs of residents. This was true for 2 of 2 residents (Resident #3 and Resident #173) reviewed for activities. This created the potential for residents to become bored and foster increased negative behaviors due to a lack meaningful and engaging activities throughout the day and evening. Findings include:</p> <p>The facility's undated Activity's policy documented residents' activities should be meaningful and individualized according to their needs.</p> <p>The March 2019 Activity Calendar was completed between 3/1/19 and 3/18/19, and it documented activities occurred seven days a week with minimal times set aside for activities. The Activity Calendar documented the following activities:</p> <ul style="list-style-type: none"> * Sundays: activity cart upon request, puzzles in the dining room, Church services on television from 9:00 AM to 10:00 AM, and Sacrament in the afternoon * Mondays: activity cart upon request, puzzles in the dining room, riddle of the week, and Bingo at 4:30 PM * Tuesdays: Salon by appointment only, activity cart upon request, puzzles in the dining room, Tuesday 3/15/19 Wine and Cheese at 3:00 PM * Wednesdays: activity cart upon request, puzzles in the dining room, Wednesday 3/6/19 a board game at 4:30 PM * Thursdays: activity cart upon request, puzzles in the dining room, Thursday 3/15/19 St. Patrick's 	F 679	<p>include:</p> <p>An activities assessment for #3 and #173 was completed on 4/3/19.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. An audit of all activities assessments have been complete. Current patient's comprehensive care plans were updated to reflect preferences.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: Education with the activities assistant and Social Services designee was completed to ensure calendar contains a variety of patient's preferences. Activities have been revamped to include activities during various hours throughout the day/evening and weekend. Social Services or Designee will review with the patient and/or family member during the initial care conference to ensure the activities assessment is complete with preferences, the activities are meeting the patient's preferences, and those items are reflected in accordance with the care plan.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The Social Services or Designee will complete a random weekly audit of activities assessment/preferences to</p>		

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F 679	<p>Continued From page 30</p> <p>Day Craft at 5:00 PM</p> <p>* Fridays: Salon by appointment only, activity cart upon request, puzzles in the dining room, Dinner and a Movie on 3/1/19 and 3/16/19 (the movies were the same), and on 3/8/19 a different movie at 4:00 PM.</p> <p>* Saturdays: activity cart upon request, puzzles in the dining room</p> <p>The activity calendar from 3/1/19 through 3/18/19, did not include activities scheduled after 5:00 PM. The activity cart and puzzles were scheduled daily. The activity cart had the same items available of books, magazines, crosswords, word searches, and other games. There were 10 activities scheduled that were not the activity cart or puzzles, or that were not by appointment only. The activity Calendar instructed residents to contact their religions if they wanted religious services.</p> <p>a. Resident #173 was readmitted to the facility on 2/23/19, with diagnoses which included failure to thrive and pain.</p> <p>An admission MDS assessment, dated 3/1/19, documented Resident #173's activity preferences which were very important to her included pet visits, and activities that were important but she could no longer do included favorite activities and religious activities.</p> <p>An Activity Assessment, dated 3/1/19, documented Resident #173's activity preferences that were very important to her included pet visits. The assessment documented things somewhat important to her included listening to music, current events/news, reading,</p>	F 679	<p>ensure the facility is meeting the patient's interests and the care plan reflects their preferences.</p> <p>The Social Services or designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.</p>		

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F 679	<p>Continued From page 31</p> <p>socials/parties, and group discussions. The assessment documented activities that were important to Resident #173, but she was no longer able to do, included religious services and favorite activities.</p> <p>The Activities care plan, dated 2/26/19, documented Resident #173 enjoyed activities where she played the piano or the organ and pet visits. The care plan did not document other activities she enjoyed, as documented in the 3/1/19 Activity Assessment.</p> <p>Resident #173's Activities Flowsheet, dated 2/1/19 through 2/28/19, did not include documentation of pet visits or playing the piano or organ. The flowsheet documented she actively participated in a social on 2/14/19, and she received a copy of the activities calendar four times. Resident #173 declined seven offers for activities such as bingo, crafts, activities cart, movie night, and a special event. Resident #173's flowsheet did not include other activities offered or provided.</p> <p>Resident #173's record was reviewed on 3/15/19 and did not include an Activities Flowsheet for March 2019.</p> <p>On 3/11/19 at 3:30 PM, Resident #173 stated the activities at the facility did not interest her and they were the same thing. Resident #173 stated she enjoyed playing the piano or organ and the facility did not have one. Resident #173 stated she stayed in her bed most of the day when she was not receiving therapy.</p> <p>b. Resident #3 was admitted to the facility on</p>	F 679			

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F 679	<p>Continued From page 32</p> <p>12/18/18, with diagnoses which included pain and a fractured leg.</p> <p>An admission MDS assessment, dated 12/24/18, documented Resident #3's activity preferences which were very important to him included music and getting outside air.</p> <p>An Activity Assessment, dated 12/20/18, documented Resident #3's activity preferences that were very important to him were music and going outside for fresh air. The assessment documented it was not important to him to keep up with the current events/news, pet visits, read, socials/parties, and religious activities.</p> <p>The Activities care plan, dated 2/26/19, documented Resident #3 enjoyed activities of television, hunting, fishing, and vaping outside. The care plan did not include music and going outside as activities he enjoyed.</p> <p>Resident #3's Activities Flowsheet, dated 2/1/19 through 2/28/19, did not include documentation of being outside. The flowsheet documented he actively participated in a social on 2/6/19 and 2/14/19, a special event on 2/14/19, and he received a copy of the activities calendar four times. Resident #3 declined five offers for activities such as bingo, activities cart, and movie night. Resident #3's flowsheet did not include other activities offered or provided.</p> <p>Resident #3's record was reviewed on 3/15/19 and did not include an Activities Flowsheet for March 2019.</p> <p>On 3/11/19 at 1:46 PM, Resident #3 stated the</p>	F 679			

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F 679	Continued From page 33 activities provided by the facility did not pertain to a person of his age. On 3/13/19 at 10:06 AM, the Social Services Director stated the facility was currently working on updating the activities program due to resident complaints.	F 679			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and interviews with residents and staff, it was determined the facility failed to ensure professional standards were met for wound care, medication administration, treatment provided in a timely manner, and bowel care. This was true for 3 of 13 residents (#13, #73, and #126) reviewed for quality of care. These failures created the potential for harm should residents experience worsening of wounds, constipation or fecal impaction, and/or adverse effects from medications. Findings include: The Facility's Medication Therapy policy, dated April 2009, documented a resident's record must contain physician orders for all medications and treatments.	F 684	1. Immediate action(s) taken for the resident(s) found to have been affected include: An assessment on resident #13 was completed, orders and care plan reviewed and updated. Resident #73 and #126 have discharged and no further action is required. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. A skin assessment was completed on current residents in the facility on 3/28/19. Orders and care plans were reviewed and updated as indicated.	4/15/19	

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F 684	<p>Continued From page 34</p> <p>1. Resident #73 was admitted to the facility on 7/23/18, with diagnoses which included a fractured left femur (thigh bone), tobacco use, and stroke.</p> <p>a. Resident #73 developed a skin impairment on her left inner thigh. Resident #73's Total Skin and Body Assessment, dated 9/4/18, documented she had a raised area on the inside of her left thigh without drainage.</p> <p>A Physician Progress Note, dated 9/10/18 documented the physician examined a two-inch boil (infection of the hair follicle) on Resident #73's left inner thigh and it "appears to have been opened by pressure at some point." The note documented the raised area was approximately four inches high.</p> <p>Resident #73's physician's order, dated 9/10/18, documented staff were to apply a warm pack three times a day to her left inner thigh.</p> <p>Resident #73's record did not include orders to monitor or treat the area to her inner left thigh between 9/4/18 and 9/10/18 (6 days).</p> <p>Resident #73's Total Skin and Body Assessment, dated 9/11/18, documented Resident #73 had a cyst on her upper inner thigh (previously referred to as a boil). The assessment did not document measurements for the area, a description of the wound bed, or include which leg it was on.</p> <p>A Wound Clinic Note, dated 9/13/18, documented Resident #73's left inner thigh abscess (i.e. boil, cyst) was initially evaluated, and she had eschar</p>	F 684	<p>Regarding bowel care interventions, the facility has determined that all residents have the potential to be affected. An audit of bowel movements in the facility was completed on 3/28/19. Bowel protocol was implemented as indicated.</p> <p>The facility has determined that all residents had the potential to be affected. A review of patients who currently are currently prescribed Digoxin was completed on 3/25/19. Patients orders and care plans were updated to reflect appropriate parameters in accordance to the Nursing 2018 Drug Handbook, including physician notification.</p> <p>The facility has determined that all residents had the potential to be affected. Surgical incision sites were assessed for appropriate treatments in accordance to physician's orders and updated as indicated.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>Licensed staff were educated on the wound care policy and procedures. Wound care education was provided by the director of a wound care unit on documentation, assessment, and staging of wounds and treatments.</p> <p>Bowel protocol; licensed staff were educated on the bowel protocol policy</p>		

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F 684	<p>Continued From page 35</p> <p>(dark dead tissue) measuring 0.4 cm long by 0.1 cm wide, which covered a fluid filled sack. The note documented the wound had a strong odor and the clinic removed a large amount of thick pus from the abscess. The note documented Resident #73's inner left thigh was not covered with a dressing on arrival.</p> <p>A Wound Clinic order, dated 9/13/18, documented an order for Resident #73's inner left thigh abscess to be cleansed with a cleansing agent, a barrier ointment applied to the surrounding skin, the wound packed with gauze, and an adhesive foam dressing applied every other day and as needed.</p> <p>Resident #73's physician orders, dated 9/17/18, (four days later) documented an order for staff to cleanse left thigh abscess with normal saline and gauze, apply skin prep to intact skin, pack the wound with gauze, and cover the wound with a foam dressing every other day. The order was entered into Resident #73's record four days after her wound clinic appointment (9/13/18 - 9/17/18).</p> <p>Resident #73's Total Skin and Body Assessment, dated 9/18/18, documented Resident #73's had a cyst on her upper inner thigh. The note documented there was an odor present with white drainage. The assessment did not document measurements for the area, a description of the wound bed, or which leg it was on.</p> <p>A Wound Clinic Note, dated 9/18/18, documented Resident #73's left inner thigh abscess was a full thickness wound with slough (a mass of dead tissue that separates from a wound bed) and</p>	F 684	<p>and procedure. A nursing task will be assigned to every patient to be completed daily concerning bowel movement in the last three days with interventions as indicated. Unit managers or designee will review the current resident's bowel movement status, by review of admission assessments and clinical alerts.</p> <p>Licensed staff, including RN #1 were educated on vital sign parameters prior to medication administration and notification to the physician. Orders will be reviewed by DON or designee to ensure parameters are established for medications as indicated with proper physician notification.</p> <p>Licensed staff were educated on following physician orders for care and treatment of surgical incision sites. The DON or designee will review current treatments of surgical incision sites for accuracy based on licensed staff assessments and current physician orders.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The DON or designee will complete a random weekly audit of skin assessments, bowel protocol and physician's orders, which include wound care and vital sign parameters.</p> <p>The DON or designee will report the findings to the monthly QA meeting for 2</p>		

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F 684	<p>Continued From page 36</p> <p>eschar present on the wound bed. The note documented the area was warm to the touch, painful, and measured 1.2 by 1.6 by 0.4 cm. The note documented the Wound Clinic was unable to debride the area due to Resident #73's high pain level.</p> <p>A Wound Clinic order, dated 9/18/18, documented an order for Resident #73's inner left thigh abscess to be cleansed with a non-cytotoxic agent, Iodosorb (a sterile formula used to clean wound beds and assist with removing slough) applied to the wound bed, and a Tegaderm foam dressing applied every other day and PRN.</p> <p>Resident #73's physician orders for treatment of her left thigh abscess were changed to include the Iodosorb on 9/25/18, 7 days after the Wound Clinic order. The orders did not include the Tegaderm foam, as ordered by the Wound Clinic.</p> <p>Resident #73's Total Skin and Body Assessment, dated 9/25/18, documented she had a healing cyst to her left upper thigh. The assessment did not document measurements for the area and a description of the wound bed.</p> <p>A Wound Clinic Note, dated 9/25/18, documented Resident #73's inner left thigh abscess was healing and measured 0.7 cm by 1.50 cm by 0.2 cm. The note documented the wound bed had minimal slough with granular (new, healthy) tissue.</p> <p>A Wound Clinic order, dated 9/25/18, documented an order for Resident #73's inner left thigh abscess to be cleansed with a</p>	F 684	months, or until there is 100% compliance and as needed.		

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F 684	<p>Continued From page 37</p> <p>non-cytotoxic agent, Iodosorb applied to the wound bed, and a Mepilex dressing applied every other day and PRN.</p> <p>Resident #73's September 2018 MAR documented staff were to cleanse Resident #73 inner left thigh abscess with normal saline, apply skin prep to the intact area, apply Iodosorb, and cover the wound with Mepilex every other day and PRN, beginning on 9/25/18 and discontinued on 10/10/18. The dressing was changed as ordered by the physician, except on 9/28/18 when Resident #73 was unavailable and on 9/25/18.</p> <p>Resident #73's Total Skin and Body Assessment, dated 10/2/18, documented she had a healing cyst to her left upper thigh. The assessment did not document measurements for the area or a description of the wound bed.</p> <p>Resident #73's Total Skin and Body Assessment, dated 10/9/18, documented Resident #73's left upper thigh was in the healing stages.</p> <p>A Wound Clinic Note, dated 10/9/18, documented Resident #73's left upper thigh abscess remained open and was healing.</p> <p>A Wound Clinic order, dated 10/9/18, documented an order for Resident #73's inner left thigh abscess to be cleansed with a non-cytotoxic agent, a collagen gel applied to the wound bed, and a Mepilex dressing applied every other day and PRN. The order for the collagen gel was not added to Resident #73's physician orders.</p>	F 684			

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F 684	<p>Continued From page 38</p> <p>On 3/15/19 at 8:45 AM, the DON stated the wound treatment orders should be entered into the system by the nurse in charge of the resident's care. The DON stated the nurses should enter the orders as soon as possible, and if the orders were not sent with the resident, the nurses should contact the Wound Clinic to get the orders faxed. The DON stated Resident #73's thigh wound appeared to be an ingrown hair when it was first identified. The DON stated she could not find orders for its monitoring or treatment until 9/17/18; however, she recalled the facility provided a bandage for the abscess prior to 9/17/18. The DON stated Resident #73 was seen by the Wound Clinic when the wound opened.</p> <p>The facility failed to implement treatments as ordered by the Wound Clinic timely, and some were not implemented. The facility also failed to consistently assess Resident #73's left inner thigh abscess.</p> <p>b. The facility's undated Bowel Protocol documented when a resident did not have a bowel movement in three days or more, staff were directed to follow the protocol. The protocol documented the following:</p> <ul style="list-style-type: none"> * Day 3 without a bowel movement - provide Milk of Magnesia, prune juice, or fiber. * Day 4 without a bowel movement - provide a suppository * Day 5 without a bowel movement - provide an enema * Day 6 without a bowel movement - contact the physician 	F 684			

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F 684	<p>Continued From page 39</p> <p>The facility failed to follow the bowel protocol as follows:</p> <p>Resident #73 was admitted to the facility on 7/23/18, with diagnoses which included a fractured left femur (thigh bone), tobacco use, and stroke. Resident #73 was discharged on 10/10/18.</p> <p>Resident #73's admission orders included:</p> <ul style="list-style-type: none"> - Follow the bowel and bladder protocol, ordered on 7/23/18. - Colace (stool softener) two times a day for constipation, ordered on 7/23/18. - Polyethylene Glycol (laxative) 17 grams by mouth PRN one time daily for constipation, ordered on 7/23/18. - Bisacodyl Suppository 10 milligrams rectally PRN one time daily for constipation, ordered on 7/23/18. <p>Resident #73's Nursing Admit Assessment, dated 7/23/18, documented her last bowel movement was on 7/19/18 (4 days prior to admission).</p> <p>Resident #73's July 2018 ADL Bowel Movement record documented the following:</p> <ul style="list-style-type: none"> - There was no documented evidence she had a bowel movement between 7/23/18 and 7/28/18 (5 days). - The record documented Resident #73 had a bowel movement on 7/29/18. This bowel movement occurred 10 days after her last documented bowel movement on 7/19/18. 	F 684			

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F 684	<p>Continued From page 40</p> <p>A Progress Note, dated 7/28/18 at 4:27 PM, documented Resident #73 refused to eat her meals due to constipation. The note documented she declined to take medications to assist with constipation; however, the nurse encouraged her to take the medication and she did.</p> <p>A Progress Note, dated 7/29/18 at 9:59 PM, documented Resident #73 threw up a substance which looked and smelled like stool and the physician assessed the substance. The note documented Resident #73's last bowel movement was "a while" ago and she declined wanting to have a bowel movement. The note documented nursing received an order for a new laxative and Resident #73 agreed to take the medication.</p> <p>Resident #73's physician order, dated 7/29/18, documented she was to receive 300 mL (milliliters) of Magnesium Citrate (laxative) one-time daily PRN for constipation.</p> <p>Resident #73's July 2018 MAR documented the following bowel medications were provided:</p> <ul style="list-style-type: none"> - Colace was administered as ordered, except on 7/30/18 and 7/31/18 when she refused. - One dose of Bisacodyl Suppository was administered on 7/27/18 and 7/29/18. The 7/27/18 dose was documented as ineffective. - 17 grams of Polyethylene Glycol was administered on 7/28/18 and it was ineffective. - 300 mL of Magnesium Citrate was administered on 7/29/18 and it was effective. 	F 684			

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F 684	<p>Continued From page 41</p> <p>The facility did not provide bowel care interventions between 7/23/18 and 7/27/18 (four days). Resident #73 received bowel care for the first time on 7/27/18, or eight days after her last bowel movement (7/19/18). The facility did not follow the protocol of initiating bowel care interventions on day 3 of no bowel movement.</p> <p>On 3/15/19 at 8:45 AM, the DON stated nurses were instructed to follow the bowel protocol after a resident went three days without a bowel movement. She stated they were instructed to start with day three interventions and continue onto the next intervention per residents' needs. The DON stated she was unable to find bowel care interventions provided to Resident #73 between 7/23/18 and 7/27/18. The DON stated if an intervention was ineffective she would expect staff to try something else or contact the physician.</p> <p>2. The Nursing 2018 Drug Handbook documented the following regarding digoxin (a heart medication):</p> <p>* Before administering the medication, measure the pulse for one minute, record the result and notify the prescribing provider of significant changes. * "Excessively slow pulse rate (60 beats/minute or less) may be a sign of digitalis toxicity. Withhold drug and notify prescriber."</p> <p>Resident #126 was admitted to the facility on 3/8/19, with multiple diagnoses including atrial fibrillation (irregular heartbeat).</p>	F 684			

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F 684	<p>Continued From page 42</p> <p>Resident #126's physician orders documented an order on 3/9/19 for digoxin 125 mcg daily for heart failure. The order further instructed staff to hold the digoxin if Resident #126's heart rate less than 60 beats per minute.</p> <p>Resident #126's MAR documented digoxin 125 mcg was administered on 3/9/19, and the heart rate was 51.</p> <p>There was no documentation in Resident #126's record the digoxin was held on 3/9/19.</p> <p>On 3/13/19 at 2:17 PM, RN #1 said before giving digoxin, the nurse should check Resident #126's pulse and check the order. RN #1 said if the pulse was in the fifties then the medication should not be given, and the physician should be notified.</p> <p>On 3/13/19 at 2:55 PM, the DON said digoxin should not have been given to Resident #126 when his pulse was 51, and she did not see documentation the digoxin was held on that day.</p> <p>3. Resident #13 was readmitted to the facility on 2/4/19, with diagnoses which included fractured prosthetic left hip joint, pain, and bacterial infection.</p> <p>An admission MDS assessment, dated 2/11/19, documented Resident #13 was cognitively intact and had a surgical wound.</p> <p>Resident #13's hospital History and Physical, dated 1/29/19, documented she had a pain pump in place on her left hip.</p>	F 684			

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F 684	<p>Continued From page 43</p> <p>Resident #13's physician orders, dated 2/4/19, included:</p> <ul style="list-style-type: none"> - Cleansing the left hip with normal saline and gauze, applying skin prep to intact surrounding skin, and covering the surgical site with bordered gauze every three days. - Monitor the incision for signs and symptoms of infection and notify the physician if there was an increase in temperature, redness, swelling, drainage, etc., every shift. <p>Resident #13's February 2019 MAR documented Resident #13's incision was monitored every shift as ordered, however, the documentation did not indicate if signs and symptoms of infection were found. The MAR documented her left hip dressing was changed as ordered.</p> <p>The following Progress Notes documented Resident #13's surgical incision was healing with Steri Strips (medical wound closure strips) in place and did not document a dressing was in place as ordered by the physician. The Progress Notes also identified Resident #13 had increased pain in her left hip area. Examples include:</p> <ul style="list-style-type: none"> - Progress Notes, dated 2/23/19, 2/24/19, and 2/26/19, documented Resident #13's left surgical incision was healing and Steri Strips were in place. - A Progress Note, dated 2/27/19, documented Resident #13's left surgical incision was clean and healing. - A Progress Note, dated 3/1/19, documented 	F 684			

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F 684	<p>Continued From page 44</p> <p>Resident #13's left surgical incision was healing and Steri Strips were in place.</p> <ul style="list-style-type: none"> - A Progress Note, dated 3/2/19, documented Resident #13's left surgical incision had Steri Strips in place and her left hip was "throbbing" with pain. - A Progress Note, dated 3/3/19, documented Resident #13's left surgical incision had Steri Strips in place and she had pain in her leg. - A Progress Note, dated 3/4/19, documented Resident #13's left hip "hurts even more" and was "throbbing." - A Progress Note, dated 3/5/19 at 1:27 PM, documented Resident #13 had no changes to her skin integrity. The note documented her left leg hurt. - A Progress Note, dated 3/5/19 at 5:38 PM, documented Resident #13's left hip/pain pump site was swelling. - A Progress Note, dated 3/6/19, documented Resident #13's left hip surgical site was swollen, draining thick fluids, and pulling apart at the top of the incision. The note documented Resident #13's left hip hurt even more and was throbbing. <p>Resident #13's March 2019 MAR documented the following:</p> <ul style="list-style-type: none"> - Resident #13's incision was monitored every shift as ordered. There was no documentation of swelling, pain, or drainage to Resident #13's surgical incision. 	F 684			

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F 684	Continued From page 45 - Cleansing the left hip with normal saline and gauze, apply skin prep to intact surrounding skin, and cover with bordered gauze every three day was changed as ordered, except on 3/1/19 and 3/4/19. The MAR documented her left hip incision was cleansed and a dressing applied on 3/7/19 and 3/11/19. - The MAR documented Resident #13 had an appointment with her physician on 3/6/19 for increased swelling in her left hip incision. Resident #13's physician orders, dated 3/8/19, documented an order for 500 mg of cephalexin (antibiotic) three times daily for an infection to her left surgical hip site. Resident #13's MAR, dated 3/8/19 through 3/12/19, documented she received the cephalexin 500 mg as ordered. On 3/12/19 at 9:58 AM, Resident #13 stated her left hip incision did not have a dressing on it, and the facility stopped using a dressing and cleansing it except when she showered a while ago. Resident #13 stated her left hip incision did not have a dressing in place this week or last week. Resident #13 stated her incision was infected and started draining a few days ago. Resident #13 stated she noticed increased pain in her hip as well. On 3/13/19 at 11:54 AM, Resident #13's left hip incision was observed without a dressing. Resident #13's incision was intact with Steri Strips. There was redness and swelling along the incision line, and a green dried crusty exudate	F 684			

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F 684	Continued From page 46 (mass of cells and fluid found during inflammation) along the entire incision line. On 3/13/19 at 2:14 PM, the DON stated she was unsure how Resident #13's left hip incision got infected. The DON stated the order to cleanse Resident #13's left hip and apply a bandage should have been discontinued on the first of March, and it was not. She stated nurses should follow all active physician orders. The DON stated she would try to find out why the nurses documented they cleansed the left hip incision and dressed the wound on 3/7/19 and 3/11/19 when Resident #13 stated it was not completed.	F 684			
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility policies, it was determined the	F 686	1. Immediate action(s) taken for the resident(s) found to have been affected	3/29/19	

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F 686	<p>Continued From page 47</p> <p>facility failed to ensure implementation of interventions to prevent the worsening of a pressure ulcer and that the pressure ulcer prevention interventions were followed. This was true for 1 of 1 resident (Resident #73) reviewed for pressure ulcers. This deficient practice caused harm to Resident #73 when the pressure ulcer on her coccyx worsened to an unstageable wound. Findings include:</p> <p>The 2014 guidelines for staging wounds from the National Pressure Ulcer Advisory Panel, Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, documents:</p> <p>* A Stage I pressure ulcer is defined as a nonblanchable (skin that remains red in color after pressure is applied) intact redness to skin over a bony area.</p> <p>* A Stage II wound is partial skin thickness loss (affects the top two layers of the skin) with red and/or pink in the wound bed without slough (a mass of dead tissue that separates from a wound bed).</p> <p>* A Stage III wound is full skin thickness loss (affects the layers of skin and subcutaneous tissue of fat) with possible slough present in the wound bed; however, the base of wound is visible.</p> <p>* A Stage IV wound is a full thickness tissue loss with exposed muscle, bone, or tendon. The guideline documented slough or eschar (dark dead tissue) could be present in parts of the wound bed.</p>	F 686	<p>include:</p> <p>Resident #73 has discharged, and no further action is required.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. A skin assessment was completed on current residents in the facility on 3/28/19. Orders and care plans were reviewed and updated as indicated, which includes repositioning.</p> <p>Unit managers or designee will complete a weekly review of skin assessments which includes wound measurements, description of the wound bed, or staging of the wound, to determine current status with appropriate treatments. The unit managers or designee will notify the physician and Interdisciplinary team of current status of compromised skin integrity on current patients. Orders and care plan will be updated as indicated.</p> <p>The facility has determined that all residents had the potential to be affected. Pressure ulcers were assessed for appropriate treatments in accordance to physician's orders and updated as indicated. The DON/or designee will review orders for accuracy, ensuring treatments are followed timely.</p> <p>3. Actions taken/systems put into place</p>		

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F 686	<p>Continued From page 48</p> <p>* An unstageable wound is of unknown depth due to the base of the wound being covered by slough or eschar.</p> <p>The facility's undated Pressure Ulcer Treatment Policy documented:</p> <p>* Interventions for a Stage I pressure ulcer included the following: evaluating the resident's skin until the redness was no longer persistent, determining the cause of the pressure, initiating appropriate interventions, notifying the physician, initiating a skin grid and care plan, and providing a turning schedule.</p> <p>* Interventions for a Stage II pressure ulcer included the following: protecting the wound, managing drainage, cleansing the wound, following physicians' orders for dressing changes, and consulting the physician for order changes as needed.</p> <p>* Interventions for a Stage III pressure ulcer included the following: protecting the wound, managing drainage, cleansing the wound, promoting moist wound healing, managing pain, following physicians' orders for dressing changes, and consulting the physician for order changes as needed.</p> <p>* Interventions for a Stage IV pressure ulcer included the following: filling in the dead space, managing drainage, debriding slough or eschar if ordered, consulting with a wound clinic, irrigating the wound, following the physician's orders for wound care, and consulting the physician for order changes as needed.</p>	F 686	<p>to reduce the risk of future occurrence include:</p> <p>Licensed staff were educated on the wound care policy and procedures. Wound care education was provided by the director of a wound care unit on documentation, assessment, and staging of wounds and treatments.</p> <p>Licensed staff were educated on following physician orders for care and treatment of pressure areas. The DON or designee will review current treatments of pressure areas for accuracy based on licensed staff assessments and current physician orders.</p> <p>Licensed staff were educated on wound care policies and procedures which include pressure relieving measures. (Ie. Repositioning, etc.)</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The DON or designee will complete a random weekly audit of skin assessments, care plans, and physician's orders.</p> <p>The DON or designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed. Corrective action completion date: March 29, 2019</p>		

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F 686	<p>Continued From page 49</p> <p>Resident #73 was admitted to the facility on 7/23/18, with diagnoses which included a fractured left femur (thigh bone), history of falling, tobacco use, and a stroke. Resident #73 was discharged on 10/10/18.</p> <p>Resident #73's Hospital History and Physical, dated 7/20/18, documented she had a sacral (low back/upper buttock area) pressure sore which was not a full thickness skin loss and was "mostly" a reddened area.</p> <p>a. Resident #73's Nursing Admission Assessment, dated 7/23/18, documented she had a 0.6 cm long by 0.6 cm wide open area to her sacrum. The nursing assessment did not include an assessment of the wound bed or include staging of the wound. Based on the description of the wound in the admission assessment, Resident #73's wound was a Stage II and no slough was documented as present.</p> <p>Resident #73's Admission orders, July 2018 MAR and TAR, and July 2018 physician's orders did not include treatment or preventative orders for the skin impairment on her sacrum/coccyx.</p> <p>An admission MDS assessment, dated 7/30/18, documented Resident #73 was cognitively intact and documented she required extensive assistance of two staff members for transfers, bed mobility, toilet use, and dressing. The MDS assessment documented Resident #73's had a stage I pressure ulcer or greater. The MDS did not describe the wound in further detail.</p> <p>Resident #73's Total Skin and Body Assessment, dated 7/31/18, documented she had a 1 cm red,</p>	F 686			

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F 686	<p>Continued From page 50</p> <p>excoriated (damaged rubbed off skin) open area to her coccyx. The pressure ulcer was 0.6 cm by 0.6 cm on 7/23/18 and increased in size to 1 cm as of 7/31/18. The assessment did not document a description of the wound bed or stage the wound.</p> <p>A Wound Clinic Note, dated 8/2/18, documented Resident #73's sacrum was initially evaluated, and she had an unstageable pressure ulcer covered with slough. The assessment documented she had three small, bridged, slough-covered open areas and the area of the wounds measured 0.4 cm long by 1 cm wide by 0.1 cm deep. The note documented she had a dressing in place upon arrival.</p> <p>A Wound Clinic order, dated 8/2/18, documented an order for Resident #73's sacral pressure ulcer be cleansed with normal saline and gauze, apply a topical agent using Iodosorb (a sterile formula used to clean wound beds and assist with removing slough), and cover the wound with Mepilex every other day and PRN.</p> <p>Resident #73's physician order, dated 8/3/18, 11 days after Resident #73's admission, documented an order for staff to cleanse the sacrococcygeal wound with normal saline and gauze, apply skin prep to the intact area, and cover the wound with Mepilex every other day. The order did not include the use of Iodosorb as a cleansing agent, as documented in Resident #73's Wound Clinic orders.</p> <p>Resident #73's August 2018 MAR documented staff were to cleanse Resident #73 sacrococcygeal wound with normal saline and</p>	F 686			

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F 686	<p>Continued From page 51</p> <p>gauze, apply skin prep to the intact area, and cover the wound with Mepilex every two days, beginning on 8/3/18 and discontinued on 8/24/18. The dressing was changed as ordered with the exception of 8/22/18 and 8/24/18.</p> <p>The care plan area addressing Resident #73's pressure ulcer, initiated on 8/6/18, documented Resident #73 had a "chronic" pressure ulcer to her coccyx. The care plan documented staff were to encourage and assist Resident #73 to with repositioning every two hours. The care plan documented Resident #73 was to receive wound care per orders and facility protocol. The care plan documented staff were to monitor and documented the location, size, and treatment of her skin impairments.</p> <p>Resident #73's Total Skin and Body Assessment, dated 8/7/18, documented she had a 1 cm red, excoriated, open area on her coccyx. The assessment did not document a description of the wound bed or the stage of the wound.</p> <p>A Wound Clinic Note, dated 8/9/18, documented Resident #73 had an unstageable sacral pressure ulcer which measured 0.4 cm by 0.5 cm by 0.1 cm. The note documented Resident #73's wound was a single open area with slough covering the wound bed and some localized redness to the tissue surrounding the wound edges. The note documented Resident #73's wound and surrounding tissue was tender when touched. The note documented the Wound Clinic applied a topical agent using Iodosorb.</p> <p>Resident #73's Total Skin and Body Assessment, dated 8/14/18, documented Resident #73's</p>	F 686			

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F 686	<p>Continued From page 52</p> <p>coccyx was healing without redness. The assessment did not document wound measurements, a description of the wound bed, or staging of the wound.</p> <p>A Wound Clinic Note, dated 8/16/18, documented Resident #73's unstageable sacral pressure ulcer measured 0.3 cm by 0.3 cm by 0.1 cm. The note documented Resident #73's wound bed was covered with slough and there was blanchable redness to the tissue surrounding the wound edges. The note documented Resident #73's wound and surrounding tissue was tender when touched. The note documented the wound care orders still included the Iodosorb.</p> <p>Resident #73's Total Skin and Body Assessment, dated 8/21/18, documented Resident #73's coccyx was healing without redness. The assessment did not document wound measurements, a description of the wound bed, or staging of the wound.</p> <p>A Wound Clinic Note, dated 8/23/18, documented Resident #73's unstageable sacral pressure ulcer measured 0.4 cm by 0.2 cm by 0.2 cm. The note documented Resident #73's wound bed was covered with slough and there was no evidence of Iodosorb on the wound or the dressing. The note documented Resident #73's wound and surrounding tissue were tender when touched. The note documented the wound care orders still included the Iodosorb and a tube of it was sent with Resident #73 to the facility.</p> <p>Resident #73's August 2018 MAR documented staff were to cleanse Resident #73 sacrococcygeal wound with normal saline and</p>	F 686			

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F 686	<p>Continued From page 53</p> <p>gauze, apply a topical agent using Iodosorb, and cover the wound with Mepilex every other day and PRN, beginning on 8/24/18. Between 8/3/18 and 8/23/18 Resident #73's physician's order did not include the use of Iodosorb. The dressing was changed as ordered by the physician during that time frame.</p> <p>Resident #73's Total Skin and Body Assessment, dated 8/28/18, documented Resident #73's coccyx was healing without redness. The assessment did not document measurements for the area, a description of the wound bed, or staging of the wound.</p> <p>A Wound Clinic Note, dated 8/30/18, documented Resident #73's unstageable sacral pressure ulcer was evaluated with slough and measured 0.4 by 0.3 by 0.1 cm.</p> <p>A Wound Clinic order, dated 8/30/18, documented an order for Resident #73's sacral pressure ulcer to be cleansed with a non-cytotoxic agent, apply a Tegaderm hydrocolloid dressing twice weekly and PRN (A sterile wound dressing which consisted of a hypoallergenic, hydrocolloid adhesive with an outer clear adhesive cover film. The film was moisture vapor permeable, waterproof, and impermeable to liquids, bacteria, and viruses.)</p> <p>Resident #73's September 2018 MAR documented staff were to cleanse her sacrococcygeal wound with normal saline and gauze, apply skin prep to the intact area, and cover the wound with Tegaderm, hydrocolloid or similar dressing every three days and PRN, beginning on 8/31/18 and discontinued on</p>	F 686			

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F 686	<p>Continued From page 54</p> <p>9/17/18. The dressing was changed as ordered except when Resident #73 refused on 9/6/18 and 9/15/18.</p> <p>Resident #73's Total Skin and Body Assessment, dated 9/4/18, documented she had a 1 cm red, excoriated, open area on her coccyx. The assessment did not document a description of the wound bed or staging of the wound.</p> <p>Resident #73's Total Skin and Body Assessment, dated 9/11/18, documented her sacrum was healing. The assessment did not document measurements of the area, a description of the wound bed, or staging of the wound.</p> <p>A Wound Clinic Note, dated 9/13/18, documented Resident #73's sacral pressure ulcer was evaluated as improved and classified as a Stage III wound pressure ulcer with slough and measured 0.4 cm by 0.2 cm by 0.1 cm.</p> <p>A Wound Clinic order, dated 9/13/18, documented an order for Resident #73's sacral pressure ulcer to be cleansed with a non-cytotoxic (not toxic to cells) agent and apply a Mepilex dressing twice weekly and PRN.</p> <p>Resident #73's physician orders, dated 9/17/18, four days after the wound clinic order, documented an order for staff to cleanse her sacrococcygeal wound with normal saline and gauze, apply skin prep to intact skin, apply Iodosorb to the wound bed, and cover the wound with Mepilex every Monday and Thursday dayshift and PRN. The Iodosorb was discontinued on 8/30/18 by the Wound Clinic, 18 days prior.</p>	F 686			

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F 686	<p>Continued From page 55</p> <p>Resident #73's September 2018 MAR documented staff were to cleanse Resident #73 sacrococcygeal wound with normal saline and gauze, apply skin prep to intact skin, apply Iodosorb to the wound bed, and cover the wound with Mepilex every Monday and Thursday dayshift and PRN, beginning on 9/17/18 and discontinued on 9/25/18. The dressing was changed as ordered except on 9/17/18.</p> <p>Resident #73's Total Skin and Body Assessment, dated 9/18/18, documented Resident #73's sacrum was healing. The assessment did not document measurements of the area, a description of the wound bed, or staging of the wound.</p> <p>A Wound Clinic Note, dated 9/18/18, documented Resident #73's sacral pressure ulcer was evaluated as improved and was classified as a Stage III wound with slough. The wound measured 0.4 cm by 0.2 cm by 0.1 cm.</p> <p>A Wound Clinic order, dated 9/18/18, documented an order for Resident #73's sacral pressure ulcer to be cleansed with a non-cytotoxic agent, a collagen gel (a water-based gel that hydrates skin) applied, and a Mepilex dressing applied twice weekly and PRN.</p> <p>Resident #73's facility physician orders did not include the collagen gel to Resident #73's sacral pressure ulcer treatment between 9/18/18 and the next new order on 9/25/18.</p> <p>Resident #73's Total Skin and Body Assessment,</p>	F 686			

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F 686	<p>Continued From page 56</p> <p>dated 9/25/18, documented she had an open area to her coccyx. The assessment did not document measurements of the area, a description of the wound bed, or staging of the wound.</p> <p>A Wound Clinic Note, dated 9/25/18, documented Resident #73's sacral pressure ulcer was a healing Stage III wound with epithelial cells (new cells) and measured 0 cm by 0 cm by 0 cm.</p> <p>A Wound Clinic order, dated 9/25/18, documented an order for Resident #73's sacral pressure ulcer to be cleansed with a non-cytotoxic agent and a Mepilex dressing applied twice weekly and PRN.</p> <p>Resident #73's Total Skin and Body Assessment, dated 10/2/18, documented Resident #73's sacrum was healing. The assessment did not document measurements for the area, a description of the wound bed, or staging of the wound.</p> <p>Resident #73's Total Skin and Body Assessment, dated 10/9/18, documented Resident #73's "coccyx/sacrum" was healed.</p> <p>A Wound Clinic Note, dated 10/9/18, documented Resident #73's sacral pressure ulcer was healed.</p> <p>The facility failed to implement pressure ulcer treatments as ordered by the Wound Clinic in a timely manner, and some were not implemented. The facility also failed to consistently assess and document the status of Resident #73's sacral pressure ulcer.</p>	F 686			

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F 686	<p>Continued From page 57</p> <p>b. Resident #73 was not repositioned consistently as follows:</p> <p>The care plan area addressing Resident #73's pressure ulcer, initiated 8/6/18, documented Resident #73 had a "chronic" pressure ulcer to her coccyx. The care plan documented staff were to encourage and assist Resident #73 with repositioning every two hours.</p> <p>The Wound Clinic Notes, dated 8/2/18, 8/9/18, 8/16/18, 8/23/18, 8/30/18, 9/13/18, 9/18/18, 9/25/18, and 10/9/18, documented Resident #73 required repositioning every 2 hours.</p> <p>Resident #73's July 2018 ADL Turning and Repositioning record documented the following:</p> <ul style="list-style-type: none"> - There was no documented evidence she was turned/repositioned between 7/23/18 through 7/30/18 (7 days). - It was documented Resident #73 was turned/repositioned once each shift on 7/30/18 and 7/31/18. <p>Resident #73's August 2018 ADL Turn and Reposition record documented the following:</p> <ul style="list-style-type: none"> - There was not documented evidence she was turned/repositioned on 8/1/18. - There was not documented evidence she was turned/repositioned the night shift of 8/2/18. - On 8/3/18 it was documented Resident #73 was turned/repositioned three times on the dayshift 	F 686			

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F 686	<p>Continued From page 58 and four times on the night shift. There was no documented evidence she was turned/repositioned on evening shift on 8/3/18.</p> <p>Resident #73's ADL Turn and Reposition record, dated 8/4/18 through 10/10/18, was changed to document when staff repositioned her every two hours.</p> <p>The facility failed to ensure Resident #73 was turned/repositioned prior to the pressure ulcer worsening into an unstageable wound.</p> <p>On 3/15/19 at 8:45 AM, the DON stated the facility initiated a low air loss mattress when Resident #73 was admitted due to her pressure ulcer. The DON stated she could not find admission treatment orders for the wound on Resident #73's coccyx. She stated the earliest order she found was from 8/3/18. The DON stated the wound was "at least" a stage II based on the description in the Nursing Admission Assessment. The DON stated nurses staged wounds if they were comfortable doing so. She stated if nurses were not comfortable staging a wound, they should ask for assistance. The DON stated the nurses should document the location of the wound, describe the wound's appearance, size, the wound bed, drainage, and more. The DON stated the wound treatment orders should be entered into the computer system by the nurse in charge of the resident's care. The DON stated the nurses should enter the orders as soon as possible, and if the orders were not sent with the resident, the nurses should contact the Wound Clinic to get the orders faxed. She stated nurses entering new orders were to ensure the orders</p>	F 686			

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F 686	Continued From page 59 were accurate. The DON stated if an order was unclear the nurse should contact the physician for clarification. The DON stated she could see there was inconsistency with the documentation of the wounds. The DON stated the CNAs were not documenting turning and repositioning accurately during the first part of July. The DON stated Resident #73 refused to reposition at times and the CNAs were not documenting that. The DON stated the staff should reposition Resident #73 minimally every 2 hours, and she could see that was not documented as completed.	F 686			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure an order was in place for CPAP machines and oxygen therapy. This was true for 2 of 4 residents (#19, and #123) reviewed for oxygen. These failures created the potential for harm should residents experience complications from CPAP machines and oxygen therapy being administered without physician directions. Findings include:	F 695	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #123 received an order for oxygen on 3/19/19. Resident #19 has discharged. No further action is required. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all	4/15/19	

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F 695	<p>Continued From page 60</p> <p>The facility's undated Oxygen Concentrator policy documented the following:</p> <p>* Staff were directed to administer oxygen under physician orders, except in case of emergency. * The physician's order for rate, flow, and route of administration for oxygen were verified by the nurse.</p> <p>1. Resident #19 was admitted to the facility on 2/7/19, with multiple diagnoses including aftercare following a joint replacement and obstructive sleep apnea (periods of cessation of breathing).</p> <p>Resident #19's care plan documented he had altered respiratory status and difficulty breathing and shortness of breath related to sleep apnea, initiated on 2/13/19.</p> <p>Resident #19's physician orders did not document an order for CPAP.</p> <p>Resident #19's Progress Notes, dated 2/27/19 at 12:24 PM, 2/28/19 at 6:14 PM, 3/5/19 at 9:20 AM, 3/9/19 at 12:46 PM, and 3/13/19 at 3:36 PM, documented he had shortness of breath on exertion and CPAP.</p> <p>On 3/11/19 at 3:17 PM, Resident #19 had a CPAP machine on his bedside table and the CPAP mask was under his pillow.</p> <p>On 3/13/19 at 11:20 AM, a CPAP machine, CPAP mask, and tubing were on Resident #19's bedside table. Resident #19 said he used the CPAP every night.</p>	F 695	<p>residents have the potential to be affected. Environmental rounds were completed on 3/29/19 to observe for respiratory care equipment. Orders and care plans were updated as indicated.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>Licensed staff were educated on the oxygen policy and procedure, which includes CPAP.</p> <p>The Interdisciplinary team will complete environmental rounds of the patient's room during initial care conferences to ensure respiratory care equipment is identified. If identified, the unit manager or designee will review orders to ensure accuracy, and update care plan as indicated.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The unit manager or designee will complete a random weekly audit of resident rooms to ensure the respiratory equipment being utilized has up to date orders and care plan.</p> <p>The DON or designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.</p>		

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F 695	<p>Continued From page 61</p> <p>On 3/13/19 at 11:32 AM, RN #1 said she expected an order for Resident #19's CPAP to document the settings used with the CPAP.</p> <p>On 3/13/19 at 11:36 AM, the DON said when a resident had a CPAP, the facility staff needed an order with the settings for the CPAP.</p> <p>2. Resident #123 was admitted to the facility on 3/9/19, with multiple diagnoses including asthma.</p> <p>Resident #123's physician orders did not document an order for oxygen.</p> <p>Resident #123's Weights and Vitals Summary documented the following:</p> <ul style="list-style-type: none"> * On 3/9/19 at 5:08 PM and 5:59 PM, the oxygen saturation (a measurement of oxygen in the blood) was 94 percent on oxygen via nasal cannula. * On 3/10/19 at 11:18 AM, the oxygen saturation was 93 percent on oxygen via nasal cannula. * On 3/11/19 at 12:02 PM, the oxygen saturation was 96 percent on oxygen via nasal cannula. * On 3/12/19 at 12:29 PM, the oxygen saturation was 100 percent on oxygen via nasal cannula. <p>Resident #123's Progress Notes documented the following:</p> <ul style="list-style-type: none"> - On 3/10/19 at 4:26 PM, the oxygen saturation was 93 percent on oxygen via nasal cannula. - On 3/11/19 at 2:09 PM, the oxygen saturation was 96 percent on oxygen via nasal cannula. <p>On 3/12/19 at 12:24 PM, Resident #123 was observed in her room with oxygen in place by</p>	F 695			

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

PRINTED: 04/24/2019
FORM APPROVED
OMB NO. 0938-0391

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F 695	Continued From page 62 nasal cannula. On 3/14/19 at 10:56 AM, an oxygen concentrator, tubing, and humidifier were in Resident #123's room. There was no active order for Resident #123 to receive oxygen. On 3/14/19 at 11:06 AM, RN #2 said Resident #123 kept removing the oxygen, so it was left it off, When RN #2 checked Resident #123's oxygen saturation it was 92 percent. RN #2 said she thought there was a standing order for oxygen and staff monitored Resident #123 for 48 hours before discontinuing the oxygen. On 3/14/19 at 3:46 PM, the DON said she could not find an order for Resident #123's oxygen, and a Hospital Progress Note documented she wore oxygen at night. The DON said staff needed an order for Resident #123's oxygen.	F 695			
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700		3/15/19	

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F 700	<p>Continued From page 63</p> <p>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, policy review, and record review, it was determined the facility failed to ensure prior to placement of side rails, residents were thoroughly assessed for the risk of entrapment, and a consent was in place. This was true for 3 of 6 residents (#8, #125, and #126) reviewed for side rail use and created the potential for harm from entrapment or injury related to the use of side rails. Findings include:</p> <p>The facility's Bed Safety policy, revised December 2018, documented the following:</p> <ul style="list-style-type: none"> * Staff were directed to assess the sleeping environment, "considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding side rail safety assessment." * Staff were directed to obtain consent for side rails from the resident or their representative prior to using side rails. * Side rails may be used if the safety assessment determined they were necessary to assist with management of a medical symptom or condition, or to assist the resident with repositioning and transferring. * Staff were directed to complete the side rail safety assessment prior to using side rails and 	F 700	<ol style="list-style-type: none"> 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #8, #125, and #126 have discharged, no further action is required. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. Environmental rounds inspecting the presence of side rails were assessed for the risk of entrapment, orders obtained, a consent was completed, and care plan updated on 3/19/19. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed staff were educated on the bedrail policy. The process was changed so that the person installing bedrails will verify with nursing to ensure orders, assessment, consent, and care plan are in place prior to placement of bedrails for mobility. 		

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F 700	<p>Continued From page 64</p> <p>ensure the resident was able to use side rails safely.</p> <p>1. Resident #8 was readmitted to the facility on 1/19/19, with multiple diagnoses including orthopedic aftercare and fusion of the lumbosacral spine (lower back).</p> <p>On 3/12/19 at 10:38 AM, bilateral 1/4 side rails were present on Resident #8's bed.</p> <p>Resident #8's record did not contain a side rails safety assessment or consent for the use of the side rails.</p> <p>Resident #8's care plan documented 1/4 side rails to assist with bed mobility, initiated on 2/4/19.</p> <p>On 3/13/19 at 9:37 AM, the DON said she could not find a side rail safety assessment, or a signed consent for the side rails in Resident #8's record. The DON said if a resident expressed a desire for side rails on admission, a side rails safety assessment was completed by the admitting nurse, the physician was contacted for an order, and the resident signed a consent for side rails.</p> <p>2. Resident #125 was admitted to the facility on 3/8/19, with multiple diagnoses including aftercare following a joint replacement.</p> <p>On 3/12/19 at 10:14 AM and 3/13/19 at 4:05 PM, Resident #125 had bilateral 1/4 side rails on her bed.</p> <p>Resident #125's record did not contain a consent for side rails.</p>	F 700	<p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The unit manager or designee will complete a random weekly audit of resident rooms, if bedrails are being utilized, consents, orders, and assessments have been obtained and care plan updated.</p> <p>The DON or designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed. Corrective action completion date: April 15, 2019</p>		

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F 700	<p>Continued From page 65</p> <p>Resident #125's Side Rail Assessment, dated 3/15/19 at 12:22 PM, documented she was evaluated for the use of bilateral 1/4 side rails and was determined to be safe, a physician's order was obtained prior to placing the side rails, and a consent was signed prior to placing the side rails.</p> <p>On 3/14/19 at 9:44 AM, the DON said she did not see an order or consent for Resident #125's side rails.</p> <p>3. Resident #126 was admitted to the facility on 3/8/19, with multiple diagnoses including acute embolism and thrombosis (blood clot).</p> <p>On 3/11/19 at 4:16 PM and on 3/13/19 at 1:55 PM, Resident #126 had bilateral bed rails in place.</p> <p>On 3/11/19 at 4:16 PM, Resident #126 said a side rail safety assessment or consent form was not done, and the side rails were already in place when he arrived in the facility.</p> <p>Resident #126's record did not contain a consent for side rails.</p> <p>Resident #126's Side Rail Assessment, dated 3/15/19 at 12:15 PM, documented he was evaluated for the use of bilateral 1/4 side rails and was determined to be safe, a physician's order was obtained prior to placing the side rails, and a consent was signed prior to placing the side rails.</p> <p>On 3/13/19 at 2:49 PM, the DON said she did not</p>	F 700			

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F 700	Continued From page 66 see an order, consent, or care plan for Resident #126's side rails.	F 700			
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: (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. §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. §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. §483.35(g)(4) Facility data retention requirements. The facility must maintain the	F 732		4/15/19	

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F 732	<p>Continued From page 67</p> <p>posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure the nurse staffing information was posted daily. This failed practice impacted 12 of 12 residents (#1, #3, #8, #11, #13, #17, #19, #123, #125, #126, #129, and #173) residing in the facility and had the potential to impact the remaining 17 residents and their visitors who may want to know the facility's staffing levels compared to the number of residents in the facility, in order to ensure enough staff were present to meet the needs of the residents. Findings include:</p> <p>On 3/11/19 at 1:45 PM, the daily posted nurse staffing was dated 3/9/19.</p> <p>On 3/13/19 at 9:18 AM, the DON provided documentation of previously posted nurse staffing. There was no documentation of posted staffing for 3/10/19, 3/8/19, 3/3/19, 3/2/19, 2/25/19, 2/24/19, 2/23/19, 2/10/19, 2/9/19, 2/8/19, 2/6/19, 2/5/19, 2/3/19, 2/2/19, and 2/1/19. The DON said usually the MDS nurse posted the daily staffing and would leave a blank copy for weekend staff to fill out, and a majority of the missing days for posted staffing were on a weekend. The DON said she was aware the daily staffing posting was inaccurate when surveyors entered the facility on 3/11/19, and they missed a day of posted staffing on the previous weekend.</p>	F 732	<ol style="list-style-type: none"> 1. Immediate action(s) taken for the resident(s) found to have been affected include: The daily posting of hours was posted on 3/11/2019. 2. Identification of other residents having the potential to be affected was accomplished by: The daily posting of hours process was reviewed and revised on 3/28/19. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Education was completed with licensed staff regarding the revised practice of daily staffing information. The responsibility of posting the hours was delegated to the night shift nurse. The day-shift charge nurse is responsible to update as necessary. The MDS coordinator or designee will be responsible keeping a log of past daily staffing information forms. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The administrator or designee will 		

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F 732	Continued From page 68	F 732	complete a random weekly audit of daily staffing information forms to ensure accuracy and completion. The Administrator or designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.		
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 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §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 policy review, record review, and staff interview, it was determined the facility failed to provide ongoing monitoring for appropriate,	F 757	1. Immediate action(s) taken for the resident(s) found to have been affected include:	4/15/19	

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F 757	<p>Continued From page 69</p> <p>effective, and safe medication use. This was true for 1 of 5 residents (Resident #1) reviewed for unnecessary medications. This failure created the potential for harm if residents experienced adverse effects from medications administered without monitoring. Findings include:</p> <p>The facility's Medication Monitoring/Medication Management policy dated 11/2017, documented each resident's drug regimen was reviewed to ensure it was free from unnecessary drugs which included review of:</p> <ul style="list-style-type: none"> * Excessive doses * Duplicate drug therapy * Excessive duration, without adequate monitoring * Adequate indications for its use * Adverse consequences which indicate the dose should be reduced or discontinued * Any combination of the above <p>To optimize the therapeutic effect of the medication therapy and minimize or prevent potential adverse consequences. The facility policy documented the staff, the attending physician/prescriber, and the consultant pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use.</p> <p>Resident #1 was admitted to the facility on 2/27/19, with multiple diagnoses including fractures of the lumbar spine and left tibia (shinbone), insulin dependent diabetes, hypertension (high blood pressure), and paroxysmal atrial fibrillation (a condition of the heart with sudden bursts of erratic heart beats).</p> <p>Resident #1's Admission MDS assessment, dated 3/5/19, documented he was cognitively</p>	F 757	<p>Orders for Resident #1 were reviewed and updated to monitor side effects and drug interaction by the pharmacy consultant. Care plan was updated as indicated.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. A review of current patient orders was completed to ensure no excessive duplicate therapy was present and adverse side effects are being monitored.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>Licensed staff were educated on medication management-this includes excessive duplicate therapy and monitoring for adverse side effects. The pharmacy recommendations will be followed up by the unit managers or designee to ensure recommendations are reviewed by provider as indicated. Orders and care plans will be reviewed and updated as indicated.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The DON or designee will complete a</p>		

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F 757	<p>Continued From page 70 intact.</p> <p>A physician order dated 2/27/19, included the following medications to be administered to Resident #1: * apixaban 2.5 mg, give 1 tablet by mouth two times a day for atrial fibrillation * aspirin 81 mg, give 1 tablet by mouth one time a day for heart health * furosemide 40 mg, give 1 tablet by mouth one time a day for edema * ibuprofen 200 mg, give 1 tablet by mouth in the morning for inflammation</p> <p>Resident #1's MAR did not include monitoring of side effects for apixaban, aspirin, and ibuprofen.</p> <p>The Medical Director Report dated 2/28/19, documented observations and recommendations to increase apixaban to 5 mg twice a day. This form was signed on 3/11/19 by a nurse practitioner with a comment apixaban was ordered and monitored by the cardiologist.</p> <p>The Admission MRR, unsigned by the physician, dated 3/5/19, documented monitoring for Resident #1 included signs and symptoms of bleeding and/or excessive bruising for apixaban use. The MMR also documented a potential drug interaction with concurrent use of the diuretic furosemide and nonsteroidal anti-inflammatory drugs (aspirin, and Ibuprofen) may result in reduced effectiveness and possible nephrotoxicity (poisonous type of effect that may cause kidney damage).</p> <p>Resident #1's care plan did not document for staff to monitor for side effects of apixaban from</p>	F 757	<p>random weekly audit of pharmacist's recommendations to ensure providers are being notified in a timely manner as indicated and to ensure orders and care plans are reviewed and updated as indicated.</p> <p>The DON or designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.</p>		

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F 757	<p>Continued From page 71 his date of admission on 2/27/19 until 3/12/19.</p> <p>A physician office visit dated 3/6/19, included a current list of Resident #1's medications. This list did not include Resident #1's apixaban or aspirin. The ibuprophen was documented as 600 mg rather than the current order of 200 mg.</p> <p>On 3/13/19 at 2:28 PM, the DON stated the Pharmacist completed the medication reviews. She said the reports were returned in a running format all together, not separated for each resident reviewed, and the reports were not included in the EMR because they are not separated. The DON said instead the Pharmacist made notations in the progress notes.</p> <p>On 3/13/19 at 3:04 PM, the DON stated the pharmacy recommendations were faxed to the facility which were placed in the providers box to review. If the provider made changes, they either provided a verbal or written order.</p> <p>On 3/15/19 at 11:50 AM, the DON stated side effect monitoring for apixaban, aspirin, and ibuprofen was not documented.</p> <p>On 03/15/19 at 11:33 AM, the DON stated the provider will write 'no changes' or verbalize to the nurse 'no changes'. The DON stated the provider did not routinely sign the pharmacy recommendations.</p> <p>03/15/19 at 11:37 AM, the DON stated bruising, nose bleeds, blood in the urine, etc. were examples of signs and symptoms of side effects of apixaban. She stated the facility monitored symptoms or side effects for apixaban, but it was</p>	F 757			

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F 757	Continued From page 72 not documented.	F 757			
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		4/15/19	

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F 758	<p>Continued From page 73</p> <p>§483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. 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 there was adequate side effect monitoring for residents receiving psychotropic medications. This was true for 4 of 5 residents (#1, #8, #13, and #19) who were reviewed for unnecessary medications. This failed practice created the potential for harm should residents experience adverse effects from psychotropic medications. Findings include: The facility's policy for Medication Management, dated 11/2017, documented the following: * For residents who received psychotropic medications, the facility must assess the effectiveness of the medication and potential adverse consequences. * The facility ensured residents were adequately monitored for adverse consequences of psychotropic medications (a medication that affects brain activity associated with mental processes and behavior). If the psychotropic medication caused or contributed to adverse</p>	F 758	<p>1. Immediate action(s) taken for the resident(s) found to have been affected include: Orders for Resident #1 and #13 were reviewed and updated to monitor side effects of Psychotropic medications. Residents #8 and #19 were discharged. No further action is required.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. A review of current patients orders on 3/20/19, patients receiving psychotropic medications were appropriately monitored for adverse side effects. The orders and care plan were updated as indicated.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:</p>		

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F 758	<p>Continued From page 74</p> <p>consequences, the facility and prescribing provider must decide whether to continue the medication.</p> <p>1. Resident #8 was readmitted to the facility on 1/19/19, with multiple diagnoses including chronic pain syndrome and restless leg syndrome.</p> <p>Resident #8's physician orders documented the following: an order on 12/19/18 for clonazepam (anti-anxiety medication) 2 mg at bedtime for restless legs and sleep, and an order on 1/23/19 for escitalopram (antidepressant medication) 10 mg in the morning for depression.</p> <p>Resident #8's care plan documented the following:</p> <p>* She used anti-anxiety medication, initiated on 1/21/19. Care plan interventions included monitor/document side effects. Anti-anxiety side effects included drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, disorientation, depression, dizziness, impaired thinking and judgment, memory loss, nausea, upset stomach, and blurry or double vision.</p> <p>* She used antidepressant medication, initiated on 2/4/19. Care plan interventions included monitor/document side effects as needed. Antidepressant side effects included dry mouth, dry eyes, constipation, urinary retention, and suicidal ideations.</p> <p>Resident #8's February 2019 MAR documented the clonazepam and escitalopram were administered each day from 2/1/19 through</p>	F 758	<p>Licensed staff were educated on medication management-this includes psychotropic medications and adverse side effects. The DON or designee will verify that psychotropic medications orders and care plan are up-to-date to include monitoring of adverse side effects.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The DON or designee will complete a random weekly audit of psychotropic medications ensuring adverse side effects are care planed and monitored. The DON or designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.</p>		

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F 758	<p>Continued From page 75 2/28/19.</p> <p>The March 2019 MAR documented the clonazepam and escitalopram were administered each day from 3/1/19 through 3/11/19.</p> <p>Resident #8's February 2019 and March 2019 MARs and TARs did not include documentation of monitoring of side effects for clonazepam and escitalopram.</p> <p>There was no documentation in Resident #8's record side effects of clonazepam and escitalopram were monitored.</p> <p>On 3/13/19 at 10:11 AM, the DON said monitoring of signs and symptoms was documented in the MAR to see if the medicine helped. The DON said it was documented as needed if adverse effects or side effects were observed, and they were not typically listed on the MAR.</p> <p>2. Resident #19 was admitted to the facility on 2/7/19, with multiple diagnoses including major depressive disorder.</p> <p>Resident #19's physician orders documented an order on 2/7/19 for bupropion ER (antidepressant medication) 150 mg once a day for depression.</p> <p>Resident #19's care plan documented he used antidepressant medication, initiated on 2/8/19. Interventions included monitor/document side effects as needed. Antidepressant side effects included dry mouth, dry eyes, constipation, urinary retention, and suicidal ideations.</p>	F 758			

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F 758	<p>Continued From page 76</p> <p>Resident #19's February 2019 MAR documented the bupropion was administered each day from 2/8/19 through 2/28/19.</p> <p>The March 2019 MAR documented the bupropion was administered each day from 3/1/19 through 3/13/19.</p> <p>Resident #19's February 2019 and March 2019 MARs and TARs did not include documentation of monitoring for side effects of bupropion.</p> <p>There was no documentation in Resident #19's record side effects of bupropion were monitored.</p> <p>On 3/13/19 at 11:58 AM, RN #1 said when a resident received antidepressant medication, the nurse should monitor vital signs and check on their level of well-being. RN #1 said side effect monitoring should come up on the MAR/TAR and she did not see side effect monitoring for Resident #19's bupropion. RN #1 said if there were side effects she documented it in the progress notes.</p> <p>On 3/13/19 at 12:16 PM, the DON said when the care plan was created the side effect monitoring was created at the same time. She said monitoring for side effects for Resident #19's bupropion was not included.</p> <p>3. Resident #13 was readmitted to the facility on 2/4/19, with diagnoses which included fractured prosthetic left hip joint, pain, bacterial infection and insomnia.</p> <p>The care plan area addressing Resident #13's insomnia, initiated 2/8/19, documented staff were</p>	F 758			

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F 758	<p>Continued From page 77</p> <p>to monitor Resident #13 for side effects of trazodone (medication used to decrease anxiety and insomnia related to depression) to include dry mouth, dry eyes, constipation, urinary retention, and suicidal ideations.</p> <p>Resident #13's physician orders, dated 2/4/19, included 100 mg of trazodone at bedtime for insomnia.</p> <p>Resident #13's March 2019 MAR documented staff were to administer trazodone at bedtime for insomnia. The medication was provided as ordered.</p> <p>Resident #13's record did not include monitoring of side effects for the psychotropic medication trazodone.</p> <p>On 3/13/19 at 2:27 PM, the DON stated monitoring of side effects was not documented for all of the residents on psychotropic medications.</p> <p>4. Resident #1 was admitted to the facility on 2/27/19, with multiple diagnoses including fractures of the lumbar spine and left tibia (shinbone), insulin dependent diabetes, hypertension (high blood pressure), and paroxysmal atrial fibrillation (a condition of the heart with sudden bursts of erratic heart beats).</p> <p>Resident # 1's physician orders, dated 2/27/19 included triazolam (medication to treat insomnia) 0.25 mg, give 1 tablet by mouth at bedtime for sleep.</p> <p>Resident #1's MAR documented nightly</p>	F 758			

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F 758	Continued From page 78 administration with hours of sleep documented each night. Residents #1's care plan dated 2/28/19 documented he used hypnotic medication related to insomnia. Care plan interventions/tasks documented the potential risks were incontinence, injury from fall, functional decline/decreased ability to ambulate, skin breakdown/abrasions, circulatory compromise, signs and symptoms of adverse reaction, decreased social contact/sedation, drowsiness, ataxia, drunk walk, and morning hangover. The care plan directed staff to notify the physician as needed if adverse side effects were observed. There was no documentation in Resident #1's record triazolam side effects were monitored. On 3/15/19 at 11:37 AM, the DON stated side effects were monitored but not documented in resident records.	F 758			
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs 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;	F 790		4/15/19	

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F 790	<p>Continued From page 79</p> <p>§483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;</p> <p>§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;</p> <p>§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</p> <p>§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 services and the extenuating circumstances that led to the delay.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, resident and staff interview, and record review, it was determined the facility failed to ensure a resident was provided dental services. This was true for 1 of 1 resident (Resident #173) reviewed for dental services. This failure created the potential for harm if residents experienced weight loss or increased mouth pain from poor fitting dentures. Findings include:</p> <p>The facility's Dental policy, undated, documented</p>	F 790	<p>1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #173 was offered a denture adjustment and declined on 3/15/19.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be</p>		

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F 790	<p>Continued From page 80</p> <p>residents were assisted in obtaining routine and emergent dental care.</p> <p>Resident #173 was readmitted to the facility on 2/23/19, with diagnoses which included failure to thrive and pain.</p> <p>Resident #173's Nursing Admit Assessment, dated 2/23/19, documented she had full upper and lower dentures.</p> <p>A Nutrition Evaluation, dated 2/27/19, documented Resident #173 had full dentures and she did not wear them because they were uncomfortable. The evaluation recommended Resident #173 visit a dentist and for nursing to assess the fit of her dentures.</p> <p>An admission MDS assessment, dated 3/1/19, documented Resident #173 was cognitively intact and she had broken or loose-fitting dentures.</p> <p>Resident #173's Care Area Assessment, dated 3/8/19, documented Resident #173 had full dentures and she did not wear them because they were uncomfortable. The evaluation recommended Resident #173 visit a dentist and for nursing to assess the fit of her dentures.</p> <p>Resident #173's care plan did not include a care area for her dentures.</p> <p>Resident #173's record did not include documentation the facility followed up with Resident #173 regarding the fit of her dentures or placed a referral to a dentist.</p> <p>On 3/12/19 at 11:12 AM, Resident #173 stated</p>	F 790	<p>affected. An audit of current patient's dentition needs was complete to ensure any dental needs were addressed on 3/22/2019.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>Social Services Designee was educated on obtaining dental services for patients needing such services. Unit managers or designee will review clinical documentation and alerts, any dental concerns will be addressed and documented within 72 hours as indicated.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The DON or designee will complete a random weekly audit of residents with dentures to ensure their dental needs are met.</p> <p>The DON or designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.</p>		

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F 790	Continued From page 81 she had full dentures and she did not wear them often because they caused her mouth pain. On 3/13/19 at 2:36 PM, the DON stated she was unsure if a referral was made to a dentist or if the fit of Resident #173's dentures was discussed with her. The DON stated she expected a referral to be made if the resident requested one.	F 790			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, review of the 2017 FDA Food Code, and staff interview, it was determined the facility failed to ensure food was maintained according to safe practices. This	F 812	1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #13 fridge was adjusted on	4/15/19	

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F 812	<p>Continued From page 82</p> <p>failed practice placed 3 of 3 residents (#13, #17, and #173) whose room refrigerators were assessed and the 26 other residents with refrigerators in their rooms, at risk for adverse health outcomes. This failed practice increased residents' risk of developing food borne illnesses. Findings include:</p> <p>The facility's Use and Storage of Family/Other Provided Foods policy, revised 1/2016, documented non-perishable foods were required to be labeled with a date, the resident's name, and what the food item was. The policy documented the food could be stored for 3 days, at which time the items needed to be discarded.</p> <p>The 2017 FDA Food Code, Chapter 3, Part 3-5, Limitation of Growth of Organisms of Public Health Concern, subpart 3-501.12 Time/Temperature Control for Safety Food, Slacking, documented, "(A) Under refrigeration that maintains the food temperature at 5 C (41 F [Fahrenheit]) or less..."</p> <p>On 3/13/19 at 11:38 AM, Resident #17's refrigerator was observed with milk, butter, cheese, nuts, and a food item wrapped in a napkin without a date, the resident's name, or description of what the food item was.</p> <p>On 3/13/19 at 11:48 AM, Resident #13's refrigerator was observed at 43 degrees F and contained potentially hazardous food which included cut melons. Other fresh fruits, including grapes, peaches, and oranges, and half of a sandwich were observed. The food items were covered with plastic wrap and were not labeled with dates or the resident's name.</p>	F 812	<p>3/13/19 and undated and unlabeled food was removed and discarded. Resident #173 the temp was adjusted on 3/13/19 and unlabeled food was discarded.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. The policy for Family/Others providing foods was revised to include the temperature of the fridge, with date of procurement. Audit of fridge temperatures was completed on March 14th, adjustments were made as indicated.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: A review of the current documentation was completed and updated to reflect the actual temperature of the fridge, a review of items located in the fridge to ensure these items contain a date, and if the procurement is expired to be removed. Dietary Staff and Certified nursing aides have been educated on the revised policy for Family/Others providing foods, which includes documentation, labeling and dating items.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p>		

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F 812	Continued From page 83 On 3/13/19 at 11:55 AM, Resident #173's refrigerator was observed at 30 degrees and had sandwiches, fruit, crackers, and milk. The food items were covered with plastic wrap and were not labeled with dates or the resident's name. On 3/13/19 at 12:15 PM, the Certified Dietary Manager (CDM) stated all the residents in the facility had a refrigerator in their room. The CDM observed the refrigerator in Resident #13's room and stated the temperature was 43 degrees F and it needed to be less than 41 degrees F. The CDM stated the food items should have dates and the residents' names on them. The CDM stated he had no way of telling how old the food items were without dates.	F 812	The CDM or designee will complete a random weekly audit of fridge temperatures to ensure food labeling, dating, and accuracy of temperate. The CDM or designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.		
F 880 SS=D	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,	F 880		4/15/19	

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

PRINTED: 04/24/2019
FORM APPROVED
OMB NO. 0938-0391

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F 880	<p>Continued From page 84</p> <p>visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility 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>	F 880			

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F 880	Continued From page 85 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented for equipment cleaning, laundry services, and avoiding cross-contamination during and after wound care. This was true for 3 of 12 residents (#6, #8, #13) reviewed for infection control. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include: 1. The facility's Infecion Prevention and Control policy, undated, documented reusable equipment requiring cleaning, disinfection, or sterilization was cleaned in accordance with their current procedures governing the cleaning and sterilization of soiled or contaminated equipment. The Centers for Disease Control and Prevention website, accessed on 3/21/19, documented: * Clean medical devices as soon as practical after use (e.g., at the point of use) * Ensure at mininum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis (such as after use on each patient or once daily or weekly).	F 880	1. Immediate action(s) taken for the resident(s) found to have been affected include: An assessment for Resident #13 was complete to ensure no infections have developed, the findings were reported to the physician as indicated. Resident #6 and #8 have discharged, and no further action is required. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. The infection control laundry policy was reviewed and updated to reflect linens located in a separate linen room are not required to be covered until such laundry leaves this area to be distributed throughout the facility. The PPE Equipment was removed and placed in the dirty laundry area on 3/15/19 to avoid cross contamination.		

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F 880	<p>Continued From page 86</p> <p>On 3/12/19 at 9:07 AM, CNA #3 moved the vital sign equipment from Resident #6's room, to Resident #13's room without cleaning the equipment between each use.</p> <p>On 3/12/19 at 9:21 AM, CNA #3 completed vital signs in Resident #74's room. The vital sign equipment was not cleaned after use, and the vital sign machine was then docked at the nurses' station.</p> <p>On 3/12/19 at 9:25, CNA #3 stated vital sign equipment should be cleaned after each resident use, and she stated she did not do this.</p> <p>2. The facility's Infection Prevention and Control Program policy, undated, documented the following: * Laundry and direct care staff should handle, store, process, and transport linens to prevent spread of infection. * Linen should be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets.</p> <p>On 3/13/19 at 3:33 PM, the residential laundry room was observed with the following: * PPE for handling soiled linen was hanging on the wall of the clean side of the room between the dryer and the folding table. * There was no covering on the clean linen rack. * Lost and found clothing and washed wool pads were stored on dirty side of the room.</p> <p>On 3/13/19 at 3:43 PM, the industrial laundry room was observed with the following: * A dirty bin of linens was positioned on the clean</p>	F 880	<p>The Maintenance Director placed tape on the floor in the laundry room to distinguish the dirty area from the clean. This will ensure clean linens do not cross into the dirty linen area.</p> <p>The tray containing wound care supplies was removed from the Medication Room and discarded.</p> <p>The wound care policy was reviewed by the IDT team, and it was determined no updates are required at this time.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: The Laundry Supervisor and Direct Care Staff were educated on the Infection Control Laundry policy.</p> <p>Direct Care staff, which includes CNA #3, were education on the infection control policy, equipment cleaning, and hand hygiene on 4/1/19.</p> <p>Licensed Staff, which includes RN #2 were educated on the infection control policy, and wound care practices.</p> <p>The DON or designee will complete routine rounding to ensure infection control practices are being followed, hand hygiene is being performed, educations will be provided immediately as indicated.</p>		

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F 880	<p>Continued From page 87</p> <p>side of the wash room in front of industrial dryer. * There was no covering on the clean linen rack</p> <p>On 3/13/19 at 3:43 PM, the Laundry Manager stated he had not separated items between the clean and dirty areas of the laundry rooms. He said he did not realize he was cross contaminating the clean area when transporting the PPE used to handle soiled linen to where it was stored on the clean side of the laundry room. The Laundry Manager also said he did not realize he was cross contaminating when he stored the dirty linen bin on the clean side of the room.</p> <p>3. The facility's Clean Dressing change policy, undated, documented: * Staff were to set up a clean field on the overbed table with needed supplies for wound cleansing and dressing application as follows: - Place a disposable cloth or linen saver under supplies - Place only the supplies to be used per wound on the clean field at one time</p> <p>Resident #8 was readmitted to the facility on 1/19/19, with multiple diagnoses including type 2 diabetes mellitus, orthopedic aftercare, and fusion of the lumbosacral spine (low back).</p> <p>Resident #8's physician orders documented the following was ordered for wound care on 1/30/19: Cleanse wound with Normal Saline, apply SkinPrep to the surrounding skin, apply Santyl (an ointment used to help heal skin ulcers) to wound, apply Telfa (a guaze dressing) over Santyl, and cover with a 3M or similar adhesive dressing.</p>	F 880	<p>The DON will complete random observation of wound care treatments to ensure infection control policies are being implemented, education will be provided immediately as indicated.</p> <p>The Laundry Supervisor or designee will complete routine rounds of the Laundry room to ensure infection control practices are being followed, education will be proved immediately as indicated.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur:</p> <p>The DON or designee will complete a random weekly audit of infection control practices including, hand hygiene, wound care treatments, and equipment cleaning.</p> <p>The DON or designee will report the findings to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.</p> <p>The Laundry Supervisor or designee will complete a randomly weekly audit of infection control laundry services to ensure infection control practices are being followed.</p> <p>The Laundry Supervisor or designee will report the finding to the monthly QA meeting for 2 months, or until there is 100% compliance and as needed.</p>		

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F 880	<p>Continued From page 88</p> <p>On 3/12/19 at 10:49 AM, RN #2 entered Resident #8's room to change her dressing on her lower back. RN #2 placed a gray plastic tray containing dressing supplies on the foot of Resident #8's bed. RN #2 adjusted Resident #8's clothing and touched her multiple times while gathering supplies from the tray. While performing the dressing change as ordered, RN #2 touched clean items on the tray multiple times after touching the resident.</p> <p>On 3/12/19 at 11:02 AM, RN #2 left Resident #8's room with the tray and returned it to the medication room. RN #2 placed the gray tray on the top shelf in the medication room cupboard. RN #2 said sometimes the tray was used in other residents' rooms, and she should have taken the individual supplies out of the tray and left the tray in the medication room.</p> <p>On 3/13/19 at 9:33 AM, the DON said when a nurse performed a dressing change, she expected the nurse to review the order, gather the supplies and take them to the resident's room. The DON said the nurse only took what was needed into the room and put down a barrier to place the supplies on so the unused supplies could be taken back out of the room. The DON said taking the tray into Resident #8's room, placing the tray on her bed, and returning the tray to the shelf in the medication room was not the standard of practice and was not the facility's policy.</p>	F 880			



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June 12, 2019

Tyler Fackrell, Administrator
Promontory Point Rehabilitation
3909 South 25th Eas
Ammon, ID 83406

Provider #: 135137

Dear Mr. Fackrell:

On **March 11, 2019** through **March 15, 2019**, an unannounced on-site complaint survey was conducted at Promontory Point Rehabilitation. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007902

ALLEGATION #1:

A resident's pressure ulcer worsened since admission related to lack of preventative measures and poor treatment of wounds and wound care.

FINDINGS #1:

During the investigation one resident was observed for wound care and two resident records, which included a closed record, were reviewed for wound management. Interviews were conducted with residents and family members. Staff members were interviewed and observed regarding wound management. Facility abuse allegations, grievances, and Resident Council minutes were reviewed between October 2018 and March 2019.

October 2018 through March 2019 facility abuse investigations and grievances did not document residents complained of concerns with developing pressure ulcers. A grievance and abuse investigation from August 2018 identified a concern with a resident's pressure ulcer worsening in the facility.

Two resident records were reviewed for wound management concerns, including a resident admitted to the facility in July 2018.

During the review of the records for one resident, admitted July 2018, a Hospital History and Physical documented she had a sacral (low back/upper buttock area) pressure sore which was not a full thickness skin loss and was "mostly" a reddened area. The resident's Nursing Admission Assessment documented she had a 0.6 cm long by 0.6 cm wide open area to her sacrum. The nursing assessment did not include an assessment of the wound bed or include staging of the wound.

The resident's Admission orders, July 2018 Medication Administration Record and Treatment Administration Record, and July 2018 physician's orders did not include treatment or preventative orders for the skin impairment on her sacrum/coccyx. The resident's Total Skin and Body Assessment documented she had a 1 cm red, excoriated (damaged rubbed off skin) open area to her coccyx. The pressure ulcer was 0.6 cm by 0.6 cm and increased in size to 1 cm a week later. The assessment did not document a description of the wound bed or stage the wound.

A Wound Clinic Note documented the resident's sacrum was initially evaluated, and she had an unstageable pressure ulcer covered with dead skin. The assessment documented she had three small, bridged areas and the area of the wounds measured 0.4 cm long by 1 cm wide by 0.1 cm deep. The note documented she had a dressing in place upon arrival. Total Skin and Body Assessments did not document a description of the wound bed or stage the wound. Orders for the wound, from the wound clinic, were not transcribed timely and treatments were not provided as ordered.

Several nurses stated they remembered the resident but did not recall what the wound looked like upon admission to the facility.

Based on the results of the investigation, the allegation was substantiated. Deficiencies were cited at F684 and F686 as it related to the failure of the facility to ensure residents' wound care followed physician's orders and pressure ulcers did not worsen.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

A resident was left wet for an extended period of time.

FINDINGS #2:

Two resident records were reviewed for positioning and incontinence management, Resident Council meeting minutes were reviewed, observations were conducted, and residents were interviewed.

Both residents had incontinence and positioning care plans in place. Their records did not document being left wet for extended periods of time, or left up in their wheelchairs for extended periods of time. Resident Council meeting minutes did not document concerns with incontinence care.

During the survey, four residents were observed for incontinence and their briefs were not left wet or positioned in the same location for extended periods of time. CNAs were observed repositioning and checking and changing the residents' briefs according to their needs and their care plans.

Two residents said they were incontinent and said staff checked their briefs regularly and they had no concerns regarding incontinence care and or assistance with repositioning. CNAs and nurses said residents were not left wet for extended periods of time and said if they found that they would report it to their supervisors. The Director of Nursing and the Administrator said residents were changed according to their needs and were not left wet for extended periods of time or not repositioned.

During review of the record for one resident, admitted July 2018, a grievance and abuse investigation were reviewed and documented the resident's family had concerns with the resident being left in their wheelchair for extended periods of time or left laying in their urine for extended periods of time. The resident's record documented she preferred to stay in bed most of the time and the facility assisted her into her wheelchair when requested for appointments or to have a smoke break. There was no documented evidence she complained of or was left in her wheelchair for extended periods of time.

The record documented the resident was assisted with toileting frequently. The facility's abuse investigation documented the resident was checked on by two staff members within an hour of the resident being found in her urine. The investigation documented she was provided medications, her vital signs obtained, and checked on, and the resident did not state she had to use the restroom.

Staff interviews from the investigation by the facility documented the resident preferred to be positioned in her bed and used her wheelchair for appointments, therapy, and smoke breaks. The staff stated they remembered the night in question for the investigation, about the resident left in her urine for extended periods of time, and stated they obtained vital signs, refilled her water cup, asked her if she needed to use the restroom, or provided medications, and she did not state she had gone to the bathroom or needed to use the restroom. The staff stated there was no odor or wetness seen on the resident's bed.

The allegation was unsubstantiated due to lack of evidence regarding residents being left wet for extended periods of time.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

A resident was not assisted with toileting by staff and was left unattended while on the toilet on separate occasions; a resident was not assisted when requiring clean up after toileting or vomiting and family had to help them.

FINDINGS #3:

Two resident records were reviewed for Activities of Daily Living (ADL) assistance, including one closed record, Resident Council meeting minutes were reviewed, observations were conducted, and residents and staff were interviewed.

Both residents had ADL care plans in place, however the care plans were unclear on how much staff assistance the residents required with toileting needs. Resident Council meeting minutes did not document concerns with ADL assistance.

During the survey, four residents were observed for ADL needs and stated they were not left on the toilet if they required staff assistance. CNAs were observed with residents, and provided care according to their needs.

Five residents said they were continent and said staff answered the call lights and assisted them onto the toilet when they needed help and had no concerns. The residents stated the staff stepped outside to provide privacy and they used the call light to notify staff of their need to get off the toilet. CNAs and nurses said residents were not left on the toilet for extended periods of time and said if they found that they would report it to their supervisors. The Director of Nursing and the Administrator said residents were assisted as their needs required.

During review of the record for one resident, admitted July 2018, a grievance and an abuse investigation were reviewed, and documented the resident's family had concerns with the resident being left on the toilet for extended periods of time and without staff supervision.

The investigation documented the resident had used her call light while on the toilet and asked for her cell phone and the aide assisted her with her request and did not ask for assistance off the toilet at that time. The investigation documented the facility received a phone call from the resident's family asking them to assist her off the toilet. The investigation documented the staff assisted her off the toilet as soon as they were made aware of the resident's concern.

The resident's record was unclear on how much assistance the resident required for toilet use. The resident's assessment documented she required extensive assistance of two staff members for transfers, bed mobility, toilet use, and dressing. The care plan documented she required 1-2 staff members assistance with toileting. The care plan did not contain up-to-date information regarding how to care for the resident.

Staff interviewed stated they remembered the incident and the resident used her call light and asked a staff member for her cell phone and she did not express her need for assistance off the toilet. The staff stated they left residents in the bathroom for privacy reasons and assisted residents as soon as they called for assistance. Staff members stated the family of the resident requested a staff member's presence in the bathroom at all times and the facility provided the assistance after they were made aware of the request. Staff members stated the care plan was the guide on how to care for the resident and when the care plan documented 1-2 persons assistance as needed it left room for error.

Based on the investigative findings, the allegation was substantiated. A deficiency were cited at F656 and F657 as it relates to the failure of the facility to ensure residents' care plans outlined their toileting needs.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

A resident's blouse was cut off by staff and thrown away.

FINDINGS #4:

Twelve resident records were reviewed for dignity, Resident Council meeting minutes were reviewed, observations were conducted, and residents were interviewed.

During review of the record for one resident, admitted July 2018, a grievance and abuse investigation were reviewed and documented the resident's family had concerns with the resident left laying in her urine for extended periods of time and the staff cut the resident's shirt off instead of assisting her to take it off. The resident's record documented the resident asked the staff to cut her shirt off and throw it away. The facility abuse investigation documented the facility offered to replace the shirt and the resident declined for the time being.

The investigation included staff interviews and documented the resident asked staff to cut off her shirt. Social services, the DNS, and the Administrator stated the facility offered to replace the shirt and the resident declined.

Based on the investigative findings, the allegation was substantiated however, no deficiency was cited due to the resident's request to cut the shirt off and the facility's offering to replace the item.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #5:

A resident had vomiting and did not receive medications as ordered for symptoms.

FINDINGS #5

During the investigation 10 residents were observed and 12 resident records were reviewed for medication management. Interviews were conducted with residents and family members. Staff members were interviewed and observed regarding medication management. Facility abuse allegations, grievances, and Resident Council minutes were reviewed. Nurses were observed during medication pass.

The 12 resident records were reviewed for medication errors and three of the 12 residents' medication orders and Medication Administration records were reviewed for anti-nausea medication administration. Anti-nausea medications for all three residents were administered as ordered by their physician.

During review of the record for one resident, admitted July 2018, physician orders and medication administration records documented the resident received nausea medications as ordered or were refused by the resident and not administered if offered for nausea. The nursing progress notes and the medication record documented the resident refused the anti-nausea medications on multiple occasions and had bouts of vomiting. A nursing progress note documented the family requested a new nausea medication be offered and the facility received and order for the medication and administered the medication.

Several nurses and residents were observed during medication pass and residents received the correct medications as ordered.

Residents and two family members said staff provided medications as ordered and listened to them when they had concerns about a medication's effectiveness. Two CNAs and three nurses who had worked with the resident, admitted July 2018, said the resident did experience vomiting and she refused to take the medications on occasion.

Based on investigative findings allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

A resident did not have a bowel movement for 10 days and did not receive treatment or care for this until requested by family.

FINDINGS #6:

During the investigation 10 residents were observed and 12 resident records, which included a closed record, were reviewed for bowel care. Interviews were conducted with residents and family members. Staff members were interviewed and observed regarding bowel care. Facility abuse allegations, grievances, and Resident Council minutes were reviewed. Nurses were observed during medication pass.

Twelve resident records were reviewed for medication errors. Two of the 12 resident's, including a resident admitted to the facility in July 2018, were reviewed for bowel care medication administration. Bowel care medications were not administered appropriately for one of the two residents' reviewed.

One resident's record, admitted July 2018, documented in a nursing admission assessment her last bowel movement was four days prior to her admission to the facility. The resident's Bowel Movement record documented she had a bowel movement 10 days later. Nursing progress notes documented she refused to eat because of constipation and she did not want to take medications to stimulate her bowels. The resident's physician orders documented she had orders for multiple laxatives and bowel stimulating medications. The resident's medication administration records documented she was not offered or provided these medications until 8 days later. The facility did not follow their protocol of initiating bowel care interventions on day 3 of no bowel movement.

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June 12, 2019
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The Director of Nursing stated nurses were instructed to follow the bowel protocol after a resident went three days without a bowel movement. She stated they were instructed to start with day three interventions and continue onto the next intervention per residents' needs. The Director of Nursing stated she was unable to find documentation bowel care interventions were provided to the resident. The Director of Nursing stated if an intervention was ineffective she expected staff to try something else or contact the physician.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F684 as it related to the failure of the facility to ensure a resident's bowel care was implemented.

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 black ink, appearing to read "Laura Thompson".

Laura Thompson, RN, Supervisor
Long Term Care Program

LT /lj