



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

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

April 17, 2019

Corrected Letter April 26, 2019

Rick Myers, Administrator  
Life Care Center Of Sandpoint  
1125 North Division Street  
Sandpoint, ID 83864-2148

Provider #: 135127

Dear Mr. Myers:

On **March 29, 2019**, a survey was conducted at Life Care Center Of Sandpoint by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 29, 2019**. Failure to submit an acceptable PoC by **April 29, 2019**, may result in the imposition of penalties by **May 20, 2019**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **May 8, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **June 29, 2019**. A change in the seriousness of the deficiencies on **May 13, 2019**, may result in a change

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in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 29, 2019** includes the following:

Denial of payment for new admissions effective **June 29, 2019**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **September 29, 2019**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 29, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

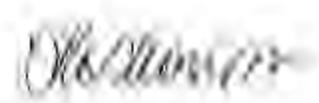
- BFS Letters (06/30/11)

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

This request must be received by **April 29, 2019**. If your request for informal dispute resolution is received after **April 29, 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,



Laura Thompson, RN, Supervisor  
Long Term Care Program

lt/dr

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

PRINTED: 05/15/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135127</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/29/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SANDPOINT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1125 NORTH DIVISION STREET SANDPOINT, ID 83864</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint investigation survey conducted March 25, 2019 through March 29, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Teresa Kobza, RDN, LD Kate Johnsrud, RN Deborah Abasciano, RN Brenda Cross, RN</p> <p>Abbreviations:</p> <p>ADLs: Activities of Daily Living CNA: Certified Nursing Assistant CPR: Cardiopulmonary Resuscitation CDC: Centers for Disease Control and Prevention DNR: Do Not Resuscitate HICPAC: Healthcare Infection Control Practices Advisory Committee LPN: Licensed Practical Nurse MAR: Medication Administration Record MDS: Minimum Data Set NQF: National Quality Forum POST: (Idaho) Physician Orders for Scope of Treatment OT: Occupational Therapy OTA: Occupational Therapy Assistant RCM: Resident Care Manager RD: Registered Dietitian RDCS: Regional Director of Clinical Services RN: Registered Nurse SLP: Speech Language Pathologist SS: Social Services</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

04/29/2019

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

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F 578 SS=D	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>§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.</p> <p>§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.</p> <p>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (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. (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.</p>	F 578		5/7/19	

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F 578	<p>Continued From page 2</p> <p>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 policy review, record review, and staff interview, it was determined the facility failed to ensure residents' records included a copy of the residents' advance directive or there was documentation of their decision not to formulate an advance directive. This was true for 3 of 12 residents (#37, #38, and #74) reviewed for advance directive information. This failed practice created the potential for harm should the resident's wishes not be followed due to lack of direction and documentation in their record.</p> <p>Findings include:</p> <p>The facility's Advance Directive policy, undated, documented the following:</p> <ul style="list-style-type: none"> <li>* At admission, the facility's admissions director or designee would determine the need and knowledge of an advance directive with the resident and/or family.</li> <li>* If the resident chose to execute an advance directive, the interdisciplinary team assisted the resident to prepare an advance directive through discussions and receipt of the Advance Directive policy.</li> <li>* If an advance directive was executed, social services placed a copy of the advance directive in the resident's record.</li> <li>* A signed copy of the Acknowledgement of Receipt Checklist for advance directives was placed in the resident's record.</li> <li>* The advance directive remained in the resident's record indefinitely.</li> </ul>	F 578	<p>Corrective Action: Resident 37, 38 and 74 had Advance Directive preferences reviewed and care plans updated to reflect most recent preference on or before 5-7-19.</p> <p>Identification: 100% Audit was conducted on or before 5-7-19 to ensure that all residents had current Advance Directive. Additionally a 100% audit was conducted on or before 5-7-19 to ensure care plans reflected the Advance Directive preference.</p> <p>Systematic Changes: Staff Development Coordinator to ensure education was provided on or before 5-7-19 to the IDT team related to policy and procedures for Advanced Directives obtaining and updating.</p> <p>Monitor: DON or designee will audit documentation for 10 resident preferences for Advanced Directive weekly x4 then monthly x3 and report findings to QAPI Committee.</p>		

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F 578	<p>Continued From page 3</p> <p>* The attending physician was made aware of the advance directive choices with appropriate orders completed and these orders were incorporated in the care plan.</p> <p>* The advance directive was reviewed on admission, quarterly, after a significant change, and as needed.</p> <p>1. Resident #37 was admitted to the facility on 11/6/13, with multiple diagnoses including multiple sclerosis (a potentially disabling disease of the brain and spinal cord), major depressive disorder, and muscle wasting.</p> <p>Resident #37's record did not include a signed copy of the Acknowledgement of Receipt for advance directive choices. Resident #37's record did not include an advance directive.</p> <p>On 3/28/19 at 3:17 PM, the SS Assistant stated during care conferences, the POST, care plan, and the face sheet were reviewed for accuracy.</p> <p>On 3/28/19 at 3:19 PM, the SS Director stated advance directive education and choices were not completed nor documented by social services this was completed by nursing.</p> <p>2. Resident #38 was admitted to the facility on 10/9/17, with multiple diagnoses including hip fracture with hip replacement, history of falls, chronic obstructive pulmonary disease (a progressive lung disease that restricts breathing), cognitive communication deficit, dementia, and overall muscle weakness.</p> <p>Resident #38's record did not include a signed copy of the Acknowledgement of Receipt for</p>	F 578			

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F 578	Continued From page 4 advance directive choices or an advance directive.  On 3/28/19 at 3:17 PM, the SS Assistant stated during care conferences, the POST, care plan, and the face sheet were reviewed for accuracy.  On 3/28/19 at 3:19 PM, the SS Director stated advance directive education and choices were not completed nor documented by social services this was completed by nursing.  3. Resident #74 was initially admitted to the facility on 7/21/17, and readmitted on 10/16/17, with diagnoses that included pain, heart disease, fractured wrist, dementia, muscle weakness, and osteoporosis (fragile bones).  Resident #74's POST, signed 7/21/17, documented her code status was DNR and she had a Living Will. Resident #74's record did not include a copy of her Living Will.  On 3/28/19 at 1:52 PM, RDCS #1 stated she was going to locate the advance directive for Resident #74.  On 3/28/19 at 3:15 PM, RDCS #1 stated Resident #74's family was going to bring in a copy of her Living Will.	F 578			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)  §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.	F 583		5/7/19	

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F 583	<p>Continued From page 5</p> <p>§483.10(h)(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure a resident was provided personal privacy during a physical assessment. This was true for 1 of 22 residents (Resident #81) reviewed for privacy. This practice created the potential for psychosocial harm if residents experienced a lack of self-esteem and embarrassment due to</p>	F 583	<p>Corrective Action: Resident 81 is no longer receiving hospice Services. Resident 81 was interviewed by social services on 4-18-19, to ensure no current signs or symptoms psychological harm related to a physical assessment being provided in a public area.</p>		

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F 583	<p>Continued From page 6</p> <p>disregard of personal privacy, and confidentiality during a physical assessment. Findings include:</p> <p>Resident #81 was admitted to the facility on 2/22/19, with multiple diagnoses including palliative care, malignant neoplasm of the lung (a form of cancer of the lung), chronic obstructive pulmonary disease (a progressive lung disease that restricts breathing) and anxiety disorder. She also received hospice services.</p> <p>On 3/26/19 at 9:31 AM, the Hospice RN was observed sitting in front of Resident #81 in the dining room with Resident #56 and #74. The Hospice RN completed blood glucose testing, blood pressure, pulse, removed Resident #81's shoes and socks, examined her feet, and lifted her sweater and assessed her breath sounds with a stethoscope.</p> <p>On 3/26/19 at 10:20 AM, the Hospice RN stated he preferred to complete assessments in the resident's room, and at times, completed assessments in the shower with a CNA to assess skin condition. He stated if the resident assessment was completed in the resident's room, he pulled the curtains and closed the window blinds. He stated since he was not doing invasive procedures such as wound care, he felt it was appropriate to have completed his assessment in the Day Room while other residents were present. The Hospice RN stated he was not aware of the facility's policy on dignity, privacy, and where to perform resident assessments.</p> <p>On 3/28/19 at 2:43pm, RDCS #1 stated the facility expected resident assessments were</p>	F 583	<p>Identification: All resident have potential to be affected by this deficient practice.</p> <p>Systematic Changes: SDC or designee will educate any new hospice LN on dignity policy prior to patient care. SDC or designee to educate all LN staff on resident rights/dignity related to providing privacy during physical assessments of residents.</p> <p>Monitor: DON or Designee to Audit 5 LN performing Physical Assessments to ensure privacy is provided weekly x4 then monthly x3 and report findings to QAPI Committee.</p>		

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F 583	Continued From page 7 completed in privacy.	F 583			
F 584 SS=D	<p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,</p>	F 584		5/7/19	

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F 584	<p>Continued From page 8</p> <p>1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a safe, clean, homelike environment. This was true for 2 of 22 residents (#43 and #191) whose environment was observed. This deficient practice created the potential for harm if residents were embarrassed by odors and dirty equipment and/or felt the lack of cleanliness was unacceptable, disrespectful, or undignified. Findings include:</p> <p>The facility's Scope of Services policy, revised 7/20/16, documented the facility provided an environment that was safe, comfortable, aesthetically pleasing, and physically conducive to meet the needs of all residents.</p> <p>1. Resident #43 was admitted to the facility on 11/12/18, with multiple diagnoses that included ribs and right clavicle fractures and multiple sclerosis (a potentially disabling disease of the brain and spinal cord).</p> <p>A quarterly MDS, dated 2/3/19, documented Resident #43 was incontinent of bowel and bladder and required extensive assistance from staff for ADLs.</p> <p>On 3/25/19 at 11:26 AM, Resident #43 was in her room lying in her bed. There was a strong odor of</p>	F 584	<p>Corrective Action:</p> <p>Residents 43 Room was immediately addressed by RCM at time of discovery of room odor and personal care provided. Housekeeping deep cleaned the room and mattress on 3-28-19, and again on 4-4-19. The wheelchair cushion was replaced on 3-28-19. LN removed and discarded identified irrigation syringe and containers from room for resident 191 on 3/26/19. Social Services interviewed Residents 43 and 191 to ensure there are no current signs or symptoms of psychological harm related to potential embarrassment due to odors or cleanliness of room and equipment.</p> <p>Identification:</p> <p>On or before 5-7-19, audit of all residents identified with urinary incontinence to ensure room, mattress and wheelchair cushion free from odor. On or before 5-7-19, audit of all residents with enteral tube feeding to ensure that irrigation syringes and containers are cleaned and stored per policy.</p> <p>Systematic Changes:</p> <p>SDC to provide education to all staff on or before 5-7-19 on policy related to maintaining a safe/ clean/ homelike</p>		

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F 584	<p>Continued From page 9</p> <p>urine in the room. There was also an odor of urine in the hallway outside of her room.</p> <p>On 3/26/19 at 9:22 AM, Resident #43 was in her room lying in her bed. There was a strong odor of urine in her room. There was also an odor of urine in the hallway outside of her room.</p> <p>On 3/26/19 at 11:53 AM, Resident # 43 was sitting in her wheelchair in the hallway near the nursing station on the 100 hall. There was a strong urine smell. A cushion was observed on the seat of her wheelchair. Resident #43 stated she did not smell anything but said "my sniffer doesn't work very well."</p> <p>On 3/27/19 at 9:58 AM and 11:27 AM, Resident #43 was lying in her bed. There was a strong odor of urine in the room and in the hallway outside of her room.</p> <p>On 3/27/19 at 3:16 PM, CNA #10 was in Resident #43's room. She stated she smelled urine. She stated the sheets were changed because Resident #43 was incontinent of urine. CNA #10 pulled the top sheets down and the odor of urine was stronger.</p> <p>On 3/28/19 at 2:25 PM, RCM #1 stated she smelled urine in the hallway outside Resident #43's room. She stated she smelled urine really strong near Resident #43's bed. RCM #1 stated staff should have requested housekeeping clean the mattress. She stated the urine was saturated in Resident #43's mattress and her wheelchair cushion. RCM #1 stated Resident #43 needed to be changed more often as the urine was soaking through to the mattress and cushion.</p>	F 584	<p>environment.</p> <p>Monitor: DON or Designee to Audit 5 resident rooms weekly x4 then monthly x3 and report findings to QAPI Committee.</p>		

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F 584	Continued From page 10  2. Resident #191 was admitted to the facility on 3/15/19, with diagnoses including diabetes, Parkinson's disease (a progressive disease of the nervous system that affects movement), and a tube for feeding.  On 3/25/19 at 1:00 PM, an irrigation syringe and container was observed in Resident #191's bathroom. The container was dated 3/22/19, and it had a dried substance on the bottom that was blackish/blue/green in color. A second container, dated 3/19/19, was also in the bathroom.  On 3/26/19 at 9:00 AM and 1:00 PM, the two containers remained in Resident #191's bathroom.  On 3/29/19 at 12:08 PM, RDCS #1 stated the syringe and container were used for Resident #191's tube feeding. RDCS #1 stated the feeding supplies should be cleaned after each use.	F 584			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)  §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is	F 622		5/7/19	

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F 622	<p>Continued From page 11</p> <p>endangered due to the clinical or behavioral status of the resident;</p> <p>(D) The health of individuals in the facility would otherwise be endangered;</p> <p>(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;</p> <p>or</p> <p>(F) The facility ceases to operate.</p> <p>(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical</p>	F 622			

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F 622	Continued From page 12 record must include: (A) The basis for the transfer per paragraph (c) (1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure information was provided to the receiving hospital for emergent situations for 2 of 3 residents (#3 and #49) reviewed for transfers. This deficient	F 622	Corrective Action: Residents #3 & 49 have been readmitted to the SNF. Residents #3 & 49 (or their representatives) have been educated on the current transfer/discharge Policy of		

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F 622	<p>Continued From page 13</p> <p>practice had the potential to cause harm if the resident was not treated in a timely manner due to lack of information. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 7/14/17, with diagnoses that included Parkinson's disease (a progressive disease of the nervous system that affects movement). She was readmitted from the hospital on 3/7/19, for care related to the surgical repair of a left hip fracture.</p> <p>A discharge MDS assessment, dated 3/4/19, documented Resident #3 was discharged to a hospital.</p> <p>On 3/4/19 at 3:24 PM, a nursing progress note documented Resident #3 had a fall at 8:00 AM while trying to get out of bed. A new order was received to transport Resident #3 to the hospital, and her family was informed. Resident #3's record did not include documentation information was provided to the paramedics, emergency room, or the hospital to ensure a safe and effective transition of care.</p> <p>On 3/28/19 at 2:00 PM, RDCS #1 stated she did not find documentation information was provided to the hospital at the time Resident #3 was transferred.</p> <p>2. Resident #49 was admitted to the facility on 11/10/18, with diagnoses that included cancer and reaction to chemotherapy. He was readmitted from the hospital on 11/26/18, for care related to pneumonia.</p> <p>A discharge MDS assessment, dated 11/22/18, documented Resident #49 was discharged to a</p>	F 622	<p>the facility.</p> <p>Identification: An audit was completed by the HIM Director on 100% of resident transfers for the prior 30 days to ensure there has been adequate notification of transfer/discharge to the resident or their representative. There were zero residents (or their representatives) noted to require additional notification.</p> <p>Systematic Changes: Education was provided on/before 5-7-19 by the SDC or designee to 100% of LN staff r/t the policies and procedures of the facility for transfer/discharge with focused training on ensuring that the receiving facility has the documentation needed to provide a safe/effective transition of care and on ensuring the resident's representative has notification of the transfer status.</p> <p>Monitor: The SNF is to maintain a log of transfers/discharges from the facility, with Nursing Administration then ensuring that there is documentation that the resident and their representative receive notification of the transfer and that appropriate documentation was provided to the receiving facility. The DON or Designee is to review log weekly x4 then monthly x3 months. Findings to be reported to QAPI Committee.</p>		

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F 622	Continued From page 14 hospital.  A Resident Transfer Record, dated 11/22/18, documented Resident #49 had decreased oxygen saturation and was shivering. The transfer record documented the resident's family was not notified of the transfer. The transfer record had a section titled, Additional Information Attached, where the facility was able to document if they included copies of a history and physical, labs, chest x-ray, physician orders, and the MAR. This section was incomplete on Resident #49's transfer record.  Resident #49's record did not include documentation appropriate information was provided to the paramedics, emergency room, or the hospital to ensure a safe and effective transition of care.  On 3/28/19 at 2:51 PM, RDCS #1 stated she looked for the transfer documentation for Resident #49. She stated the facility should include the following documents when transferring a resident; a history and physical, progress notes, vital signs, the POST, the MAR, recent labs, any applicable x-rays, and physician orders.	F 622			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The	F 623		5/7/19	

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F 623	<p>Continued From page 15</p> <p>facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p>	F 623			

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F 623	<p>Continued From page 16</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who</p>	F 623			

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F 623	<p>Continued From page 17</p> <p>is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, review of admission agreement paperwork, and record review, it was determined the facility failed to ensure transfer notices were provided in writing to residents upon transfer. This was true for 3 of 3 residents (#3, #49, and #287) reviewed for transfers. This deficient practice had the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's Resident Admission Agreement documented if a more immediate transfer or discharge is required due to urgent medical need a notice of transfer was given to the resident or their representative as much in advance as is practicable.</p> <p>1. Resident #3 was admitted to the facility on 7/14/17, with diagnoses that included Parkinson's disease. She was readmitted from the hospital on 3/7/19, for care related to the surgical repair of a left hip fracture.</p> <p>A discharge MDS assessment, dated 3/4/19, documented Resident #3 was discharged to a hospital.</p>	F 623	<p>Corrective Action: Residents #3 &amp; 49 have been readmitted to the SNF. Resident #287 never returned to the SNF due to natural death while in the hospital. Residents #3 &amp; 49 (or their representatives) have been educated on the current transfer/discharge Policy of the facility.</p> <p>Identification: An audit was completed by the HIM Director on 100% of resident transfers for the prior 30 days to ensure there has been adequate notification of transfer/discharge to the resident or their representative. There were zero residents (or their representatives) noted to require additional notification.</p> <p>Systematic Changes: Education was provided on/before 5-7-19 by the SDC or designee to 100% of LN staff related to the policies and procedures of the facility for transfer/discharge with focused training on ensuring that the transferred resident (or their representative) receive and sign</p>		

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F 623	<p>Continued From page 18</p> <p>On 3/4/19 at 3:24 PM, a nursing progress note documented Resident #3 had a fall at 8:00 AM while trying to get out of bed. A new order was received to transport Resident #3 to the hospital and the family was informed. A written notification of transfer was not in Resident #3's record.</p> <p>On 3/28/19 at 2:00 PM, RDSCS #1 stated she did not find documentation written notification of transfer was completed for Resident #3 or her representative.</p> <p>2. Resident #49 was admitted to the facility on 11/10/18, with diagnoses that included cancer and reaction to chemotherapy. He was readmitted from the hospital on 11/26/19, for care related to pneumonia.</p> <p>A discharge MDS assessment, dated 11/22/18, documented Resident #49 was discharged to a hospital.</p> <p>A Resident Transfer Record, dated 11/22/18, documented Resident #49 had decreased oxygen saturation (measurement of oxygen in the blood) and was shivering. The transfer record documented the resident's family was not notified of the transfer. A written notification of transfer was not in Resident #49's record.</p> <p>On 3/28/19 at 2:51 PM, RDSCS #1 stated she looked for the transfer documentation for Resident #49 and she did not find written notification to Resident #49 or his family.</p> <p>3. Resident #287 was admitted to the facility on 5/1/18, with multiple diagnoses that included dementia and depression.</p>	F 623	<p>the notification of transfer or discharge from the facility.</p> <p>Monitor: The SNF is to maintain a log of transfers/discharges from the facility, with Nursing Administration then ensuring that there is documentation that the resident and their representative receive notification of the transfer and that appropriate documentation provided to and signed by the resident (or their representative). The DON or Designee is to review log weekly x4 then monthly x3 months. Findings to be reported to QAPI Committee.</p>		

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F 623	Continued From page 19  A discharge MDS assessment, dated 2/11/19, documented Resident #287 was discharged to the community.  On 2/11/19, a physician's order directed staff to discharge Resident #287 to the hospital. A written notification of discharge was not in Resident #287's record.  On 3/29/19 at 12:45 PM, the Administrator stated a written notice of discharge was not completed for Resident #287 or her representative.	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At	F 625		5/7/19	

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F 625	<p>Continued From page 20</p> <p>the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on policy review, record review, and staff interview, it was determined the facility failed to ensure a bed-hold notice was provided to a resident and/or their representative upon transfer to the hospital. This was true for 3 of 3 residents (#3, #49, and #287) who were reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time and may cause psychosocial distress if not informed they may be charged to reserve their bed/room. Findings include:</p> <p>The facility's Bed-Hold/Reservation of Room policy, revised 11/28/16, documented the following:</p> <p>* Bed-hold policies were provided and explained to the resident upon admission and before each temporary absence.</p> <p>* Before the resident transfers to a hospital, the facility provided written information to the resident or resident representative that specifies:</p> <p>a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return.</p> <p>b. The reserve bed payment policy in the state</p>	F 625	<p>Corrective Action: Residents #3 &amp; 49 have been readmitted to the SNF. Resident #287 never returned to the SNF due to natural death while in the hospital. Residents #3 &amp; 49 (or their representatives) have been educated on the current Bed Hold Policy of the facility.</p> <p>Identification: An audit was completed by the HIM Director on 100% of resident transfers for the prior 30 days to ensure there has been adequate notification of bed hold to the resident or their representative. There were zero residents (or their representatives) noted to require additional notification.</p> <p>Systematic Changes: Education was provided on/before 5-7-19 by the SDC or designee to 100% of LN staff r/t the policies and procedures of the facility for bed holds with focused training on ensuring that the resident (or their representatives) received the appropriate documentation regarding bed hold, per facility policy.</p> <p>Monitor:</p>		

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F 625	<p>Continued From page 21 plan.</p> <p>c. The facility's policies regarding bed-hold.</p> <p>1. Resident #3 was admitted to the facility on 7/14/17, with diagnoses that included Parkinson's disease (a progressive disease of the nervous system that affects movement). She was readmitted from the hospital on 3/7/19, for care related to the surgical repair of a left hip fracture.</p> <p>A discharge MDS assessment, dated 3/4/19, documented Resident #3 was discharged to a hospital.</p> <p>On 3/4/19 at 3:24 PM, a nursing progress note documented Resident #3 had a fall at 8:00 AM while trying to get out of bed. A new order was received to transport Resident #3 to the hospital and the family was informed. A bed-hold notice was not included in Resident #3's record.</p> <p>On 3/28/19 at 2:00 PM, RDCS #1 stated the facility did not provide a bed-hold notification when Resident #3 was transferred to the hospital.</p> <p>2. Resident #49 was admitted to the facility on 11/10/18, with diagnoses that included cancer and reaction to chemotherapy. He was readmitted from the hospital on 11/26/19, for care related to pneumonia.</p> <p>A discharge MDS assessment, dated 11/22/18, documented Resident #49 was discharged to a hospital.</p> <p>A Resident Transfer Record, dated 11/22/18, documented Resident #49 had decreased</p>	F 625	<p>The SNF is to maintain a log of transfers/discharges from the facility, with Nursing Administration then ensuring that there is documentation that the resident and their representative receive notification of the bed hold. The DON or Designee is to review log weekly x4 then monthly x3 months. Findings to be reported to QAPI Committee.</p>		

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F 625	Continued From page 22 oxygen saturation and was shivering. The transfer notice had a section which stated if the bed hold policy was sent with the resident. This section was not completed or checked off for Resident #49.  On 3/28/19 at 2:51 PM, RDCS #1 stated she looked for the transfer documentation regarding Resident #49's bed hold, and to ask social services for the location of the documentation.  On 3/28/19 at 3:24 PM, the SS Director stated the social services department did not complete the bed hold notice documentation when a resident was transferred to the hospital.  3. Resident #287 was admitted to the facility on 5/1/18, with multiple diagnoses that included dementia without and depression.  A discharge MDS assessment, dated 2/11/19, documented Resident #287 was discharged to the community.  On 2/11/19, a physician's order directed staff to discharge Resident #287 to the hospital. A bed-hold notice was not included in Resident #287's record.  On 3/29/19, at 10:05 AM, the SS Assistant stated a bed hold notice was not provided to Resident #287 or her representative when she discharged to the hospital.  On 3/28/19 at 6:18 PM, the Administrator stated the bed hold notifications were not completed for the residents.	F 625			
F 656	Develop/Implement Comprehensive Care Plan	F 656		5/7/19	

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F 656 SS=D	Continued From page 23 CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (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.	F 656			

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F 656	<p>Continued From page 24</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, hospice and facility agreement review, and staff interview, it was determined the facility failed to ensure comprehensive resident-centered care plans included delineation of care and responsibilities between hospice/palliative care agency and facility services. This was true for 1 of 1 resident (Resident #81) reviewed for hospice services. This failure created the potential for harm if residents were to receive inadequate or inappropriate care which negatively impacted the resident's quality of end-of-life care. Findings include:</p> <p>A hospice and facility agreement, dated 12/22/08, documented the hospice provider and the facility communicated with each other verbally weekly or at each hospice patient visit to ensure the needs of each hospice patient were addressed and met 24 hours a day. It further documented, this communication would be included in the patient's record. The contract was silent related to coordination and communication of palliative care services.</p> <p>Resident #81 was admitted to the facility on 2/22/19, with multiple diagnoses including palliative care, malignant neoplasm of the lung (a form of cancer of the lung), chronic obstructive pulmonary disease (a progressive lung disease that restricts breathing) and anxiety disorder.</p>	F 656	<p>Corrective Action: Resident 81 had a Significant Change MDS completed on 4-15-19, to identify that she is no longer receiving hospice services.</p> <p>Identification: 100% Audit was conducted on or before 5-7-19 to ensure that all residents receiving hospice/ palliative care had appropriate measures identified on the Plan of Care.</p> <p>Systematic Changes: SDC or designee to ensure education was provided on or before 5-7-19 to the IDT team related to policy and procedures for Care Planning regarding Hospice/Palliative Services.</p> <p>Monitor: DON or Designee will audit hospice/palliative care plans weekly x4 then Monthly x5 and report findings to QAPI Committee.</p>		

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F 656	Continued From page 25 Resident #81's Hospice/Facility Coordinated Plan of Care, dated 2/22/19, documented a hospice nurse visit one time per week, a hospice CNA visit one time per week, which was increased on 3/26/19 to two times per week, and a social worker visit one to two times per month. Incontinent supplies, wound dressings and foley (urinary) catheter supplies were to be provided by hospice services if needed. The hospice/facility Coordinated Plan of Care did not include the type of care each discipline provided.  Resident #81's comprehensive care plan, updated 3/14/19, did not include palliative/hospice services and care for nursing, CNA, and social services.  On 3/28/19 at 1:30 PM, RDCS #1 stated the coordination of care between the facility and hospice services was not included on Resident #81's comprehensive 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	F 657		5/7/19	

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F 657	<p>Continued From page 26</p> <p>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.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</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 resident care plans included their code status. This was true for 8 of 8 residents (#29, #42, #43, #67, #68, #69, #74, and #85) reviewed for care plan revision. This deficient practice had the potential for harm if resident wishes for end of life care were not honored. Findings include:</p> <p>A facility policy, dated 6/8/10, documented a DNR order is incorporated into the resident's care plan.</p> <p>This policy was not followed.</p> <p>a. Resident #42 was admitted to the facility on 11/3/18, with multiple diagnoses that included multiple sclerosis (a potentially disabling disease of the brain and spinal cord) and diabetes.</p> <p>The physician orders and POST for Resident #42 documented her code status was Full Code (cardiopulmonary resuscitation).</p>	F 657	<p>Corrective Action: Resident 29,42,43,67,68,69,74, and 85 had code statuses reviewed and care plan updated to reflect most recent preference on or before 5-7-19.</p> <p>Identification: 100% Audit was conducted on or before 5-7-19 to ensure that all residents had current code statuses. Additionally a 100% audit was conducted on or before 5-7-19 to ensure care plans reflected the code status preference.</p> <p>Systematic Changes: SDC or designee to ensure education was provided on or before 5-7-19 to the IDT team related to policy and procedures for Care Planning timing and revision as it relates to Code Status.</p> <p>Monitor: DON or designee will audit Advanced</p>		

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F 657	Continued From page 27  Resident #42's care plan documented advance directives were in effect. The care plan did not include her specific code status.  b. Resident #67 was admitted to the facility on 11/19/18, with multiple diagnoses that included multiple fractures and high blood pressure.  The physician orders and POST for Resident #67 documented her code status was DNR.  Resident #67's care plan documented advance directives were in effect. The care plan did not include her specific code status.  c. Resident #69 was admitted to the facility on 3/15/18, with multiple diagnoses that included Alzheimer's disease, diabetes, and high blood pressure.  The physician orders and POST for Resident #69 documented her code status was DNR with comfort measures.  Resident #69's care plan documented advance directives were in effect. The care plan did not include her specific code status.  d. Resident #85 was admitted to the facility on 8/02/18, with multiple diagnoses that included hemiparesis/hemiplegia (weakness/paralysis) related to a stroke.  A physician's order dated 8/2/18, documented Resident #85 was a Full Code.  Resident #85's POST, dated 11/28/18,	F 657	Directives care plans on new admissions weekly x4 then 5 monthly x3 and report findings to QAPI Committee.		

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F 657	<p>Continued From page 28 documented Resident #85 was a Full Code.</p> <p>Resident #85's care plan documented advance directives were in effect. The care plan did not include his specific code status.</p> <p>e. Resident #68 was admitted to the facility on 8/29/18, with multiple diagnoses that included chronic kidney disease with dependence on dialysis and diabetes mellitus.</p> <p>Resident #68's POST, dated 8/29/18, documented his code status was DNR.</p> <p>A physician's order, dated 8/29/18, documented Resident #65 had a DNR directive.</p> <p>Resident #68's care plan documented advance directives were in effect. The care plan did not include his specific code status.</p> <p>f. Resident #74 was readmitted on 10/16/17, with diagnoses that included pain, heart disease, fractured wrist, dementia, muscle weakness, and osteoporosis (fragile bones).</p> <p>Resident #74's POST, signed 7/21/17, documented her code status was DNR and she had a Living Will.</p> <p>Resident #74's care plan area addressing her code status, dated 7/21/17, documented staff were to carry out her wishes as stated in her advance directives. The care plan did not specify if her code status was full code or DNR.</p> <p>g. Resident #29 was readmitted to the facility on 6/3/18, with multiple diagnoses including</p>	F 657			

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F 657	<p>Continued From page 29 dementia and Atrial fibrillation (an irregular heartbeat).</p> <p>A physician order, dated 3/22/19, directed staff Resident #29's code status was DNR with comfort measures.</p> <p>Resident #29's Living Will, dated 1/31/17, documented she was DNR.</p> <p>Resident #29's care plan, dated 1/6/17, documented advance directives were in effect. The care plan did not document Resident #29's code status.</p> <p>h. Resident #43 was admitted to the facility on 11/12/18, with multiple diagnoses that included ribs and right clavicle fractures and multiple sclerosis (a potentially disabling disease of the brain and spinal cord).</p> <p>A physician order, dated 3/22/19, directed staff Resident #43's code status was DNR with limited interventions.</p> <p>Resident #43's POST, dated 11/12/18, documented her code status was DNR with limited interventions. The Durable Power of Attorney documented Resident #43's code status was DNR with limited interventions.</p> <p>Resident #43's care plan, dated 11/26/18, documented advance directives were in effect and to see the POST. The care plan did not document Resident #43's code status.</p> <p>On 3/27/19 at 3:00 PM, the MDS nurse stated the code status was documented on the admission</p>	F 657			

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F 657	Continued From page 30 baseline care plans. She stated when the comprehensive care plan was completed, they referred to the chart for the advance directive and the POST to determine the resident's code status. She stated if a resident's code status changed and the care plan was not updated, then it would be wrong. She stated the POST and advance directives are in the chart and every employee was able to get to the chart in case of an emergency.	F 657			
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)  §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, policy review, resident interview, and staff interview, it was determined the facility failed to ensure residents were provided assistance with bathing and toileting consistent with their needs. This was true for 4 of 9 residents (#20, #38, #74, and #81) reviewed for bathing. This practice created the potential for harm if the lack of assistance for personal hygiene and toileting led residents to experience embarrassment, isolation, decreased sense of self-worth, skin impairment, or otherwise compromise their physical and/or sense of psychosocial well-being. Findings include:  The facility's Activities of Daily Living policy, dated 12/11/18, documented residents received assistance, as needed with ADLs.  1. Resident #74 was initially admitted to the	F 677	Corrective Action: On or before 5-7-19, Resident 5,20,38,74 and 81 were assessed and care plans updated to reflect current need for assistance with Bathing, toileting eating and transfers.  Identification: 100% Audit completed on or before 5-7-19, to include current resident functional status with bathing, toileting, eating and transfers. Care plans were updated to reflect any changes. 100% Audit for residents to determine resident bathing schedule preferences, updates as needed to resident care plans.  Systematic Changes: SDC or designee to provide education to	5/7/19	

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F 677	<p>Continued From page 31 facility on 7/21/17, and readmitted on 10/16/17, with diagnoses that included pain, heart disease, fractured wrist, dementia, muscle weakness, and osteoporosis (fragile bones).</p> <p>A quarterly MDS assessment, dated 2/28/19, documented Resident #74 had severe cognitive impairment and required extensive assistance of one staff for showers. The MDS also documented Resident #74 required two staff members' assistance for bed mobility, transfers, dressing, and toilet use.</p> <p>a. Resident #74's care plan area addressing her ADL's, dated 7/21/17, documented Resident #74 required the assistance of one staff with bed mobility and toileting.</p> <p>Resident #74 attempted to notify staff of her needs and staff did not recognize her asking for assistance as follows:</p> <p>* On 3/25/19 at 11:10 AM, Resident #74 was observed with tears in her eyes, sniffing, and said she could not see. Resident #74 was observed with her left hand placed in her lap and her left leg was extended out in front of her with her shoe approximately three inches off the ground. Resident #74 was observed to use her right hand and right leg to propel herself forward and backwards in circles running into walls and other residents. Resident #74 was observed holding out her right hand when two staff members walked near her, and the staff members continued on their way. Resident #74 grabbed the surveyor's hand and stated she had to use the restroom. CNA #1 was asked to attend to Resident #74's needs.</p>	F 677	<p>all Nursing staff on bathing, toileting, eating and transfers to include resident preferences and documentation requirements.</p> <p>Monitor: DON or designee to audit 10 residents shower documentation weekly x4 then monthly x3months. DON or designee to 5 care plans to ensure accurate functional status with bathing, toileting, eating and transfers weekly x4 then monthly x3 months. Findings to be reported to QAPI Committee.</p>		

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F 677	<p>Continued From page 32</p> <p>* On 3/26/19 from 11:54 PM to 12:01 PM, Resident #74 was observed holding out her hand to three staff members in the area without being acknowledged by the staff. At 12:01 PM, Resident #74 grabbed the surveyor's hand and held it. When Resident #74 was asked what she needed she stated she needed help. RN #4 came over to Resident #74's side and asked her if she was hungry and Resident #74 stated, "Yes." Resident #74 was assisted down to the dining room for lunch.</p> <p>* On 3/26/19 from 3:41 PM to 4:07 PM, Resident #74 was observed in her wheelchair and she appeared restless. She was holding out her right hand appearing to try and get someone's attention. At 4:07 PM, Resident #74 grabbed the surveyor's hand and when asked if she had to go to the bathroom, she whispered, "Yes." The surveyor located CNA #4 in the hallway leaving another resident's room and was notified of Resident #74's need for the bathroom. CNA #4 stated she did not know Resident #74's transfer requirements and was going to try and find the CNA assigned to assist.</p> <p>On 3/26/19 from 4:08 AM to 4:17 PM, CNA #4 was observed looking for the CNA assigned to Resident #74 and she could not locate one. CNA #4 looked up Resident #74's transfer status and stated she was going to assist Resident #74 once she found assistance. CNA #4 found CNA #12 to assist her.</p> <p>On 3/26/19 at 4:17 PM, CNA #4 and CNA #12 were observed assisting Resident #74 into the bathroom and onto the toilet.</p>	F 677			

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F 677	<p>Continued From page 33</p> <p>On 3/26/19 at 4:20 PM, CNA #12 left the bathroom and stated she normally did not work with Resident #74 and she was going to find Resident #74's CNA and left the room. Resident #74 was heard making noises from the bathroom and CNA #4 stated, "[Resident #74] you can hold my hand if you need to." At 4:24 PM, CNA #1 entered the room to assist CNA #4 with Resident #74's needs. The CNAs assisted Resident #74 off the toilet, provided peri care, and assisted her back into her wheelchair. CNA #1 assisted Resident #74 back into the hallway when they were finished. CNA #4 stated Resident #74 had a large bowel movement.</p> <p>* On 3/29/19 from 10:32 AM to 10:39 AM, Resident #74 appeared agitated and was observed wheeling down the hallway backwards and in circles. There was no staff present.</p> <p>On 3/29/19 at 10:40 AM, Resident #74 grabbed the surveyor's hand and when asked if she had to go the bathroom she said, "Yes." An OTA entered the hallway and saw the exchange with Resident #74. The OTA asked Resident #74 if she had to go to the bathroom, and she said yes. From 10:40 AM to 10:47 AM, the OTA pushed Resident #74's wheelchair up and down the long-term unit hallways and could not find an aide or a nurse to assist Resident #74. At 10:47 AM, LPN #4 walked into the unit from the foyer and was notified of Resident #74's need by the OTA and the OTA left the area. At 10:48 AM, LPN #4 located two aides to assist Resident #74 with her to the bathroom. Resident #74's needs were not met for 16 minutes between 10:32 AM to 10:48 AM when staff was not available.</p>	F 677			

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F 677	<p>Continued From page 34</p> <p>On 3/29/19 at 10:53 AM, CNA #13, who was also the restorative nursing aide, stated Resident #74 did not vocalize her needs often and she was hard to communicate with.</p> <p>On 3/29/19 at 11:04 AM, the aides, who were assisting Resident #74 with the restroom, exited the room. CNA #1 stated Resident #74 did not make it to the bathroom in time and it took them longer to clean her up.</p> <p>On 3/28/19 at 1:59 PM, RDCS #1 and RCM #1 stated Resident #74 could communicate her needs and if staff saw her reaching out they should stop and find out what she needed.</p> <p>b. Resident #74's care plan area addressing her ADLs, dated 7/21/17, documented she required the assistance of one staff with showers twice weekly and as needed.</p> <p>Resident #74's ADL flowsheet from 2/1/19 through 3/28/19, documented she did not receive a shower between 2/7/19 and 2/23/19, 16 days. She received her next shower on 3/7/19 12 days later and then was showered on 3/11/19, 3 days later. Resident #74 received her next shower on 3/21/19, 10 days later. The flowsheet documented "NA" on 3/14/19 and 3/18/19.</p> <p>On 3/28/19 at 1:06 PM, RCM #1 stated "NA" meant the activity did not occur.</p> <p>2. Resident #20 was initially admitted to the facility on 7/2/13, and readmitted on 11/18/18, with diagnoses including pain, pressure ulcer to her coccyx (tail bone area), diarrhea, anorexia,</p>	F 677			

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F 677	<p>Continued From page 35 and arthritis.</p> <p>Resident #20's care plan area addressing her ADLs, dated 5/25/16, documented she required the assistance of one staff with showers twice weekly between 10:00 PM and 11:00 PM.</p> <p>A quarterly MDS assessment, dated 1/2/19, documented Resident #20 had severe cognitive impairment and was totally dependent on two staff for assistance with showers.</p> <p>Resident #20's ADL flowsheet from 2/1/19 through 3/28/19, documented she did not receive a shower between 2/1/19 and 2/11/19, 10 days. She received her next shower on 3/3/19, 20 days later and then on 3/11/19, 8 days later. Resident #20's next shower was documented on 3/21/19, 10 days later.</p> <p>Resident #20 was documented as refusing showers on 3/26/19 and 3/28/19. The flowsheet documented "NA" on 3/5/19 to 3/9/19, and on 3/25/19.</p> <p>On 3/25/19 at 9:29 AM, Resident #20 stated the facility was short staffed and she did not receive showers consistently.</p> <p>On 3/26/19 at 3:52 PM, CNA #4 stated the long-term unit was short staffed and residents did not always receive their showers.</p> <p>On 3/26/19 at 3:55 PM, CNA #3 stated the long-term unit was supposed to have 4 CNAs and 1 shower aide and this was not currently the case. CNA #3 stated she heard from residents they were not receiving their showers</p>	F 677			

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F 677	<p>Continued From page 36 consistently. CNA #3 stated if a resident told her they had missed a shower she provided one.</p> <p>On 3/27/19 at 10:35 AM, CNA #6 stated the facility was short a shower aide. CNA #6 stated she provided showers when needed to residents.</p> <p>On 3/27/19 at 10:46 AM, CNA #7 stated the facility was short staffed in the long-term unit and when staff called off or did not show up to work, the shower aide was pulled to work the floor. CNA #7 stated if a shower aide was pulled to work the floor, the CNAs on the floor were responsible for completing showers. CNA #7 stated the long-term unit did not currently have a shower aide.</p> <p>3. Resident #81 was admitted to the facility on 2/22/19, with multiple diagnoses including malignant neoplasm of the lung (a form of cancer of the lung), chronic obstructive pulmonary disease (a progressive lung disease that restricts breathing) and anxiety disorder.</p> <p>Resident #81's admission MDS, dated 2/27/19, documented Resident #81 was severely cognitively impaired and needed extensive assistance with ADLs which included the assistance of one staff for bathing.</p> <p>The ADL care plan, revised on 3/14/19, documented Resident #81 had impaired mobility with weakness due to end of life, and she needed assistance with ADLs which included complete daily hygiene needs.</p> <p>Resident #81's ADL flowsheet from 2/22/19 through 3/28/19, did not include documentation</p>	F 677			

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F 677	<p>Continued From page 37</p> <p>she received a bath from 2/22/19 to 3/3/19, 9 days. There was no documentation she received a bath between 3/6/19 to 3/12/19, 6 days.</p> <p>On 3/28/19 at 1:05 PM, LPN #1 stated hospice completed bathing every Friday. She also stated baths or showers for all residents in the facility were scheduled once a week or were individualized per residents' request. LPN #1 said scheduled bathing for Resident #81 was not documented in her record.</p> <p>On 3/28/19 at 1:30 PM, RDCS #1 stated Resident #81's record did not include documentation bathing was completed by hospice aides.</p> <p>4. Resident #38 was admitted to the facility on 10/9/17, with multiple diagnoses including hip fracture with hip replacement, history of falls, chronic obstructive pulmonary disease (a progressive lung disease that restricts breathing), cognitive communication deficit, and dementia.</p> <p>Resident #38's annual MDS assessment, dated 1/29/19, documented she was cognitively intact. The MDS functional status documented Resident #38 required no setup or physical help from staff for bathing.</p> <p>Resident #38's ADL flowsheet documented she required assistance with bathing which included limited supervision, and extensive assistance. The ADL flowsheet did not include documentation she received a bath from 2/14/19 to 2/22/19, 8 days apart, and from 3/7/19 to 3/15/19, 8 days.</p> <p>On 3/28/19 at 1:05 PM, LPN #1 stated baths or</p>	F 677			

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F 677	Continued From page 38 showers for all residents in the facility were scheduled once a week or were individualized per residents' request. LPN #1 stated Resident #38 often refused baths. Scheduled bathing for Resident #38, and her refusal of bathing was not found in her record.  On 3/28/19 at 1:30 PM, RDCS #1 stated Resident #38's record did not include documentation of Resident #38's refusal of bathing.  On 3/28/19 at 1:06 PM, RCM #1 and RDCS #1 stated the residents were provided one shower a week minimally and two showers a week was the ideal number of times provided. RDCS #1 stated they did not have a shower schedule outlined anywhere and it was embedded into the charting software. RDCS #1 stated she looked for the missing showers on Resident #20, Resident #38, Resident #74, and Resident #81. Further documentation was not provided. RCM #1 stated she thought the CNAs were not documenting showers correctly and stated was going to discuss not using "NA" with staff.	F 677			
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)  §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence	F 679		5/7/19	

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F 679	<p>Continued From page 39 and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and Activity Calendar review, it was determined the facility failed to ensure there was a variety of activities scheduled to meet the needs of residents with cognitive impairment. This was true for 1 of 2 residents (Resident #74) reviewed for activities. This created the potential for residents to become bored and foster an increase in negative behaviors when not provided with meaningful engaging activities. Findings include:</p> <p>The facility's activity policy, undated, documented residents' activities should be meaningful and individualized according to their needs.</p> <p>The March 2019 Activity Calendar documented activities occurred seven days a week. The Activity Calendar documented the following activities:</p> <ul style="list-style-type: none"> <li>* Music activities: noon music, during the lunch hour, 7 days during the month and a music activity not during the lunch hour 4 days during the month.</li> <li>* Religious activities: 5 days during the month.</li> <li>* 1:1 activities: 21 days during the month.</li> </ul> <p>Resident #74 was initially admitted to the facility on 7/21/17, and readmitted on 10/16/17, with diagnoses that included pain, heart disease, fractured wrist, dementia, muscle weakness, and osteoporosis (fragile bones).</p> <p>An annual MDS assessment, dated 6/27/18,</p>	F 679	<p>Corrective Action: Resident #74 was reassessed for activity needs on. Care Plan was updated with current activity preferences.</p> <p>Identification: 100% audit of residents diagnosed with dementia to identify resident activity preferences. Care plans were updated on or before 5-7-19 to reflect individualized resident preferences.</p> <p>Systematic Changes: SDC or designee to provide education to the Activities staff on activities for cognitively impaired residents.</p> <p>Monitor: DON or designee to Audit 5 residents with dementia diagnoses care plans and activity participation record, weekly x4 then monthly x3 months. Findings reported to QAPI Committee.</p>		

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F 679	<p>Continued From page 40</p> <p>documented Resident #74's activity preferences which were very important to her included books and magazines she liked, listening to music, keeping up with the news, fresh air and outside activities, religion, group activities, and participating in favorite activities.</p> <p>The Activity Assessment, updated on 11/1/18, documented Resident #74's activity preferences had not changed since admission on 7/21/17. The assessment documented Resident #74 enjoyed listening to the radio and music, participating in sing-alongs, family and friend visits, arts and crafts, going to the beauty parlor, bingo, exercise, religious activities, sports, television, and parties. The assessment documented Resident #74 had past interests in walking/wheeling around the facility, gardening, and cooking. The assessment documented Resident #74 had no interests in current events and news, group discussions, and reading. This was not consistent with the MDS assessment.</p> <p>The care plan area addressing Resident #74's Activities, updated 3/23/19, documented she enjoyed activities involving religion and spending time outside. The care plan documented Resident #74 enjoyed visits with a family member and being outside, weather permitting. The care plan did not include all the interests identified as very important to Resident #74 according to her MDS and their activity assessment.</p> <p>Resident #74's Activities Flowsheet, dated 2/1/19 through 3/27/19, did not include documentation if she was offered or participated in going to the beauty parlor, reading books and magazines, listening to the radio, sing-alongs, bingo, or</p>	F 679			

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F 679	<p>Continued From page 41 walking and/or wheeling around. The flowsheets documented the following activities:</p> <ul style="list-style-type: none"> <li>* She was offered and participated in a music activity on 3/15/19 (one time) and refused to participate on 2/11/19 and 3/11/19.</li> <li>* She was offered and participated in news events on 2/6/19, 2/20/19, 3/6/19, 3/13/19, and 3/27/19, which her assessment documented as "no" interest.</li> <li>* She was offered and participated in religious activities on 2/7/19, 2/22/19, 2/28/19, 3/14/19, and 3/26/19, and refused to participate on 3/3/19 and 3/7/19.</li> <li>* She was offered and participated in 1:1 visits on 2/7/19, 2/9/19, 2/26/19, 3/6/19, and 3/26/19, and refused to participate on 2/11/19.</li> <li>* She participated in family visits on 2/19/19, 2/25/19, 2/28/19, 3/5/19, 3/7/19 to 3/9/19, 3/11/19, 3/13/19, 3/15/19, 3/18/19, and 3/25/19.</li> <li>* She was offered and participated in a cooking or baking activity on 2/1/19 to 2/3/19, 2/6/19 to 2/11/19, 2/14/19 to 2/28/19, 3/1/19 to 3/3/19, 3/5/19 to 3/11/19, 3/13/19 to 3/18/19, 3/21/19, and 3/25/19 to 3/27/19, which her assessment documented as a past interest.</li> <li>* She was offered and participated in "stop by" on 2/1/19 to 2/3/19, 2/6/19 to 2/11/19, 2/14/19 to 2/28/19, 3/1/19 to 3/18/19, 3/20/19, 3/21/19, and 3/25/19 to 3/27/19. On 3/29/19 at 1:39 PM, the Activities Director stated "S/B" meant "stop by." She said a "stop by" was a quick visit by staff to</li> </ul>	F 679			

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F 679	<p>Continued From page 42</p> <p>ask a resident how they were doing and if they needed anything.</p> <p>Resident #74 had minimal participation in activities identified on her care plan and her activities were not individualized with her identified interests.</p> <p>Resident #74 was observed to sit near the nurses' station or lay in bed or in an activities room without stimulation or sensory activities provided, as follows:</p> <ul style="list-style-type: none"> <li>* Resident #74 was observed in her wheelchair or bed, without participating in an activity on 3/25/19 from 10:38 AM to 11:14 AM, on 3/26/19 from 9:16 AM to 12:01 PM, from 1:39 PM to 4:20 PM, on 3/27/19 from 8:53 AM to 11:54 AM and from 2:45 PM to 3:55 PM, on 3/28/19 from 9:19 AM to 10:00 AM, and on 3/29/19 from 10:03 AM to 11:05 AM. Specific examples include: <ul style="list-style-type: none"> <li>* On 3/26/19 from 10:16 AM to 11:54 AM and from 1:39 PM to 4:20 PM, Resident #74 was observed wheeling in circles and running into various objects.</li> <li>* On 3/27/19 from 8:53 AM to 9:38 AM, Resident #74 was observed near the nurses' station, with her head bent over, eyes closed, and her body leaning slightly to the right of her wheelchair.</li> <li>* On 3/27/19 from 9:56 AM to 11:54 AM, Resident #74 was observed in bed with her eyes closed without the music playing or the television turned on.</li> <li>* On 3/28/19 from 9:19 AM to 10:00 AM,</li> </ul> </li> </ul>	F 679			

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F 679	<p>Continued From page 43</p> <p>Resident #74 was observed wheeling in circles backwards and repeatedly bumped her wheelchair into the back of Resident #64's wheelchair.</p> <p>* On 3/29/19 from 10:03 AM to 11:05 AM, Resident #74 was in the hallway near the nurses' station moving her wheelchair forward and backwards in circles.</p> <p>On 3/28/19 at 4:56 PM, the Activities Director stated the facility had multiple activities available for residents with dementia and cognitive impairments. She stated they provided aroma therapy, lotion on the hand, music, and a sensory device that filled with water and had an object floating around in it, and 1:1 visits. The Activities Director stated the activity personnel brought the sensory and 1:1 activities to the residents. She stated Resident #74 enjoyed walking/wheeling outside with her family and she was unsure if staff provided Resident #74 with the opportunity to walk/wheel. The Activities Director stated she did not know Resident #74 to watch television often and she did enjoy music. She stated the activities department two staff members to attend to all the residents' needs. She stated as long as the activity personnel stayed on schedule there was enough staff to meet the needs of the residents. The Activities Director stated she was looking to hire another staff member soon. The Activities Director stated the activities calendar scheduled multiple 1:1 visits for residents with dementia or cognitive impairments.</p> <p>On 3/29/19 at 1:39 PM, the Activities Director stated Resident #74's 1:1 visits and dementia specific activities were not documented as</p>	F 679			

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F 679	Continued From page 44 completed.	F 679			
F 689 SS=D	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, and staff interview, it was determined the facility failed to ensure adequate supervision was provided. This was true for 1 of 6 residents (Resident #74) reviewed for accidents and supervision. This failure had the potential for harm if residents sustained injuries from accidents and incidents. Findings include:</p> <p>Resident #74 was initially admitted to the facility on 7/21/17, and readmitted on 10/16/17, with diagnoses that included pain, heart disease, fractured wrist, dementia, muscle weakness, and osteoporosis (fragile bones).</p> <p>Resident #74's care plan area addressing her ADL's, dated 7/21/17, documented Resident #74 required the assistance of one staff with bed mobility and toileting. The care plan documented Resident #74 was able to self-propel her wheelchair and she had back-up brakes on her wheelchair.</p> <p>A quarterly MDS assessment, dated 2/28/19,</p>	F 689	<p>Corrective Action: Resident 74 reassessed for supervision needs with mobility. Therapy screen completed on 4-3-19, with implementation of new wheelchair and cushion Care plan was updated with new interventions on 4-29-19.</p> <p>Identification: 100% audit for resident with dementia diagnosis for needs of supervision with mobility. Care plans updated with new interventions, as needed.</p> <p>Systematic Changes: SDC or designee to educate all Nursing and Rehab staff on notification of change of condition and stop and watch protocol to include need for additional supervision or assistance and changes to patterns of behavior.</p> <p>Monitor: DON or designee to audit identified</p>	5/7/19	

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F 689	<p>Continued From page 45</p> <p>documented Resident #74 had severe cognitive impairment and required extensive assistance of one staff for moving around her room and the facility. The MDS documented Resident #74 required two staff members' assistance for bed mobility, transfers, dressing, and toilet use. This MDS was inconsistent with her care plan and documented she needed more assistance than documented on her care plan for bed mobility, transfers, dressing, and toilet use.</p> <p>An OT Evaluation and Plan of Treatment, dated 10/2/18, documented Resident #74 was wheelchair bound and she was able to propel her wheelchair with both of her legs. The evaluation documented Resident #74 required range of motion therapy for her left upper extremity. The evaluation did not include documentation if Resident #74's wheelchair had back-up brakes. This evaluation was not consistent with the MDS evaluation for Resident #74's mobility.</p> <p>Resident #74 was observed propelling her wheelchair using her right arm and foot without staff present and no back-up brake device attached to her wheelchair. Resident #74 had difficulty with maneuvering her wheelchair and was running into other residents' wheelchairs without staff supervision or assistance. Examples include:</p> <p>* On 3/25/19 at 11:10 AM, Resident #74 was observed struggling to move her wheelchair without the use of her left arm and left leg. Her left hand was placed in her lap and her left leg was extended out in front of her, while she moved backwards and forwards in circles. Resident #74 repeatedly bumped into the back of</p>	F 689	<p>changes of condition weekly x4 weeks, 10 change of conditions monthly x3 months to ensure documentation and appropriate interventions in place. Findings to be reported to QAPI Committee.</p>		

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F 689	<p>Continued From page 46</p> <p>Resident #43's wheelchair. Resident #43 stated her day would be better if Resident #74 stopped running into her wheelchair.</p> <p>* On 3/26/19 from 9:16 AM through 9:47 AM, Resident #74 was observed in an activity room on the long-term hall, with her left hand placed in her lap and her left leg extended out in front of her. Resident #74 was observed to use her right hand and right leg to propel herself forward and backwards in circles running into walls, chairs, and tables.</p> <p>During the same observation, from 9:39 AM to 9:47 AM, Resident #74 was wedged between a table and a chair. She could not free herself from the confined area and no staff were present in the room. CNA #5 entered the room at 9:47 AM and assisted her out of the confined area then CNA #5 left the room.</p> <p>At 9:48 AM, Resident #74 continued to wheel around the room in circles running into objects including the side of Resident #81's wheelchair. At 9:53 AM, Resident #74 was observed to reach for an object on a table, and while she leaned forward, her back wheels came up off the ground slightly. Resident #74 let go of the object and flopped back into her wheelchair with a startled look on her face. Resident #74 continued to move around the room in circles and bumped into various objects without staff present.</p> <p>* On 3/26/19 at 9:58 AM, Resident #74 was assisted into the hallway near the nurses' station by CNA #5. Resident #74 was observed sniffing and continued to move in circles in the hallway while running into various objects. Resident #74</p>	F 689			

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F 689	<p>Continued From page 47</p> <p>wedged herself in a doorframe on her left side and she was unable to free herself from the doorframe. At 10:03 AM, RDCS #2 assisted her out of the doorframe.</p> <p>* On 3/26/19 from 10:16 AM to 11:54 AM, Resident #74 was observed with her left hand placed in her lap and her left leg was extended out in front of her with her shoe approximately three inches off the ground, wheeling in circles and running into various objects.</p> <p>* On 3/28/19 from 9:20 AM to 9:24 AM, Resident #74 was wheeling in circles backwards and repeatedly bumped her wheelchair into the back of Resident #64's wheelchair. Resident #64 stated, "Quit it."</p> <p>On 3/28/19 at 1:59 PM, RDCS #1 and RCM #1 stated they were unaware Resident #74 was running her wheelchair into other residents. RDCS #1 said she was aware Resident #74 propelled her wheelchair backwards. RDCS #1 stated she was going to try to locate documentation this was discussed and the plan for it (Nothing was provided). RDCS #1 stated she did not recall if Resident #74's wheelchair was evaluated for tipping over in the front and stated she would look for an evaluation. RDCS #1 stated she thought Resident #74 had anti-tip bars on the back of her wheelchair and she was going to check.</p> <p>On 3/29/19 at 10:53 AM, CNA #13, who was also the restorative nursing aide, stated she noticed Resident #74 not utilizing her left leg a few weeks ago. CNA #13 stated she worked with Resident #74's upper left extremity not her lower left</p>	F 689			

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F 689	Continued From page 48 extremity. CNA #13 stated Resident #74's left leg bent fine at the knee joint, but guessed she was using her leg extended as a bumper. CNA #13 stated she was unsure why she was using her leg as a possible bumper. CNA #13 stated she had not notified nursing of the changes she noticed but thought someone else had. CNA #13 stated Resident #74 did not vocalize her needs often and she was hard to communicate with.	F 689			
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)  §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-  §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;  §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;  §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, policy review, and record review, it was determined the facility failed to ensure residents were	F 692	Corrective Action: On or before 5-7-19, Resident 20, 74 were assessed and care plans updated to	5/7/19	

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F 692	<p>Continued From page 49</p> <p>consistently provided adequate nutritional and hydration interventions. This was true for 2 of 4 residents (#20 and #74) reviewed for weight loss and hydration concerns. This failure created the potential for harm if residents became dehydrated and they experienced unplanned weight loss. Findings include:</p> <p>The facility's Hydration and Nutrition policy, dated 11/26/18, documented adequate nutrition and hydration were offered to residents. The policy documented fluids were available to residents "at all times." The policy documented residents were positioned properly at meals and snacks and assistance was provided as needed.</p> <p>1. Resident #20 was initially admitted to the facility on 7/2/13, and readmitted on 11/18/18, with diagnoses that included diarrhea, vitamin D deficiency, and anorexia.</p> <p>Resident #20's care plan area addressing nutrition, dated 7/15/13, documented she required one staff member's assistance with meal setup and cueing at times. The care plan documented she required nectar thick liquids and mechanical soft textured foods (foods that are easy to chew and swallow, such as ground or pureed).</p> <p>Resident #20's care plan area addressing her ADL's, dated 5/25/16, documented Resident #20 required one staff member's assistance with meals as she allowed.</p> <p>Resident #20's care plan area addressing her fluid status, dated 2/13/18, documented Resident #20 had frequent loose stools that placed her at</p>	F 692	<p>reflect current functional status with eating and hydration.</p> <p>Identification: 100% Audit completed on or before 5-7-19, to include current resident functional status with eating. Care plans were updated to reflect any changes.</p> <p>Systemic Changes: SDC or designee to provide education to all Nursing and Dietary staff on residents requiring assistance with eating. Dietary staff will continue to stock nourishment rooms with a variety of beverages, to be available at resident's request. Residents who are dependent on staff for hydration needs will be offered an additional 240ml fluids TID between meals by nursing. Residents will be offered two different beverages at each meal. The CNA will pass fresh fluids twice a day on morning and evening shift unless resident's condition is contraindicated.</p> <p>Monitor: DON or designee to visually audit 10 residents requiring assistance with eating to ensure care planned level of assistance was provided to consume food and beverages. DON will audit to ensure that 2 beverages were offered at meals and audit TAR to ensure that additional fluids offered per order. Audits will be completed weekly x4, then monthly x3 months. DON or designee to audit 5 care</p>		

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F 692	<p>Continued From page 50</p> <p>risk of dehydration. The care plan documented staff were to offer her fluids with cares, medications, and meals. The care plan documented if Resident #20 had decreased levels of urine output nursing was to notify the physician.</p> <p>A quarterly MDS assessment, dated 1/2/19, documented Resident #20 had severe cognitive impairment and required limited assistance of one staff member with meals.</p> <p>Resident #20's record did not document the facility was monitoring her fluid intake or output.</p> <p>On 3/25/19 at 9:29 AM, Resident #20 was observed lying in bed positioned onto her right side eating breakfast. The head of Resident #20's bed was elevated 65 degrees. Resident #20 was coughing with a wet vocal quality to her voice when she spoke. Resident #20's food was cut into large pieces and she had thickened water and juice.</p> <p>On 3/25/19 at 9:37 AM, Resident #20 was observed coughing, not eating her breakfast, and positioned in the same way as described above.</p> <p>On 3/26/19 from 9:12 AM to 10:22 AM, Resident #20 was observed in bed asleep on her right-side with a full glass of thickened liquid on a bed side table.</p> <p>On 3/26/19 at 10:22 AM to 11:35 AM, Resident #20 was observed in bed asleep and a full glass of fluid was approximately 1 1/2 feet from her reach.</p>	F 692	plans to ensure accurate functional status with eating, weekly x4, then monthly x3 months. Findings to be reported to QAPI Committee.		

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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SANDPOINT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1125 NORTH DIVISION STREET SANDPOINT, ID 83864</b>		
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F 692	<p>Continued From page 51</p> <p>On 3/26/19 from 1:33 PM to 3:45 PM, Resident #20 was observed in bed asleep without fluids readily available.</p> <p>On 3/27/19 from 9:19 AM to 9:47 AM, Resident #20 was observed sleeping on her right side. Her meal tray and thickened liquid were sitting on the bed side table untouched. Resident #20 was not offered assistance with her meal tray or cued to eat. At 9:47 AM an aide entered the room and removed her meal tray but left the full glass of thickened liquid at her bedside.</p> <p>On 3/27/19 from 9:53 AM to 9:59 AM, Resident #20 was provided wound care. After the conclusion of the wound care she was not cued or offered assistance with her fluids.</p> <p>On 3/27/19 from 10:01 AM to 11:52 AM, Resident #20 was observed asleep on her back with a full glass of thickened liquid next to her.</p> <p>On 3/28/19 at 3:56 PM, the RD stated Resident #20 ate at the nurses' station for meals to ensure she was supervised and provided cueing. The RD stated she did not ensure nursing staff provided the cueing or the supervision because it was a nursing function. The RD was unaware Resident #20 was eating in her room. She stated Resident #20 should be positioned upright to eat her meals due to increased difficulty with swallowing. The RD stated if fluids were not within a resident's reach it was difficult to consume them, and fluids should be within residents' reach.</p> <p>2. Resident #74 was initially admitted to the facility on 7/21/17, and readmitted on 10/16/17,</p>	F 692			

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F 692	<p>Continued From page 52 with diagnoses that included heart disease, dementia, muscle weakness, and osteoporosis (fragile bones).</p> <p>A quarterly MDS assessment, dated 2/28/19, documented Resident #74 had a severe cognitive impairment and required extensive assistance of one staff member for eating. The MDS documented she had a catheter.</p> <p>The care plan area addressing Resident #74's difficulty with swallowing, dated 7/21/17, documented she had difficulty swallowing foods and fluids and staff were to supervise her consumption of food and fluid.</p> <p>The care plan area addressing Resident #74's potential for dehydration, dated 7/27/17, documented she did not show signs and symptoms of dehydration. The care plan documented staff were to offer her food and fluid with cares, medications, and meals. The care plan documented if Resident #74 had decreased levels of urine output nursing was to notify the physician.</p> <p>Resident #74's record did not document the facility was monitoring her fluid intake or output.</p> <p>Resident #74 was observed to not be offered fluid after resident cares, or when observed with dry lips, and/or with minimal urine output as follows:</p> <p>On 3/25/19 at 11:10 AM, Resident #74 was observed in her wheelchair, by herself, without fluids or offers of fluids. She was also observed in her wheelchair without fluids or offers of fluids</p>	F 692			

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F 692	<p>Continued From page 53</p> <p>on 3/26/19 from 9:16 AM through 9:47 AM, from 9:48 AM to 10:05 AM, from 10:16 AM to 11:54 AM, from 1:39 PM to 4:20 PM, on 3/27/19 at 3:55 PM, on 3/28/19 at 9:19 AM, from 9:20 AM to 9:24 AM, at 10:10 AM, and on 3/29/19 from 10:03 AM to 10:48 AM.</p> <p>On 3/25/19 at 11:14 AM, CNA #1 and CNA #2 were observed providing cares to Resident #74 and she was not offered fluids after cares concluded.</p> <p>On 3/26/19 at 9:47 AM, Resident #74 was observed assisted out of the confined area by CNA #5 without offering her fluids.</p> <p>On 3/26/19 at 10:09 AM, CNA #5 and CNA #4 were observed providing cares to Resident #74 and she was not offered fluids after cares concluded.</p> <p>On 3/26/19 at 1:24 PM, Resident #74 was provided juice and she finished the juice within minutes.</p> <p>On 3/26/19 from 1:39 PM to 3:41 PM, Resident #74 was observed sitting in the hallway near the nurses' station with an empty juice container in her hand.</p> <p>On 3/26/19 at 4:20 PM, CNA #4 and CNA #12 were observed providing cares to Resident #74 and she was not offered fluids after cares concluded. Resident #74's lips looked dry and chapped.</p> <p>On 3/27/19 at 9:39 AM, CNA #10 was observed asking Resident #74 if she wanted to lay down</p>	F 692			

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F 692	Continued From page 54 and Resident #74 stated, "Yes." Resident #74 was assisted with laying down by CNA #10. Resident #74's body was positioned slightly on her left side with pillows under her knees. Resident #74 was not offered fluids after she was assisted into bed.  On 3/27/19 from 9:56 AM to 11:54 AM, Resident #74 was observed in bed with her eyes closed. Resident #74 had a cup of fluids in her room on a dresser to her right, at the head of her bed, approximately three feet from within her reach.  On 3/28/19 at 9:38 AM, CNA #10 provided cares to Resident #74 and did not offer her fluids.  On 3/29/19 at 10:03 AM, Resident #74 was observed with her lips dry and starting to crack.  On 3/28/19 at 1:59 PM, RDCS #1 stated all residents had fluids available to them in their rooms and she would expect staff to offer fluids at meals, if a resident requested fluids, or after long contacts with the residents, meaning after cares. RDCS #1 stated she wouldn't expect staff to offer fluids after every resident contact because they were so often. RDCS #1 stated the fluids needed to be accessible. RDCS #1 stated the facility did not monitor fluid output unless ordered by the physician.	F 692			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		5/7/19	

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F 695	<p>Continued From page 55</p> <p>care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, facility policy review, and staff interview, it was determined the facility failed to ensure residents received oxygen therapy per physician orders, and failed to ensure staff changed, dated, and stored residents' oxygen tubing per facility policy. This was true for 2 of 2 residents (#38 and #46) reviewed for oxygen therapy. This failure created the potential for harm if residents' respiratory needs were not met, and from respiratory infections due to the growth of pathogens (organisms that cause illness) in oxygen tubing. Findings include:</p> <p>The facility's oxygen policy, dated 12/3/19, documented the following:</p> <ul style="list-style-type: none"> <li>* The oxygen supplies were changed weekly and when visibly soiled, then labeled with the resident's name and dated when supplies were changed.</li> <li>* Regardless of water level, the humidifier aerosol bottles were dated and changed every 7 days.</li> <li>* Oxygen respiratory supplies were stored in a bag labeled with the resident's name when not in use.</li> </ul> <p>1. Resident #38 was admitted to the facility on 10/9/17, with multiple diagnoses including hip fracture with hip replacement, history of falls, chronic obstructive pulmonary disease (a</p>	F 695	<p>Corrective Action: Resident # 38's O2 supplies replaced on 3-28-19, per policy. On 3-28-19, RN notified MD of Resident # 46's change of O2 needs and received new order. Resident's care plan updated on or before 5-7-19.</p> <p>Identification: All residents with orders for oxygen are identified as potentially being affected by this deficiency.</p> <p>Systemic Changes: SDC or designee to educate nursing staff regarding oxygen policy.</p> <p>Monitor: DON or Designee to conduct audit of 10 residents with oxygen orders for accurate implementation of those orders and proper labelling of O2 supplies. Audits to be conducted weekly x4, then monthly x3 months. Findings to be reported to QAPI Committee.</p>		

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F 695	<p>Continued From page 56</p> <p>progressive lung disease that restricts breathing), cognitive communication deficit, dementia, and overall muscle weakness.</p> <p>Resident #38's physician's order, dated 3/24/19, documented oxygen therapy at 2 liters per minute via nasal cannula to keep oxygen saturation levels (measure of oxygen in the blood stream) above 90% for shortness of breath.</p> <p>On 3/26/19 at 8:42 AM, Resident #38's oxygen tubing and the humidifier aerosol bottle were not labeled with the resident's name and date, and a storage bag for respiratory supplies was not present. A mask with a nebulizer unit was lying on Resident #38's bedside table.</p> <p>On 3/26/19 at 10:07 AM, RN #4 stated the policy for oxygen tubing was to date and label the oxygen tubing and to place oxygen supplies in a bag attached to the oxygen concentrator handle when they were not in use. She also stated, oxygen tubing maintenance was completed weekly.</p> <p>On 3/26/19 at 10:18 AM, CNA #5 changed the oxygen tubing on Resident #38's oxygen concentrator. She stated, the tubing was changed once a week. CNA #5 stated she changed the oxygen supplies once a week, but she was unsure how often the humidifier aerosol bottle was changed. She stated, she knew the humidifier aerosol bottle was changed last Sunday, because she changed it, but she did not date it.</p> <p>2. Resident #46 was initially admitted to the facility on 9/3/15, and readmitted on 1/13/17, with</p>	F 695			

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F 695	<p>Continued From page 57</p> <p>diagnoses that included heart disease and dementia.</p> <p>An annual MDS assessment, dated 2/7/19, documented Resident #46 was cognitively intact and received oxygen therapy.</p> <p>The care plan area addressing Resident #46's oxygen requirements, dated 11/27/18, documented she had difficulty breathing related to chronic obstructive pulmonary disease and complaints of shortness of breath. The care plan documented staff applied oxygen as ordered.</p> <p>Resident #46's physician orders were for her to receive 3 liters per minute of oxygen continuously via nasal cannula and the oxygen saturation levels were to be documented every shift, ordered 2/28/19.</p> <p>Resident #46's 2/1/19 through 3/18/19 Treatment Administration Record (TAR) documented staff assessed her oxygen saturation level daily. The TAR documented staff administered up to 5 liters per minute of oxygen. Resident #46 did not receive oxygen on 2/26/19, 3/3/19, 3/5/19, 3/7/19, 3/8/19, and 3/17/19. She received 2 L of oxygen on 2/1/19 through 2/12/19, 2/14/19 through 2/16/19, 2/20/19, 2/22/19 through 2/25/19, 2/27/19 through 3/2/19, 3/4/19, 3/6/19, 3/9/19 through 3/16/18, and 3/17/19. She received 3 L of oxygen on 2/13/19, 2/17/19, and 2/18/19. She received 5 L of oxygen on 2/19/19. The oxygen was not administered consistently per physician orders.</p> <p>On 3/27/19 from 8:40 AM to 8:53 AM, Resident #46 was observed eating breakfast with her</p>	F 695			

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F 695	Continued From page 58 oxygen turned off and the oxygen tubing was draped over the tank on the back of her wheelchair.  On 3/27/19 at 8:57 AM, RN #1 stated he thought Resident #46's order was to wear her oxygen when she was in bed and left the room. CNA #11 stated she thought the order for Resident #46's oxygen was PRN.  On 3/27/19 at 9:02 AM, RN #1 returned to the room and stated he reviewed Resident #46's order and stated she should wear the oxygen continuously at three liters. RN #1 assessed Resident #46's oxygen saturation level and stated he would speak to the MD about changing the order to PRN.  On 3/28/19 at 2:23 PM, RDCS #1 stated the order was corrected when the issue was brought to the RNs attention and staff needed to assess her oxygen saturation level every six hours if she was using it as PRN.	F 695			
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)  §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		5/7/19	

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F 725	<p>Continued From page 59</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, review of nurse staffing information, review of daily assignment sheets, policy review, review of resident appointment schedules, review of Resident Council Meeting Minutes, and review of the Facility Assessment, it was determined the facility failed to ensure sufficient numbers of staff were provided to meet the supervision, bathing, nutrition and hydration, and nursing oversight needs of residents. This deficient practice directly impacted 13 of 18 residents (#4, #20, #35, #38, #34, #39, #43, #46, #49, #50, #64, #74, and #81) reviewed for sufficient staffing and had the potential to negatively impact the other 78 residents residing in the facility. The deficient practice placed residents a) at risk of isolation, embarrassment, and health declines due to lack of consistent baths/showers and b) at risk of falls due to lack of supervision . Findings include:  The facility's staffing policy, undated,</p>	F 725	<p>Corrective Action: Residents 4, 20, 35, 38, 34, 39, 43, 46, 49, 50, 64, 74, and 81 had care conferences completed on or before 5-7-19 with resident to assure care needs are being met. All concerns will be addressed at that time and plan of care updated to reflect choices and care needs.</p> <p>Identification: All residents have the potential to be affected by this deficient practice.</p> <p>Systemic Changes: Grievance cards for the last 30 days will be reviewed by the Executive Director to determine if any Resident or family concerns were identified regarding unmet care needs. Executive Director has met with the</p>		

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F 725	<p>Continued From page 60</p> <p>documented the facility maintains adequate staffing on each shift to ensure residents needs were met.</p> <p>The Facility Assessment, dated November 2018, directed staff:</p> <ul style="list-style-type: none"> <li>* To ensure staffing needs were based on individualized needs.</li> <li>* To review census and acuity staffing levels and to adjust accordingly per hallway.</li> <li>* The staffing plan for the facility documented they required 10 direct care licensed nursing personnel for 24 hours, 20 CNAs for 24 hours, and 8 administrative nursing personnel.</li> </ul> <p>The facility's policy and assessment were not followed. Examples include:</p> <p>a. Resident #74 was not adequately supervised by staff.</p> <p>Resident #74 was initially admitted to the facility on 7/21/17, and readmitted on 10/16/17, with diagnoses that included pain, heart disease, fractured wrist, dementia, muscle weakness, and osteoporosis (fragile bones).</p> <p>Resident #74's care plan area addressing her ADL's, dated 7/21/17, documented Resident #74 required the assistance of one staff with bed mobility and toileting. The care plan documented Resident #74 was able to self-propel her wheelchair and she had back-up brakes on her wheelchair.</p> <p>A quarterly MDS assessment, dated 2/28/19, documented Resident #74 had severe cognitive</p>	F 725	<p>Resident Council to discuss Resident care and staffing concerns. Regional Director of Clinical Services will educate Executive Director and Director of Nursing on Sufficient Nursing staff F725 CFR(s): 483(a)(1)(2). Clinical Liaison or designee will schedule employees from Marketing, Activities, Social Services, and Maintenance as primary personnel to accompany residents on appointments outside of the facility.</p> <p>Effective 5-12-19, the facility has changed 12-hour CNA shifts to all 8-hour shifts in an effort to reduce staff "burn out," make filling vacant shifts easier, and eliminate the 6pm CNA shift change (when resident needs increase after dinner and before bedtime).</p> <p>The Weekend Call-Off Policy has been changed to require personnel who call-off for their weekend shift to fill a vacancy that occurs on a subsequent weekend. SDC or designee will educate all staff on need to communicate with the Executive Director and/or DON if they feel that current staffing levels are not adequate to meet the Resident care needs.</p> <p>The Executive Director or designee will review staffing sheets daily to assure that adequate staff are assigned to meet resident needs.</p> <p>The Executive Director and DON will meet weekly with the Resident Council for the next 2 months to determine if current Resident care needs are being met.</p> <p>Monitoring</p>		

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F 725	<p>Continued From page 61</p> <p>impairment and required extensive assistance of one staff for moving around her room and the facility. The MDS documented Resident #74 required two staff members' assistance for bed mobility, transfers, dressing, and toilet use. This MDS was inconsistent with her care plan and documented she needed more assistance than documented on her care plan for bed mobility, transfers, dressing, and toilet use.</p> <p>Resident #74 was observed propelling her wheelchair using her right arm and foot without staff present and no back-up brake device attached to her wheelchair. Resident #74 had difficulty with maneuvering her wheelchair and was running into other residents' wheelchairs without staff supervision or assistance. Examples include:</p> <p>* On 3/25/19 at 11:10 AM, Resident #74 was observed struggling to move her wheelchair without the use of her left arm and left leg. Her left hand was placed in her lap and her left leg was extended out in front of her, while she moved backwards and forwards in circles. Resident #74 repeatedly bumped into the back of Resident #43's wheelchair. Resident #43 stated her day would be better if Resident #74 stopped running into her wheelchair.</p> <p>* On 3/26/19 from 9:16 AM through 9:47 AM, Resident #74 was observed in an activity room on the long-term hall, with her left hand placed in her lap and her left leg extended out in front of her. Resident #74 was observed to use her right hand and right leg to propel herself forward and backwards in circles running into walls, chairs, and tables.</p>	F 725	<p>DON or designee to audit shower charting ensure that showers are being completed to meet the care planned needs of the residents. Audit to be completed 3 times a week x 4 weeks then weekly x 4 weeks, then monthly x 2 months.</p> <p>ED or designee will audit call light response times. Audit will consist of 10 call light responses on varied shifts weekly x4 then monthly x3.</p> <p>ED or designee will audit grievance cards and staffing sheets 3 times a week x 4 weeks then weekly x 4 weeks and then monthly x 2 months. Findings to be reported to QAPI Committee.</p>		

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F 725	<p>Continued From page 62</p> <p>During the same observation, from 9:39 AM to 9:47 AM, Resident #74 was wedged between a table and a chair. She could not free herself from the confined area and no staff were present in the room. CNA #5 entered the room at 9:47 AM and assisted her out of the confined area then CNA #5 left the room.</p> <p>At 9:48 AM, Resident #74 continued to wheel around the room in circles running into objects including the side of Resident #81's wheelchair. At 9:53 AM, Resident #74 was observed to reach for an object on a table, and while she leaned forward, her back wheels came up off the ground slightly. Resident #74 let go of the object and flopped back into her wheelchair with a startled look on her face. Resident #74 continued to move around the room in circles and bumped into various objects without staff present.</p> <p>* On 3/26/19 at 9:58 AM, Resident #74 was assisted into the hallway near the nurses' station by CNA #5. Resident #74 was observed sniffing and continued to move in circles in the hallway while running into various objects. Resident #74 wedged herself in a doorframe on her left side and she was unable to free herself from the doorframe. At 10:03 AM, RDCS #2 assisted her out of the doorframe.</p> <p>* On 3/26/19 from 10:16 AM to 11:54 AM, Resident #74 was observed with her left hand placed in her lap and her left leg was extended out in front of her with her shoe approximately three inches off the ground, wheeling in circles and running into various objects.</p>	F 725			

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F 725	<p>Continued From page 63</p> <p>* On 3/28/19 from 9:20 AM to 9:24 AM, Resident #74 was wheeling in circles backwards and repeatedly bumped her wheelchair into the back of Resident #64's wheelchair. Resident #64 stated, "Quit it."</p> <p>On 3/28/19 at 1:59 PM, RDCS #1 and RCM #1 stated they were unaware Resident #74 was running her wheelchair into other residents. RDCS #1 said she was aware Resident #74 propelled her wheelchair backwards. RDCS #1 stated she was going to try to locate documentation this was discussed and the plan for it (Nothing was provided). RDCS #1 stated she did not recall if Resident #74's wheelchair was evaluated for tipping over in the front and stated she would look for an evaluation. RDCS #1 stated she thought Resident #74 had anti-tip bars on the back of her wheelchair and she was going to check.</p> <p>On 3/29/19 at 10:53 AM, CNA #13, who was also the restorative nursing aide, stated she noticed Resident #74 not utilizing her left leg a few weeks ago. CNA #13 stated she worked with Resident #74's upper left extremity not her lower left extremity. CNA #13 stated Resident #74's left leg bent fine at the knee joint, but guessed she was using her leg extended as a bumper. CNA #13 stated she was unsure why she was using her leg as a possible bumper. CNA #13 stated she had not notified nursing of the changes she noticed but thought someone else had. CNA #13 stated Resident #74 did not vocalize her needs often and she was hard to communicate with.</p> <p>b. Residents did not receive personal care consistent with their needs.</p>	F 725			

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F 725	<p>Continued From page 64</p> <p>The facility's Activities of Daily Living policy, dated 12/11/18, documented residents received assistance as needed with ADLs.</p> <p>Resident #74 did not receive assistance with toileting as needed.</p> <p>Resident #74 was initially admitted to the facility on 7/21/17, and readmitted on 10/16/17, with diagnoses that included pain, heart disease, fractured wrist, dementia, muscle weakness, and osteoporosis (fragile bones).</p> <p>A quarterly MDS assessment, dated 2/28/19, documented Resident #74 had severe cognitive impairment and required extensive assistance of one staff for showers. The MDS also documented Resident #74 required two staff members' assistance for bed mobility, transfers, dressing, and toilet use.</p> <p>Resident #74's care plan area addressing her ADL's, dated 7/21/17, documented Resident #74 required the assistance of one staff with bed mobility and toileting.</p> <p>Resident #74 attempted to notify staff of her needs and staff did not recognize her asking for assistance as follows:</p> <p>* On 3/25/19 at 11:10 AM, Resident #74 was observed with tears in her eyes, sniffing, and said she could not see. Resident #74 was observed with her left hand placed in her lap and her left leg was extended out in front of her with her shoe approximately three inches off the ground. Resident #74 was observed to use her</p>	F 725			

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F 725	<p>Continued From page 65</p> <p>right hand and right leg to propel herself forward and backwards in circles running into walls and other residents. Resident #74 repeatedly bumped into the back of Resident #43's wheelchair. Resident #43 stated her day would be better if Resident #74 stopped running into her wheelchair. Resident #74 was observed to hold out her right hand when two staff members walked near her, and the staff members continued on their way. Resident #74 grabbed the surveyor's hand and stated she had to use the restroom. CNA #1 was asked to attend to Resident #74's needs.</p> <p>* On 3/26/19 from 11:54 PM to 12:01 PM, Resident #74 was observed to hold out her hand to three staff members in the area without being acknowledged by the staff. At 12:01 PM, Resident #74 grabbed the surveyor's hand and held it. When Resident #74 was asked what she needed she stated she needed help. RN #4 came over to Resident #74's side and asked her if she was hungry and Resident #74 stated, "Yes." Resident #74 was assisted down to the dining room for lunch.</p> <p>* On 3/26/19 from 3:41 PM to 4:07 PM, Resident #74 was observed in her wheelchair and she appeared restless. She was holding out her right hand appearing to try and get someone's attention. At 4:07 PM, Resident #74 grabbed the surveyor's hand and when asked if she had to go to the bathroom, she whispered, "Yes." CNA #4 was found in the hallway leaving another resident's room and was notified of Resident #74's need for the bathroom. CNA #4 stated she did not know Resident #74's transfer requirements and was going to try and find the</p>	F 725			

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F 725	<p>Continued From page 66 CNA assigned to assist.</p> <p>On 3/26/19 from 4:08 AM to 4:17 PM, CNA #4 was observed looking for the CNA assigned to Resident #74 and she could not locate one. CNA #4 looked up Resident #74's transfer status and stated she was going to assist Resident #74 once she found assistance. CNA #4 found CNA #12 to assist her.</p> <p>On 3/26/19 at 4:17 PM, CNA #4 and CNA #12 were observed assisting Resident #74 into the bathroom and onto the toilet.</p> <p>On 3/26/19 at 4:20 PM, CNA #12 left the bathroom and stated she normally did not work with Resident #74 and she was going to find Resident #74's CNA and left the room. Resident #74 was heard making noises from the bathroom and CNA #4 stated, "[Resident #74] you can hold my hand if you need to." At 4:24 PM, CNA #1 entered the room to assist CNA #4 with Resident #74's needs. The CNAs assisted Resident #74 off the toilet, provided peri care, and assisted her back into her wheelchair. CNA #1 assisted Resident #74 back into the hallway when they were finished. CNA #4 stated Resident #74 had a large bowel movement and thanked the surveyor for letting her know about Resident #74's needs.</p> <p>* On 3/29/19 from 10:32 AM to 10:39 AM, Resident #74 appeared agitated and was observed wheeling down the hallway backwards and in circles. There was no staff present.</p> <p>On 3/29/19 at 10:40 AM, Resident #74 grabbed the surveyor's hand and when asked if she had to go the bathroom she said, "Yes." An OTA</p>	F 725			

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F 725	<p>Continued From page 67</p> <p>entered the hallway and saw the exchange with Resident #74. The OTA asked Resident #74 if she had to go to the bathroom, and she said yes. From 10:40 AM to 10:47 AM, the OTA pushed Resident #74's wheelchair up and down the long-term unit hallways and could not find an aide or a nurse to assist Resident #74. At 10:47 AM, LPN #4 walked into the unit from the foyer and was notified of Resident #74's need by the OTA and the OTA left the area. At 10:48 AM, LPN #4 located two aides to assist Resident #74 with her to the bathroom. Resident #74's needs were not met for 16 minutes between 10:32 AM to 10:48 AM when staff was not available.</p> <p>On 3/29/19 at 10:53 AM, CNA #13, who was also the restorative nursing aide, stated Resident #74 did not vocalize her needs often and she was hard to communicate with.</p> <p>On 3/29/19 at 11:04 AM, the aides, who were assisting Resident #74 with the restroom, exited the room. CNA #1 stated Resident #74 did not make it to the bathroom in time and it took them longer to clean her up.</p> <p>On 3/28/19 at 1:59 PM, RDCS #1 and RCM #1 stated Resident #74 could communicate her needs and if staff saw her reaching out they should stop and find out what she needed.</p> <p>Showers were not completed consistently for the following residents:</p> <p>i. Resident #74 was initially admitted to the facility on 7/21/17, and readmitted on 10/16/17, with diagnoses that included pain, heart disease, fractured wrist, dementia, muscle weakness, and</p>	F 725			

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F 725	<p>Continued From page 68 osteoporosis (fragile bones).</p> <p>A quarterly MDS assessment, dated 2/28/19, documented Resident #74 had severe cognitive impairment and required extensive assistance of one staff for showers. The MDS also documented Resident #74 required two staff members' assistance for bed mobility, transfers, dressing, and toilet use.</p> <p>Resident #74's care plan area addressing her ADLs, dated 7/21/17, documented she required the assistance of one staff with showers twice weekly and as needed.</p> <p>Resident #74's ADL flowsheet from 2/1/19 through 3/28/19, documented she did not receive a shower between 2/7/19 and 2/23/19, 16 days. She received her next shower on 3/7/19 12 days later and then was showered on 3/11/19, 3 days later. Resident #74 received her next shower on 3/21/19, 10 days later. The flowsheet documented "NA" on 3/14/19 and 3/18/19.</p> <p>On 3/28/19 at 1:06 PM, RCM #1 stated "NA" meant the activity did not occur.</p> <p>ii. Resident #20 was initially admitted to the facility on 7/2/13, and readmitted on 11/18/18, with diagnoses including pain, pressure ulcer to her coccyx (tail bone area), diarrhea, anorexia, and arthritis.</p> <p>Resident #20's care plan area addressing her ADLs, dated 5/25/16, documented she required the assistance of one staff with showers twice weekly between 10:00 PM and 11:00 PM.</p>	F 725			

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F 725	<p>Continued From page 69</p> <p>A quarterly MDS assessment, dated 1/2/19, documented Resident #20 had severe cognitive impairment and was totally dependent on two staff for assistance with showers.</p> <p>Resident #20's ADL flowsheet from 2/1/19 through 3/28/19, documented she did not receive a shower between 2/1/19 and 2/11/19, 10 days. She received her next shower on 3/3/19, 20 days later and then on 3/11/19, 8 days later. Resident #20's next shower was documented on 3/21/19, 10 days later.</p> <p>Resident #20 was documented as refusing showers on 3/26/19 and 3/28/19. The flowsheet documented "NA" on 3/5/19 to 3/9/19, and on 3/25/19.</p> <p>On 3/25/19 at 9:29 AM, Resident #20 stated the facility was short staffed and she did not receive showers consistently.</p> <p>On 3/26/19 at 3:52 PM, CNA #4 stated the long-term unit was short staffed and residents did not always receive their showers.</p> <p>On 3/26/19 at 3:55 PM, CNA #3 stated the long-term unit was supposed to have 4 CNAs and 1 shower aide and this was not currently the case. CNA #3 stated she heard from residents they were not receiving their showers consistently. CNA #3 stated if a resident told her they had missed a shower she provided one.</p> <p>On 3/27/19 at 10:35 AM, CNA #6 stated the facility was short a shower aide. CNA #6 stated she provided showers when needed to residents.</p>	F 725			

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F 725	<p>Continued From page 70</p> <p>On 3/27/19 at 10:46 AM, CNA #7 stated the facility was short staffed in the long-term unit and when staff called off or did not show up to work, the shower aide was pulled to work the floor. CNA #7 stated if a shower aide was pulled to work the floor, the CNAs on the floor were responsible for completing showers. CNA #7 stated the long-term unit did not currently have a shower aide.</p> <p>iii. Resident #81 was admitted to the facility on 2/22/19, with multiple diagnoses including malignant neoplasm of the lung (a form of cancer of the lung), chronic obstructive pulmonary disease (a progressive lung disease that restricts breathing) and anxiety disorder.</p> <p>Resident #81's admission MDS, dated 2/27/19, documented Resident #81 was severely cognitively impaired and needed extensive assistance with ADLs which included the assistance of one staff for bathing.</p> <p>The ADL care plan, revised on 3/14/19, documented Resident #81 had impaired mobility with weakness due to end of life, and she needed assistance with ADLs which included complete daily hygiene needs.</p> <p>Resident #81's ADL flowsheet from 2/22/19 through 3/28/19, did not include documentation she received a bath from 2/22/19 to 3/3/19, 9 days. There was no documentation she received a bath between 3/6/19 to 3/12/19, 7 days.</p> <p>On 3/28/19 at 1:05 PM, LPN #1 stated hospice completed bathing every Friday. She also stated baths or showers for all residents in the facility</p>	F 725			

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F 725	<p>Continued From page 71</p> <p>were scheduled once a week or were individualized per residents' request. LPN #1 said scheduled bathing for Resident #81 was not documented in her record.</p> <p>On 3/28/19 at 1:30 PM, RDCS #1 stated Resident #81's record did not include documentation bathing was completed by hospice aides.</p> <p>iv. Resident #38 was admitted to the facility on 10/9/17, with multiple diagnoses including hip fracture with hip replacement, history of falls, chronic obstructive pulmonary disease (a progressive lung disease that restricts breathing), cognitive communication deficit, and dementia.</p> <p>Resident #38's annual MDS assessment, dated 1/29/19, documented she was cognitively intact. The MDS functional status documented Resident #38 required no setup or physical help from staff for bathing.</p> <p>Resident #38's ADL flowsheet documented she required assistance with bathing which included limited supervision, and extensive assistance. The ADL flowsheet did not include documentation she received a bath from 2/14/19 to 2/22/19, 8 days apart, and from 3/7/19 to 3/15/19, 8 days.</p> <p>On 3/27/19 at 10:52 AM, CNA #8 stated the facility pulled the shower aide approximately 15 times per month to assist on the floors. She stated when this was done showers were the responsibility of the floor staff.</p> <p>On 3/27/19 at 11:19 AM, CNA #10 stated the long-term unit staffing should consist of four</p>	F 725			

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F 725	<p>Continued From page 72</p> <p>CNAs plus a shower aide. She stated currently there were three CNAs and no shower aide. CNA #10 stated the hall she was working on had 11 residents who required 2-person assistance which was half the residents. CNA #10 stated she would have residents request showers because they had not received theirs, and she would provide one.</p> <p>On 3/27/19 at 11:30 AM, CNA #11 stated the long-term unit staffing should consist of four CNAs plus a shower aide. She stated currently there were three CNAs and no shower aide. CNA #11 stated it was the CNAs responsibility on the floors to complete the showers and if a shower was not completed the CNA was responsible to stay after to complete the shower. CNA #11 stated it was difficult when the facility was short staffed to complete all the showers.</p> <p>On 3/28/19 at 1:05 PM, LPN #1 stated baths or showers for all residents in the facility were scheduled once a week or were individualized per residents' request. LPN #1 stated Resident #38 often refused baths. Scheduled bathing for Resident #38, and her refusal of bathing was not found in her record.</p> <p>On 3/28/19 at 1:30 PM, RDCS #1 stated Resident #38's record did not include documentation of Resident #38's refusal of bathing.</p> <p>On 3/28/19 at 1:06 PM, RCM #1 and RDCS #1 stated the residents were provided one shower a week minimally and two showers a week was the ideal number of times provided. RDCS #1 stated they did not have a shower schedule outlined</p>	F 725			

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F 725	<p>Continued From page 73</p> <p>anywhere and it was embedded into the charting software. RDCS #1 stated she looked for the missing showers on Resident #20, Resident #38, Resident #74, and Resident #81. Further documentation was not provided. RCM #1 stated she thought the CNAs were not documenting showers correctly and stated was going to discuss not using "NA" with staff.</p> <p>c. On 3/27/19 at 3:28 PM, CNA #12, who also was a scheduler for the facility, and a Scheduler from a sister facility stated the facility used two shift types, a 12-hour and an 8-hour shift for their CNAs. CNA #12 stated full staffing coverage for dayshift included 13 CNAs and 5 direct care licensed nurses. The evening shift included 10 CNAs and 5 direct care licensed nurses, and the night shift included 7 CNAs and 3 direct care licensed nurses. CNA #12 stated she had two CNA positions and one nursing position she needed to fill. She stated the long-term unit was currently without a shower aide and she was attempting to fill this position as well. CNA #12 stated she did not know how to use an acuity level for scheduling. CNA #12 stated the facility did not utilize agency staff and stated replacements could not always be found, and sometimes she and/or the RCM worked the floor as needed.</p> <p>The facility's Three-Week Nursing Schedule documented the following days, evening, and night coverage which did not meet the staffing requirements as described above by CNA #12.</p> <p>* The day shift did not have 13 CNAs scheduled, based on an 8-hour schedule, on 3/3/19, 3/4/19, 3/7/19, 3/8/19, 3/9/19, 3/10/19, 3/11/19, 3/13/19,</p>	F 725			

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F 725	Continued From page 74 3/14/19, 3/15/19, 3/16/19, 3/17/19, 3/18/19, 3/19/19, 3/20/19, 3/21/19, 3/22/19 and 3/23/19. Examples include:  - The Three-Week Nursing Schedule documented there were 5-6 aides, based on an 8-hour schedule, on 3/3/19, 3/10/19, and 3/17/19.  - The Three-Week Nursing Schedule documented there were 7-8 aides, based on an 8-hour schedule, on 3/9/19, 3/16/19, and 3/23/19.  * The evening shift did not have 10 or more CNAs, based on an 8-hour schedule, on 3/3/19, 3/4/19, 3/7/19 3/8/19, 3/9/19, 3/10/19, 3/11/19, 3/12/19, 3/13/19, 3/14/19, 3/17/19, 3/18/19, 3/20/19, 3/22/19 and 3/23/19. Examples include:  - The Three-Week Nursing Schedule documented there were 7-8 aides, based on an 8-hour schedule, on 3/4/19, 3/7/18, 3/10/19, 3/13/19, and 3/14/19, 3/17/19, 3/18/19, and 3/22/19.  * The night shift did not have 7 or more CNAs, based on an 8-hour schedule, on 3/3/19, 3/6/19, 3/7/19, 3/8/19, 3/9/19, 3/10/19, 3/11/19, 3/12/19, 3/13/19, 3/14/19, 3/15/19, 3/16/19, 3/17/19, 3/18/19, 3/19/19, 3/20/19, 3/21/19, 3/22/19, and 3/23/19. Examples include:  - The Three-Week Nursing Schedule documented there were 3-4 aides, based on an 8-hour schedule, on 3/9/19, 3/10/19, and 3/21/19.  - The Three-Week Nursing Schedule documented there were 5-6 aides, based on an 8-hour schedule, on 3/3/19, 3/6/19, 3/7/19,	F 725			

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F 725	<p>Continued From page 75 3/8/19, 3/11/19, 3/12/19, 3/16/19, 3/17/19, 3/18/19, 3/19/19, 3/20/19, 3/22/19, and 3/23/19.</p> <p>* The facility's daily staffing assignment sheets documented the following:</p> <ul style="list-style-type: none"> <li>- On 3/17/19, there was one CNA shift unfilled.</li> <li>- On 3/3/19, 3/21/19, and 3/25/19, there were two CNA shifts unfilled.</li> <li>- On 3/2/19, 3/4/19, 3/7/19, 3/10/19, 3/11/19, 3/13/19, 3/14/19, 3/19/19, and 3/24/19, there were three CNA shifts unfilled.</li> <li>- On 3/1/19, 3/8/19, 3/9/19, 3/22/19, and 3/23/19, there were four CNA shifts unfilled.</li> <li>- On 3/18/19, there was five CNA shifts unfilled.</li> <li>- On 3/17/19 and 3/25/19, one licensed nurse shift was unfilled.</li> <li>- On 3/23/19, two licensed nurse shifts were unfilled.</li> </ul> <p>RDCS #1 provided documentation that 16 of 39 residents on the long-term unit required two-person assistance.</p> <p>d. The facility appointment records documented when a resident required an aide to attend the appointment with them, which removed CNA staff from working on a unit. Examples include:</p> <ul style="list-style-type: none"> <li>- One resident required a staff member's presence on 3/1/19, 3/4/19, 3/5/19, 3/9/19, 3/12/19, 3/14/19, 3/19/19, 3/22/19, 3/27/19,</li> </ul>	F 725			

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F 725	<p>Continued From page 76 3/28/19, and 3/29/19.</p> <ul style="list-style-type: none"> <li>- Two residents each required a staff member's presence on 3/8/19, 3/15/19, 3/18/19, 3/25/19, and 3/26/19.</li> <li>- Three residents each required a staff member's presence on 3/11/19, 3/13/19, and 3/20/19.</li> <li>- Four residents each required a staff member's presence on 3/7/19.</li> </ul> <p>On 3/27/19 at 11:19 AM, CNA #10 stated the long-term unit staffing should consist of four CNAs plus a shower aide. She stated currently there were three CNAs and no shower aide because of a resident who required assistance at an appointment and one of the floor CNAs was pulled to provide assistance. CNA #10 stated the hall she was working on had 11 residents who required 2-person assistance which was half the residents. CNA #10 stated when the staffing was down to three it was difficult to complete her tasks.</p> <p>On 3/27/19 at 11:30 AM, CNA #11 stated a CNA was called in to assist her today and if she had not assisted, she would be the only CNA for her hall. CNA #11 stated the staff was pulled often, at least 2-3 times a week, to attend appointments with residents.</p> <p>On 3/27/19 at 12:02 PM, LPN #2 stated she had three CNAs working on the hall and no shower aide because a resident required assistance at an appointment.</p> <p>On 3/28/19 at 9:20 AM, Resident #64 was</p>	F 725			

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F 725	<p>Continued From page 77</p> <p>observed sitting in the hallway waiting for a CNA to attend an appointment with him. LPN #2 was observed trying to locate a CNA to attend the appointment with Resident #64. LPN #2 asked multiple CNAs to attend the appointment with Resident #64 and they were busy with tasks. LPN #2 found CNA #5 to attend the appointment with Resident #64 at 9:24 AM.</p> <p>On 3/28/19 at 10:29 AM, LPN #2 stated it was frustrating when she had to pull staff off the floor to attend appointments. She stated recently it was occurring more often and it was CNA #12's responsibility to find staff to attend appointments. LPN #2 stated there were staffing concerns in general and this was one of the issues.</p> <p>On 3/27/19 at 3:16 PM, RN #2 stated she scheduled resident appointments and determined if residents required staff assistance at the appointments. RN #2 stated she provided the appointment documentation to CNA #12 who scheduled the CNAs for these appointments.</p> <p>On 3/27/19 at 3:28 PM, CNA #12 stated when a resident had an appointment she was notified sometimes one day in advance and had to find a CNA to go with the resident. She said she did not like to pull staff off the floor if she could not find someone to attend to the resident. She said she went with the resident if she could not find assistance.</p> <p>On 3/28/19 at 2:32 PM, RDCS #1 stated she heard about the CNAs pulled off the floor to attend appointments with residents the last two days and stated the floor staff should not be pulled. RDCS #1 stated the scheduler, social</p>	F 725			

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F 725	<p>Continued From page 78</p> <p>services, family, RCMs, or activity staff could attend appointments with residents.</p> <p>e. Resident interviews and observations:</p> <p>* On 3/26/19 at 1:57 PM, Resident #34 and Resident #50 stated there was not enough staff to assist the residents in the dining room. Resident #34 stated if CNAs were in the dining room there was no one in the halls to answer call lights and when residents were assisted back to their rooms, it left the dining rooms without supervision.</p> <p>* On 3/26/19 at 1:57 PM, Resident #4 stated if CNAs were assisting residents with eating their meals, other residents were not assisted with their needs.</p> <p>* On 3/26/19 at 1:57 PM, Resident #39 and Resident #4 stated at night there was not enough CNAs to assist residents whom required two-person assistance. Resident #39 stated she required two staff members for her cares and sometimes at night she is not able to make it to the bathroom in time.</p> <p>* On 3/26/19 at 1:57 PM, Resident #50 stated during the Resident Council Meetings in January 2019 and February 2019 staffing concerns were discussed with the administration and she felt there was no change. Resident #50 said call lights go off on her unit and some residents require extensive assistance from staff and there is not enough staff to meet their needs.</p> <p>* On 3/27/19 from 8:30 AM to 8:38 AM, Resident #35's call light was on and two non-nursing</p>	F 725			

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F 725	<p>Continued From page 79</p> <p>personnel walked by the room and did not stop. At 8:38 AM, Resident #35 was observed to exit her room and appeared to be searching for help and no nursing staff were present. At 8:40 AM, Resident #35 found CNA #14 exiting a room and she assisted Resident #35 with her needs. Resident #35 had to wait 10 minutes before her needs were met and after she left her room to find help.</p> <p>f. Staff interviews:</p> <p>On 3/26/19 at 3:52 PM CNA #4 stated a resident had complained to her recently that at night there was not enough staff to assist them with their needs and when staff were able to answer their call lights, they still had to wait for a second person to assist. CNA #4 stated she worked night shift on occasions and when she did it was difficult to round on all the residents without assistance. CNA #4 stated on average 1-2 good rounding's were completed where incontinent residents were changed, residents repositioned, and other needs were met. CNA #4 stated there were multiple days when the scheduling had open shifts. She stated staff was pulled often to attend resident appointments.</p> <p>On 3/26/19 at 3:55 PM, CNA #3 stated the long-term unit was supposed to have four CNAs and 1 shower aide and this was not currently the case.</p> <p>On 3/27/19 at 10:35 AM, CNA #6 stated the facility was short a shower aide. CNA #6 stated the facility needed more staff during all shifts to assist in the dining rooms, answer call lights at meals, and at night due to the residents needing</p>	F 725			

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F 725	<p>Continued From page 80</p> <p>the assistance of two persons and one CNA assigned to each hall.</p> <p>On 3/27/19 at 10:46 AM, CNA #7 stated the facility was shortest staffed in the long-term unit and when staff called-in or did not show up to work, the shower aide was pulled to work the floor. CNA #7 stated if a shower aide was pulled to work the floor, the CNAs on the floor were responsible for completing showers.</p> <p>On 3/28/19 at 2:32 PM, RDCS #1 and RCM #1 stated the CNAs work 8 to 12 hour shifts and for an easier work life balance on the long-term hall staff there should be four CNAs and one shower aide on day and evening shift, and two and half for the night shift. RDCS #1 stated the facility assessment was completed by the Administrator. RDCS #1 stated the facility did not utilize staffing agencies and used internal CNAs. RCM #1 stated when CNA #12 was present in the building she offered other CNAs the open shifts. RCM #1 stated the open shifts were not always filled and CNA #12 or an RCM sometimes worked the floor. RDCS #1 stated she had open position she needed to fill for a shower aide, CNAs, and a nurse.</p> <p>On 3/29/19 at 8:22 AM, the Administrator stated CNA #12 and the SDC attempted to fill open shifts and he had not heard of shifts not being filled. The Administrator stated the staffing levels had not changed as far as he was aware. The Administrator stated if the nursing staff determined the acuity level of residents increased, and more staff was required, he opened positions accordingly. The Administrator stated nursing staff completed the acuity level of</p>	F 725			

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F 725	Continued From page 81 the facility assessment and provided him with data. The Administrator stated he recently became aware that floor CNAs were pulled to attend appointments with residents.	F 725			
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 failed practice placed 19 of 19 residents (#3, #4, #18, #20, #29, #37, #38, #42, #43, #49, #50, #67, #68, #69, #74, #77, #80, #81, #85, #187, #191, and #192) who ate snacks or foods from the unit refrigerators and the 72 other residents	F 812	Corrective Action: All of the unit refrigerator temperatures and their thermometer functions were checked on 3-28-19. Thermometer on 400 Hall refrigerator was replaced. All items in unit refrigerators that were outdated were discarded. 100% audit of all unit refrigerators completed on 3-28-19 to ensure no outdated food items were	5/7/19	

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F 812	<p>Continued From page 82</p> <p>who ate food from the refrigerators, at risk for adverse health outcomes. This failed practice increased residents' risk of developing food borne illnesses. Findings include:</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 3/28/19 at 5:21 PM, the long-term unit refrigerator was observed with food items such as thickened juice containers with use by dates of 3/3/19. There was also multiple butters and containers of half and half cream without dates.</p> <p>On 3/28/19 at 5:30 PM, a refrigerator in the sub-acute unit was observed with multiple thickened juice containers with use by dates of 3/3/19, multiple cottage cheese containers with use by dates of 3/27/19, a resident's plate of food dated 2/19/19, containers of dressing dated 1/29/19, and multiple containers of half and half cream without dates.</p> <p>On 3/28/19 at 5:32 PM the RD stated the food items should be thrown out and she was going to notify the Certified Dietary Manager (CDM).</p> <p>On 3/28/19 at 5:40 PM, the refrigerator in the 400 hall was observed at 56 degrees F and full of food items, including fruits, milk items, and half and half cream.</p> <p>On 3/28/19 at 5:45 PM, LPN #3 verified the</p>	F 812	<p>present and they were at the proper temperature.</p> <p>Identification: All residents have the potential to be affected by this deficiency.</p> <p>Systematic Changes: SDC or designee to provide education to all nursing and dietary staff on checking for proper refrigerator temperatures, properly dated food items, and discarding undated/outdated items.</p> <p>Monitor: DSM or designee to audit unit refrigerator temperatures and food contents weekly x4 then monthly x3months. Findings to be reported to QAPI Committee.</p>		

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

PRINTED: 05/15/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135127</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/29/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SANDPOINT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1125 NORTH DIVISION STREET SANDPOINT, ID 83864</b>		
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F 812	Continued From page 83 temperature in the refrigerator was at 56 degrees F and it should be lower.  On 3/28/19 at 5:46 PM, the CDM stated she noticed the thermometer in the 400 hall and was going to replace the thermometer to see if the temperature was off or if the thermometer was broken. The CDM stated she was in the process of removing all the outdated foods and the foods should not be outdated.	F 812			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and	F 880		5/7/19	

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F 880	<p>Continued From page 84</p> <p>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> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p>	F 880			

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F 880	<p>Continued From page 85</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>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 hand hygiene during perineal care (peri-care) and wound care, equipment cleaning, and care of urinary catheters and reservoir (urine collection bag). This was true for 4 of 19 residents (#20, #37, #45, #56, #74) reviewed for infection prevention practices. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include:</p> <p>1. The facility's Infection Control Plan, revised on 3/2017, documented the facility followed the hand hygiene program according to the CDC hand hygiene guidelines.</p> <p>The CDC website, accessed on 4/3/19, documented hand hygiene should be performed as follows:</p> <ul style="list-style-type: none"> <li>* Before eating</li> <li>* Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed)</li> <li>* After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings</li> <li>* After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient</li> </ul>	F 880	<p>Corrective Action: Resident 74 was changed to a catheter leg bag on 3-26-19. All mechanical lifts deep-cleaned on on or before 5-7-19 by housekeeping staff.</p> <p>Identification: All residents have the potential to be affected by this deficient practice.</p> <p>Systematic Changes: On or before 5-7-19, SDC or designee will educate all staff on hand washing policy. SDC or designee will educate nursing staff on cleaning of mechanical lifts and proper catheter tube placement.</p> <p>Monitor: DON or designee to visually audit 5 residents receiving personal cares to ensure proper hand washing. DON or designee will audit 5 mechanical lift transfers to ensure proper cleaning of equipment, per policy. DON or designee will audit 5 residents with catheter tubes to ensure proper placement. Audits will be completed weekly x4, then monthly x3 months. Findings to be reported to QAPI Committee.</p>		

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F 880	<p>Continued From page 86</p> <ul style="list-style-type: none"> <li>* If hands will be moving from a contaminated-body site to a clean-body site during patient care</li> <li>* After glove removal</li> <li>* After using a restroom</li> </ul> <p>This policy and CDC hand hygiene guidelines were not followed.</p> <p>a. On 3/26/19 at 9:16 AM, CNA #3 and CNA #5 were observed performing peri-care for Resident #45. The two CNAs were not observed to remove gloves and perform hand hygiene after peri-care was completed.</p> <p>On 3/26/19 at 9:16 AM, CNA #3 stated she did not remove her gloves and perform hand hygiene after peri-care and handling Resident #45's soiled incontinence brief.</p> <p>On 3/26/19 at 9:16 AM, CNA #5 stated she did not perform hand hygiene after her gloves were removed following peri care for Resident #45.</p> <p>b. On 3/25/19 at 10:33 AM, CNA #1 and CNA #2 were observed during resident care. CNA #1 did not change gloves and perform hand hygiene after cleansing Resident #37's peri area, before applying a clean brief, before handling clean bed linen, or after Resident #37's shirt was changed. CNA #2 did not perform hand hygiene after glove removal following peri-care, or before applying a clean brief. CNA #2 then touched Resident #37's pillow, clean linens, and assisted CNA #1 in changing Resident #37's shirt. CNA #1 and CNA #2 then removed their gloves and did not perform hand hygiene. CNA #1 used bare hands to gather dirty linen from the floor and placed them</p>	F 880			

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F 880	<p>Continued From page 87</p> <p>in the dirty linen bag. CNA #1 and CNA #2 completed hand hygiene after leaving Resident #37's room.</p> <p>After the observation on 3/25/19, CNA #1 stated multiple opportunities for hand washing were missed during resident care including after peri-care and after removal of gloves. CNA #2 stated multiple opportunities for hand washing were missed during resident care including after peri-care and after removal of gloves.</p> <p>c. On 3/27/19 at 9:53 AM, RN #1 was observed providing wound care to a pressure ulcer on Resident #20's sacral region. RN #1 performed hand hygiene after gathering supplies and before the procedure. RN #1 did not remove his gloves and perform hand hygiene after the soiled wound dressing was removed. RN #1 then cleansed the wound with wound cleanser and a sterile gauze pad. RN #1 did not change gloves and perform hand hygiene after the wound was cleansed. RN #1 applied a self-adhesive foam dressing to the wound. Then RN #1 applied cream to the reddened area of Resident #20's buttocks below the dressing.</p> <p>RN #1 used one pair of gloves and performed hand hygiene before the procedure and after the procedure. RN #1 did not perform hand hygiene after contact with blood, body fluids or excretions, such as after cleansing Resident #20's wound and before applying a new dressing, per policy and CDC guidelines.</p> <p>On 3/27/19 at 9:59, RN #1 stated he did not remove gloves and perform hand hygiene after removal of old the dressing, after wound</p>	F 880			

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F 880	<p>Continued From page 88</p> <p>cleansing, or after applying the clean dressing and before applying cream to a different skin area because he performed hand hygiene before and after the procedure.</p> <p>4. The facility's Infection Control Plan, revised on 3/2017, documented goals to minimize the risk of transmitting infections included cleaning and disinfecting medical equipment according to the CDC infection control and prevention recommendations.</p> <p>The CDC website, accessed on 4/3/19, documented: * Clean medical devices as soon as practical after use (e.g., at the point of use) * Ensure at minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis.</p> <p>On 3/26/19 at 9:16 AM, after a hoyer lift transfer was completed for Resident #45, CNA #3 and CNA #5 did not clean the hoyer lift. On 3/26/19 at 9:16 AM, CNA #3 stated the hoyer lift was not cleaned before leaving Resident 45's room.</p> <p>On 3/26/19 at 9:16 AM, CNA #5 stated the hoyer lift was not cleaned after use for Resident #45. CNA #5 stated the Sani-Cloth wipes were provided for this purpose and the dry time was "instant".</p> <p>On 3/26/19 at 9:30 AM, directions on the Sani-Cloth wipes package were reviewed with CNA #3 and CNA #5. The directions on the package stated, treated areas were to remain wet for a full 2 minutes in order to allow the disinfectant enough time to kill the germs.</p>	F 880			

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F 880	Continued From page 89  5. Residents were observed with their catheter tubing and bag on the floor as follows:  On 3/25/19 at 11:10 AM, Resident #74's catheter tubing and catheter bag were observed dragging on the floor while she was self propelling her wheelchair. Resident #74's catheter tubing and reservoir were observed to also drag on the floor on 3/25/19 at 11:19 AM, and on 3/26/19 at 8:50 AM and from 9:16 AM through 9:58 AM.  On 3/26/19 at 10:01 AM, CNA #3 stated Resident #74's catheter tubing and bag should not touch the floor and corrected it.  On 3/26/19 at 10:03 AM, the RDCS #2 stated the catheter tubing and bag should not touch the floor.  On 3/26/19 at 10:05 AM, Resident #74's catheter tubing dropped to the ground again and she ran over the tubing with the front right wheel of her wheelchair.  On 3/26/19 at 10:09 AM, CNA #5 and CNA #4 changed out Resident #74's catheter bag for a bag that was strapped to her leg.  On 3/27/19 at 12:00 PM, Resident #56's catheter tubing was observed on the floor.  On 3/28/19 at 5:51 PM, RDCS #1 stated the catheter tubing should not be on the floor.	F 880			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001420</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/29/2019</b>
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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the facility's state licensure survey conducted at the facility from March 25, 2019 to March 29, 2019.</p> <p>The team members conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Teresa Kobza, RDN, LD Kate Johnsrud, RN</p> <p>Abbreviations:</p>	C 000		
C 664	<p><b>02.150,02,a Required Members of Committee</b></p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative.</p> <p>This Rule is not met as evidenced by: Based on staff interview and review of the Infection Control Committee (ICC) meeting attendance records, it was determined the facility failed to ensure a representative from each required department attended quarterly meetings. The lack of participation by these departments created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings include:</p> <p>On 3/29/19 at 1:00 PM, the Administrator provided staff attendance records for the Infection Control Committee meetings. He reported that Infection Control is combined with the Quality Assurance meetings, which met monthly.</p>	C 664	<p><b>Corrective Action:</b> Executive Director (Administrator) educated Maintenance Director on 4-17-19, regarding attendance at Infection Control Committee (ICC) Meetings at least quarterly.</p> <p><b>Identification:</b> All residents have the potential to be affected by this deficient practice.</p> <p><b>Systematic Changes:</b> On or before 5-7-19, SDC or designee to provide education to personnel responsible for attending Infection Control meetings regarding attendance of at least once a quarter.</p>	5/7/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/29/19

Bureau of Facility Standards

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C 664	Continued From page 1  Attendance records provided by the facility documented the Maintenance Director, or a representative from the maintenance department, did not attend Infection Control meetings from April 2018 through March 2019.  On 3/29/19 at 1:00 PM, the Administrator stated the sign in sheets were accurate for the ICC meeting.	C 664	Monitor: Executive Director or designee will audit ICC Meeting attendance to ensure all appropriate members were present, per policy. Audit will be completed monthly x6. Findings to be reported to QAPI Committee.	
C 763	02.200,02,c,iii When Average Census 90 or More  iii. In SNFs with an average occupancy rate of ninety (90) or more patients/residents a registered professional nurse shall be on duty at all times. This Rule is not met as evidenced by: Based on review of staffing records and staff interview, it was determined the facility did not ensure that when the census was greater than 90 residents, there was 8 hours of Registered Nurse (RN) coverage on every shift. The findings include:  On 3/29/19 at 8:22 AM, the nursing schedules from 3/3/19 through 3/23/19 were reviewed. They did not include RN coverage on the night shift when the census was 90 or above.  On 3/23/19, RN coverage for the nightshift was 2.70 hours.  The facility failed to provide 8 hours of RN coverage for all shifts when the census was greater than 90 residents.  On 3/29/19 at 8:22 AM, the Administrator stated he would have Regional Director of Clinical	C 763	Corrective Action: Regional Director of Clinical Services educated Executive Director, SDC, and Staffing Coordinator on Idaho State requirements for RN coverage.  Identification: All residents have the potential to be affected by this deficient practice.  Systematic Changes: On or before 5-7-19, SDC or designee to provide education on Idaho State requirements for RN coverage to IDT Team and licensed nursing staff.  Monitor: DON or designee to audit nursing schedule daily x4 weeks, then weekly x4. Findings to be reported to QAPI Committee.	5/7/19

Bureau of Facility Standards

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C 763	<p>Continued From page 2</p> <p>Services #1 (RDCS) look for the missing nursing hours.</p> <p>On 3/29/19 at 8:30 AM, RDCS #1 stated she was unable find nursing hours for the 3/23/19 night shift and the hours were accurate.</p>	C 763		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

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

August 23, 2019

Rick Myers, Administrator  
Life Care Center of Sandpoint  
1125 North Division Street  
Sandpoint, ID 83864-2148

Provider #: 135127

Dear Mr. Myers:

On **March 24, 2019** through **March 29, 2019**, an unannounced on-site recertification and complaint survey was conducted at Life Care Center of Sandpoint. Observations were made, records reviewed, and residents, families, and staff were interviewed. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008016**

ALLEGATION #1:

The facility failed to ensure there was adequate staffing to meet residents needs and safety.

FINDINGS #1:

Review of resident records did not include documentation of concerns for falls. There were no observations of residents falling during survey. Incident and Accident reports were reviewed with no fall concerns identified.

However, during observations of the facility, one resident's call light was on and two non-nursing personnel walked by the room and did not stop. Eight minutes later, the resident was observed exiting her room and appeared to be searching for help and no nursing staff were present. Two minutes later the resident found a CNA exiting a room and the CNA assisted the resident with her needs. The resident waited 10 minutes before her needs were met and after she left her room to find help.

During another observation a Resident was observed in her wheelchair and appeared restless. She was holding out her right hand appearing to try and get someone's attention. Twenty-six minutes later the resident grabbed the surveyor's hand and when asked if she had to go to the bathroom, she whispered, "Yes." A CNA was found in the hallway leaving another resident's room and was notified of the resident's need for the bathroom. The CNA stated she did not know the resident's transfer requirements and was going to try and find the CNA assigned to the resident to assist.

Nine minutes later the CNA was observed looking for the CNA assigned to the resident and she could not locate one. The CNA then looked up the resident's transfer status and stated she was going to assist the resident once she found assistance.

In an interview, a CNA stated a resident had complained to her recently that at night there was not enough staff to assist them with their needs and when staff were able to answer their call lights, they still had to wait for a second person to assist. The CNA stated she worked night shift on occasions and when she did it was difficult to round on all the residents without assistance. The CNA said on average 1-2 good rounding's were completed where incontinent residents were changed, residents repositioned, and other needs were met. The CNA also said there were multiple days when the scheduling had open shifts that were not filled.

In an interview with a resident, the resident said during the Resident Council Meetings in January 2019 and February 2019 staffing concerns were discussed with the administration and she felt there was no change. The resident said call lights go off on her unit and some residents require extensive assistance from staff and there is not enough staff to meet their needs.

In another interview, two residents stated at night there was not enough CNAs to assist residents who required two-person assistance. One of the residents stated she required two staff members for her cares and sometimes at night she is not able to make it to the bathroom in time.

Based on the investigative findings, the allegation regarding inadequate staffing was substantiated, and the facility was cited at federal regulation F 725 as it relates to insufficient staffing.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #2:

The facility failed to ensure residents were kept safe from abuse by other residents.

FINDINGS #2:

Twenty-two residents were observed and reviewed for violent behaviors. Incident/Accident reports were reviewed with no concerns identified. Interviews with 6 staff indicated there was a resident who required 1:1 supervision, but the resident was no longer in the facility. There were no residents requiring 1:1 supervision at the time of the survey.

A review of two closed records included two residents with histories of violent outbursts. One of these residents had 1:1 supervision until more appropriate placement could be found. The resident was discharged to the hospital prior to placement in another facility. The other resident with violent behaviors was discharged home with family.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility failed to ensure appropriate measures were taken to minimize risks of residents falling or having accidents.

FINDINGS #3:

Nineteen residents were observed and their record reviewed related to falls and fractures and overall resident safety. No concerns were identified. Incident/Accident reports were reviewed, as well as facility reported incidents/investigations with no concerns.

A review of the facility's incident/accident reports included a resident with a fall and fracture and 2 additional falls after the fracture. This resident was ambulatory prior to her fall with the fractures. She was sent to the hospital and returned without repair of the fractures. Interventions to prevent falls were implemented when the resident returned to the facility. Interventions included: a room closer to the nursing station, a low bed and fall mat, and a motion sensor by the bed and in the bathroom to alert staff if the resident attempted to transfer without calling for assistance. The facility does not use restraints of any kind.

However, one Resident's care plan area addressing her activities of daily living (ADLs) dated 2/28/19, documented she required the assistance of one staff with bed mobility and toileting. The care plan documented the resident was able to self-propel her wheelchair and she had back-up brakes on her wheelchair.

The resident's quarterly Minimum Data Set (MDS) assessment, dated 2/28/19, documented the resident had severe cognitive impairment and required extensive assistance of one staff for moving around her room and the facility. The MDS documented the resident required two staff members' assistance for bed mobility, transfers, dressing, and toilet use. This MDS was inconsistent with her care plan and documented she needed more assistance than documented on her care plan for bed mobility, transfers, dressing, and toilet use.

An Occupational Therapy Evaluation and Plan of Treatment, dated 10/2/18, documented the resident was wheelchair bound and she was able to propel her wheelchair with both of her legs. The evaluation did not include documentation if the resident's wheelchair had back-up brakes. This evaluation was not consistent with the MDS evaluation for the resident's mobility.

The resident was observed propelling her wheelchair using her right arm and foot without staff present and no back-up brake device was attached to her wheelchair. The resident had difficulty with maneuvering her wheelchair and was running into other residents' wheelchairs without staff supervision or assistance.

The resident was also observed struggling to move her wheelchair without the use of her left arm and left leg. Her left hand was placed in her lap and her left leg was extended out in front of her, while she moved backwards and forwards in circles. The resident repeatedly bumped into the back of another resident's wheelchair.

The resident was also observed in an activity room on the long-term hall, with her left hand placed in her lap and her left leg extended out in front of her. The resident was observed to use her right hand and right leg to propel herself forward and backwards in circles running into walls, chairs, and tables.

During the same observation, the resident was wedged between a table and a chair for 8 minutes. She could not free herself from the confined area and no staff were present in the room. A CNA entered the room and assisted the resident out of the confined area and then left the room. The resident continued to wheel around the room in circles running into objects including the side of another resident's wheelchair. The resident was also observed to reach for an object on a table, and while she leaned forward, her back wheels came up off the ground slightly.

In an interview with the Regional Director of Clinical Services (RDCS) and the Resident Care Manager (RCM), they stated they were unaware the resident was running her wheelchair into other residents. The RDCS said she was aware the resident propelled her wheelchair backwards. The RDCS stated she was going to try to locate documentation this was discussed and the plan for it. The RDCS stated she did not recall if the resident's wheelchair was evaluated for tipping over in the front and stated she would look for an evaluation. The RDCS stated she thought the resident had anti-tip bars on the back of her wheelchair and she was going to check.

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Based on the investigative findings, the allegation regarding the facility did not ensure appropriate measures were taken to minimize risk of residents falling or sustaining accidents was substantiated. The facility was cited at federal regulation F 689 as it relates to keeping residents free of accident hazards/supervision/devices.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The facility failed to ensure only qualified staff managed medications distributed to residents.

FINDINGS #4:

A medication pass audit was completed during the survey with no concerns identified. All observations were of qualified/licensed staff administering medications. No residents voiced concerns about medication administration.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility failed to ensure residents were bathed at appropriate intervals.

FINDINGS #5:

Resident records were reviewed and residents and staff were interviewed regarding residents' activities of daily living (ADLs) and for bathing/showers.

One resident's care plan area addressing her ADLs, documented she required the assistance of one staff with showers twice weekly between 10:00 PM and 11:00 PM.

A quarterly MDS assessment documented the resident had severe cognitive impairment and was totally dependent on two staff for assistance with showers.

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The resident's ADL flowsheet from 2/1/19 through 3/28/19, documented she did not receive a shower between 2/1/19 and 2/11/19, 10 days. She received her next shower on 3/3/19, 20 days later and then on 3/11/19, 8 days later. The resident's next shower was documented on 3/21/19, 10 days later.

In an interview, the resident stated the facility was short staffed and she did not receive showers consistently.

A second resident's ADL flowsheet from 2/22/19 through 3/28/19, did not include documentation she received a bath from 2/22/19 to 3/3/19, 9 days. There was no documentation she received a bath between 3/6/19 to 3/12/19, 6 days.

A third resident's ADL flowsheet documented she required assistance with bathing which included limited supervision, and extensive assistance. The ADL flowsheet did not include documentation she received a bath from 2/14/19 to 2/22/19, 8 days apart, and from 3/7/19 to 3/15/19, 8 days.

In an interview, a CNA stated the long-term unit was short staffed and residents did not always receive their showers.

During another interview a CNA stated the long-term unit was supposed to have 4 CNAs and 1 shower aide and this was not currently the case. The CNA stated she heard from residents they were not receiving their showers consistently. The CNA stated if a resident told her they had missed a shower she provided one.

Based on the investigative findings, the allegation regarding the facility did not ensure residents were bathed at appropriate intervals was substantiated. The facility was cited at federal regulation F 677, as it relates to ADL care provided for dependent residents.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #6:

The facility failed to ensure the infection control program was implemented appropriately and as indicated.

#### FINDINGS #6:

Observations were made, records and policies were reviewed, and staff were interviewed.

The facility's Infection Control Plan, revised on 3/2017, documented the facility followed the hand hygiene program according to the CDC hand hygiene guidelines.

The CDC website, accessed on 4/3/19, documented hand hygiene should be performed as follows:

- Before eating
- Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed)
- After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings
- After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient
- If hands will be moving from a contaminated-body site to a clean-body site during patient care
- After glove removal
- After using a restroom

During two separate observations of CNAs providing peri-care for residents, the CNAs were not observed to remove gloves and perform hand hygiene after peri-care was completed.

In interviews with two of the CNAs, they stated they did not remove gloves and perform hand hygiene after peri-care.

In another interview, the other two CNAs stated multiple opportunities for hand washing were missed during the resident's care including after peri-care and after removal of gloves.

During the survey, a nurse was observed providing wound care to a resident's pressure ulcer. The nurse performed hand hygiene after gathering supplies and before the procedure. The nurse did not remove his gloves and perform hand hygiene after the soiled wound dressing was removed. The nurse then cleansed the wound with wound cleanser and a sterile gauze pad. The nurse did not change gloves and perform hand hygiene after the wound was cleansed. The nurse applied a self-adhesive foam dressing to the wound. The nurse then applied cream to the reddened area of the resident's skin below the dressing.

The nurse used one pair of gloves and performed hand hygiene before the procedure and after the procedure. The nurse did not perform hand hygiene after contact with blood, body fluids or excretions, such as after cleansing the resident's wound and before applying a new dressing, per policy and CDC guidelines.

The facility's Infection Control Plan, revised on 3/2017, documented goals to minimize the risk of transmitting infections included cleaning and disinfecting medical equipment according to the CDC infection control and prevention recommendations.

The CDC website, accessed on 4/3/19, documented:

- Clean medical devices as soon as practical after use (e.g., at the point of use)
- Ensure at minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis.

A hoyer lift (a device that helps get someone in and out of bed) transfer was observed being used by two CNAs for a resident. The CNAs did not clean the hoyer lift before or after its use.

In an interview, one of the CNAs stated the hoyer lift was not cleaned after use for the resident. She stated the Sani-Cloth wipes were provided for this purpose and the dry time was "instant".

The directions on the Sani-Cloth wipes package were reviewed with the CNAs. The directions on the package stated, treated areas were to remain wet for a full 2 minutes in order to allow the disinfectant enough time to kill the germs.

During observations, two residents were noted with their urinary catheter tubing on the floor. In an interview with one CNA, she stated the tubing should not touch the floor. The facility's Regional Director of Clinical Services, also stated in an interview that catheter tubing should not touch the floor.

Based on the investigative findings, the allegation was substantiated, and the facility was cited at federal regulation F 880, as it relates to infection prevention and control.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #7:

The facility failed to ensure resident care plans were implemented appropriately.

#### FINDINGS #7:

Twenty-two resident care plans were reviewed and staff was interviewed about resident care plans.

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Eight residents' care plans were reviewed and did not include the residents' code status for administering or withholding cardiopulmonary resuscitation as ordered by the physician and according to the residents' wishes.

In an interview the Minimum Data Set nurse, she stated the resident code status was documented on the admission baseline care plans. She stated when the comprehensive care plan was completed, they referred to the chart for the advance directive and the physician's orders for scope of treatment (POST) to determine the resident's code status. She stated if a resident's code status changed and the care plan was not updated, then it would be wrong.

Based on the investigative findings, the allegation was substantiated and the facility was cited at federal regulation F 657, as it relates to care plan timing and revision.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

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

August 23, 2019

Rick Myers, Administrator  
Life Care Center of Sandpoint  
1125 North Division Street  
Sandpoint, ID 83864-2148

Provider #: 135127

Dear Mr. Myers:

On **March 25, 2019** through **March 29, 2019**, an unannounced on-site recertification and complaint survey was conducted at Life Care Center of Sandpoint. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008067**

**ALLEGATION #1**

The facility has staffing concerns and needs more staff to assist residents needs.

**FINDINGS #1:**

During the investigation, all residents were observed for quality of care and staffing concerns. Resident Council meeting minutes were reviewed, facility grievances were reviewed, and residents and family members were interviewed regarding staffing.

Facility grievances reviewed documented concerns with staffing in the dining room.

During observations of residents and staff members interacting, there were concerns identified. The residents were observed trying to find staff members to assist them when their call lights were not answered timely or they needed assistance and no staff members were around, assistance with ADLs such as showers, toileting, and other cares were not provided, hydration was not offered, activities were not offered to residents with cognitive declines, and other cares were not offered and provided by staff when staff were busy.

Several residents said the facility needed more staff and their needs were currently not being met. Residents stated showers were hard to come by and infrequent, call light times were long, and other activities of daily living (ADL) assistance was hard to come by.

In interviews, CNAs and nurses said the facility could use more staff to ensure residents' needs were met.

The Regional Director of Clinical Services (RDCS) and the Resident Care Manager (RCM) stated CNAs work 8 to 12 hour shifts and for an easier work life balance on the long-term hall staff there should be four CNAs and one shower aide on day and evening shift, and two and half for the night shift. The RDCS stated the facility assessment was completed by the Administrator. The RDCS stated the facility did not utilize staffing agencies and used internal CNAs. The RCM stated when the scheduler was present in the building she offered other CNAs the open shifts. The RCM stated the open shifts were not always filled and the scheduler or herself sometimes worked the floor. The RDCS stated she had open positions she needed to fill for a shower aide, CNAs, and a nurse.

The Administrator stated the scheduler and the Staff Development Coordinator (SDC) attempted to fill open shifts and he had not heard of shifts not being filled. The Administrator stated the staffing levels had not changed as far as he was aware. The Administrator stated if the nursing staff determined the acuity level of residents increased, and more staff was required, he opened positions accordingly. The Administrator stated nursing staff completed the acuity level of the facility assessment and provided him with data. The Administrator stated he recently became aware, during the survey of a staff concern.

Based on the investigative findings, the allegation was substantiated, and deficiencies were cited at F677, F725, and a state tag C763 as they related to the failure of the facility to provide adequate staff for the residents' needs.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #2

The facility was unclean.

#### FINDINGS #2

During the investigation observations were conducted for environmental issues, Resident Council Meeting minutes and facility grievances were reviewed. Twenty-two resident records were reviewed, maintenance logs were reviewed, and residents and staff were interviewed regarding environmental concerns.

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One resident admitted to the facility on 11/12/18, room was observed to have an odor emanating from the room and his/her wheelchair. The resident's record documented the resident was incontinent of urine.

The RCM stated she smelled urine in the hallway outside of the resident room and near the bed. The RCM stated staff should have requested housekeeping clean the mattress. She stated the urine was saturated into the mattress and his/her wheelchair cushion.

One resident admitted to the facility on 3/15/19, room was observed with gastric tube feeding supplies in the room which included a container with a feeding syringe. The container had a dried substance on the bottom that was blackish/blue/green in color.

The RDCS stated the syringe and container were used for the resident's tube feeding. The RDCS stated the feeding supplies should be cleaned after each use.

Based on the results of the investigation, the allegation was substantiated. A deficiency was cited at F584 as it related to the failure of the facility to ensure the physical environment was maintained.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj