



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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P.O. Box 83720  
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June 7, 2019

Brandi Jeffries, Administrator  
Prestige Care & Rehabilitation - The Orchards  
1014 Burrell Avenue  
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Jeffries:

On **May 24, 2019**, a survey was conducted at Prestige Care & Rehabilitation - The Orchards by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **June 17, 2019**. Failure to submit an acceptable PoC by **June 17, 2019**, may result in the imposition of civil monetary penalties by **July 10, 2019**.

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

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

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

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

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

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

- **Civil Money Penalty**
- **Denial of payment for new admissions effective August 24, 2109**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 24, 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.**

Brandi Jeffries, Administrator  
June 7, 2019  
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If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, 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.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **June 17, 2019**. If your request for informal dispute resolution is received after **June 17, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

  
Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj

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

PRINTED: 06/27/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/24/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRESTIGE CARE &amp; REHABILITATION - THE ORCHARDS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 BURRELL AVENUE LEWISTON, ID 83501</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification and complaint survey conducted from May 20, 2019 to May 24, 2019.  The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator Ann Monhollen, RN Kate Johnsrud, RN  Survey Abbreviations: ADL = Activities of Daily Living AIMS Test = Abnormal Involuntary Movement Scale Test CNA = Certified Nursing Assistant DON = Director of Nursing EMR = Electronic Medical Record I&A = Incident and Accident LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MD = Medical Doctor MDS = Minimum Data Set mg = milligrams RN = Registered Nurse RCM = Resident Care Manager SS = Social Services	F 000			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)  §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		7/10/19	

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

TITLE

(X6) DATE

Electronically Signed

06/17/2019

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 656	Continued From page 1 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, it was determined the facility failed to develop a comprehensive care plan that	F 656	1. Resident #10's care plan and behavior monitor has been updated to reflect resident's medication Donepezil to allow		

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F 656	<p>Continued From page 2</p> <p>included a resident taking medication for Alzheimer's. This was true for 1 of 5 residents (Resident #10) reviewed for unnecessary medications. This failure created the potential for harm should residents receive inappropriate or inadequate care with a subsequent decline in health. Findings include:</p> <p>The facility's policy for Care Plans, dated February 2019, documented "direct care givers will have accurate information available to them to properly care for their residents."</p> <p>The Nursing 2019 Drug Handbook documented nursing considerations for donepezil (an Alzheimer's medication) included monitoring for evidence of gastrointestinal bleeding and bradycardia (low heart rate). Adverse reactions included headache, insomnia (a sleep disorder), seizures, dizziness, fatigue, depression, somnolence (a strong desire for sleep), pain, hallucinations, and abnormal dreams. It also documented to use caution in patients who have urinary outflow impairment.</p> <p>Resident #10 was admitted to the facility on 11/21/18, with multiple diagnoses including dementia with behavioral disturbance and benign prostatic hyperplasia (an enlarged prostate gland, which can obstruct the outflow of urine).</p> <p>Resident #10's physician orders included donepezil 10 mg at bedtime, ordered on 11/21/18, for dementia with behavioral disturbance.</p> <p>Resident #10's care plan documented he had a cognition problem related to dementia with</p>	F 656	<p>direct caregivers to have accurate information available to them to properly care for their residents.</p> <p>2. SSD educated to care plan and develop behavior monitors for residents on cholinergics/ anti-Alzheimer's agent medications. All resident's with cholinergics/ anti-Alzheimer's agent medications orders have been identified, their care plans and behavior monitors have be updated to reflect medication use and allow direct caregivers to have accurate information available to them to properly care for their residents.</p> <p>3. All resident's admitted into facility will have comprehensive care plans built within 7 days of comprehensive assessment, and if residents admits or is started on a cholinergics/ anti-Alzheimer's agent medication, care plan will be developed for that medication upon starting medication.</p> <p>4. SSD will audit 4 residents for cholinergics/ anti-Alzheimer's agent medication each week for 4 weeks; then biweekly for one month; then monthly until the QAPI team feels this is no longer needed. The Administrator or designee will review SSD audits to ensure compliance and accuracy. Results will be presented monthly at QAPI.</p>		

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F 656	Continued From page 3 behavioral disturbance. The care plan did not address the Alzheimer's medication donepezil.	F 656			
F 657 SS=D	On 5/24/19 at 12:49 PM, RCM #1 said she did not usually include information regarding donepezil on a resident's care plan. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		7/10/19	

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F 657	<p>Continued From page 4</p> <p>Based on observation, record review, resident interview, staff interview, and policy review, it was determined the facility failed to ensure a resident's care plans were revised as care needs changed. This was true for 1 of 16 residents (Resident #8) whose care plans were reviewed. This failure created the potential for harm if care was not provided or decisions were made based on inaccurate or outdated information. Findings include:</p> <p>The facility's Care Plan policy, dated June 2000, stated revisions to the care plan were made when the resident had a change of condition and as needed.</p> <p>Resident #8 was admitted to the facility on 5/18/15, with multiple diagnoses including heart failure (condition in which the heart cannot pump enough blood to meet the body's needs), dementia, diabetes, high blood pressure, and cerebral infarction (stroke in which brain tissue is destroyed due to lack of blood supply).</p> <p>Resident #8's quarterly MDS assessment, dated 2/27/19, documented her cognition was moderately impaired, she was totally dependent for activities of daily living, always incontinent, at risk for pressure ulcers, and had no skin problems.</p> <p>On 5/21/19 at 11:26 AM, Resident #8 said she had an open wound on her bottom.</p> <p>On 5/22/19 at 2:38 PM, with RCM #1 and RCM #2 present, redness was observed to Resident #8's left buttock and there were two small excoriated areas with skin visibly broken and</p>	F 657	<ol style="list-style-type: none"> <li>1. Resident #8's care plan has been updated to reflect left buttock redness and excoriation, as well as to reflect any wound care treatments.</li> <li>2. RCMs educated on including all wounds/redness/excoriation and their treatments to the care plans. Residents with wounds/redness/excoriation or care plans that reflect high risk for skin impairment have been identified, their care plans have been updated to reflect any wounds/redness/excoriation, as well as to reflect any wound care treatments.</li> <li>3. Resident's admitted into facility will have comprehensive care plans built within 7 days of comprehensive assessment, and if residents admits or develops wounds/redness/excoriation or care plans that reflect high risk for skin impairment a care plan will be developed reflecting that, as well as to reflect any wound care treatments.</li> <li>4. RCMs will audit residents orders on their unit for wounds/redness/excoriation and treatments each week for 4 weeks; then biweekly for one month; then monthly until the QAPI team feels this is no longer needed. Care Plans will be reviewed for inclusion of wound care orders. The Director of Nursing or designee will review RCM audits to ensure compliance and accuracy. Results will be presented monthly at QAPI.</li> </ol>		

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F 657	Continued From page 5 peeling. RCM #1 stated skin barrier cream was used to treat this area.  Resident #8's progress notes from 5/2/19 to 5/21/19 documented barrier cream was applied after peri-care for Resident #8.  Resident #8's care plan, revised 3/1/19, documented she was at high risk for skin impairment related to immobility and incontinence. The care plan did not include the left buttock redness and excoriated areas, nor to apply barrier cream after each incontinent episode or to excoriated areas.  On 5/24/19 at 9:09 AM, RCM #2 stated Resident #8's excoriated areas to her buttocks should have been added to the care plan to reflect the new skin problem and care interventions.	F 657			
F 684 SS=E	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, I&A review, policy review, and resident and staff interview, it was determined the facility failed to ensure neurological assessments were completed per policy after resident falls. This was	F 684	1. Resident #28 has passed away. Resident #52, #51, and #19 were thoroughly assessed for any neurological changes or decline, none were found.	7/10/19	

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F 684	<p>Continued From page 6</p> <p>true for 4 of 4 residents (#19, #28, #51 and #52) who were reviewed for falls. This failure created the potential for harm should residents experience undetected changes in neurological status. Findings include:</p> <p>The facility's policy for Neurological Assessment, revised February 2019, documented the following:</p> <ul style="list-style-type: none"> <li>* Neurological signs were monitored following head injury or suspected head injury.</li> <li>* Neurological assessments were completed every 15 minutes times 4, every 30 minutes times 4, every hour times 4, every 4 hours times 4, then every shift for 48 hours.</li> </ul> <p>The facility's Neurological Assessment Flow Sheet, undated, documented neurological assessments were performed every 15 minutes times 4, every 30 minutes times 4, every hour times 4, every 4 hours times 4, then every shift for 72 hours. The flow sheet instructed staff to document the date and time as well as level of consciousness, pupil response, motor functions, pain response, and vital signs.</p> <p>1. Resident #52 was admitted to the facility on 7/30/13, with multiple diagnoses including paranoid schizophrenia (a severe mental disorder which can result in hallucinations, delusions, and disordered thinking and behavior), muscle weakness, pain, heart failure, obesity, depression, anxiety, convulsions, and parkinsonism (a movement disorder).</p> <p>Resident #52 had neurological assessments</p>	F 684	<p>2. Staff was educated on the importance of neurological checks per Prestige policy. Residents that sustain an unwitnessed fall or fall with head trauma would immediately implement and thoroughly complete neurological checks. RCM and DNS to assess neuro checks for falls daily in MACC meeting. Medical records will review neuro sheets when turned in for scanning in to system, incomplete neuro sheets will be returned to the DNS prior to scanning to assure education and understanding of expectation.</p> <p>3. RCMs will audit resident at least 2 neuro sheets on their unit for completion in MACC week for 4 weeks; then biweekly for one month; then monthly until the QAPI team feels this is no longer needed. The Director of Nursing or designee will review RCM audits to ensure compliance and accuracy. Medical records will audit neuro sheets prior to scanning for 4 weeks; then biweekly for one month; then monthly until the QAPI team feels this is no longer needed. The Administrator or designee will review Medical Records audits to ensure compliance and accuracy.</p> <p>4. Results will be presented monthly at QAPI.</p>		

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F 684	<p>Continued From page 7</p> <p>initiated after four falls between 12/25/18 and 3/11/19. The Neurological Assessment Flow Sheets for Resident #52 were not completed as follows:</p> <p>* An I&amp;A report stated on 12/25/18 at 8:55 AM, Resident #52 dropped a colored pencil, leaned over to pick it up and fell out of her chair, hitting the back of her head on the dresser. She had a large raised area on the back of her head. The Neurological Assessment Flow Sheet did not document level of consciousness, pupil response, motor functions, or pain response on 12/25/19 at 12:40 PM.</p> <p>* An I&amp;A report stated on 1/31/19 at 4:10 AM, Resident #52 was found by a CNA sitting on a fall mat in her room and she was restless and experiencing hallucinations. The Neurological Assessment Flow Sheet documented Resident #52 was "pushing self around building" on 1/31/19 at 9:00 AM, and did not document her level of consciousness, pupil response, motor functions, pain response, or vital signs. Per the protocol on the flow sheet, on 2/3/19 Resident #52 was to have documented neurological assessments one time during the day, evening, and night shift. The flow sheet did not include documentation of Resident #52's level of consciousness, pupil response, motor functions, and pain response for the night shift on 2/3/19.</p> <p>* An I&amp;A report stated on 2/19/19 at 3:40 AM, Resident #52 was found by a CNA sitting on a fall mat in her room. The Neurological Assessment Flow Sheet documented "Change of shift" on 2/19/19 at 5:00 AM, and the level of consciousness, pupil response, motor functions,</p>	F 684			

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F 684	<p>Continued From page 8</p> <p>pain response, and vital signs were not documented at that time. The level of consciousness, pupil response, motor functions, and pain response were not documented on 2/19/19 at 7:30 AM.</p> <p>* An I&amp;A report stated on 3/11/19 at 3:05 AM, Resident #52 was found lying on the floor on a fall mat in her room. The Neurological Assessment Flow Sheet did not include documentation of level of consciousness, pupil response, motor functions, and pain response on 3/11/19 at 3:35 AM, 3:50 AM, 4:20 AM, and 4:50 AM. The level of consciousness, pupil response, motor functions, pain response, and vital signs were not documented on 3/11/19 at 5:20 AM.</p> <p>On 5/24/19 at 11:12 AM, the DON said there were some blanks on Resident #52's Neurological Assessment Flow Sheets.</p> <p>2. Resident #28 was re-admitted to the facility on 3/21/19, with multiple diagnoses including anxiety disorder and generalized muscle weakness.</p> <p>Resident #28's record included four Neurological Assessment Flow Sheets dated from 4/23/19 to 5/16/19. The Neurological Assessment Flow Sheets were not completed as follows:</p> <p>* An I&amp;A report stated on 4/23/19 at 12:10 AM, Resident #28 had an unwitnessed fall in his room. The Neurological Assessment Flow Sheet did not include documentation of vital signs at 12:45 AM and 7:00 AM on 4/23/19.</p> <p>* An I&amp;A report stated on 5/16/19 at 8:30 AM, Resident #28 was found sitting on the floor next</p>	F 684			

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F 684	<p>Continued From page 9</p> <p>to his bed. The Neurological Assessment Flow Sheet did not include documentation of an assessment at 9:00 AM, 11:30 AM, and 12:30 PM on 5/16/19. The neurological assessments scheduled for the evening shift on 5/19/19, were not completed. There were also no assessments documented for Resident #28 for the night or day shift on 5/20/19.</p> <p>On 5/24/19 at 1:30 PM, the DON stated her expectation was for nursing staff to complete and document the neurological assessments. The DON stated if the nurses were unable to complete any part of the neurological assessment, a progress note should have been completed to indicate the status of the resident. The DON said the completed Neurological Assessment Flow Sheets were scanned into the resident's EMR, and they were not reviewed by the DON or the RCM for completeness. The DON stated the facility's expectation was for the nursing staff to complete 72 hours of neurological assessments as directed on the Neurological Assessment Flow Sheet.</p> <p>3. Resident #51 was admitted to the facility on 4/29/19, with multiple diagnoses including repeated falls.</p> <p>A Progress Note, dated 5/10/19 at 1:56 PM, documented Resident #51 slid from her chair to the floor onto her bottom. There were no witnesses and no injuries noted at that time.</p> <p>Neurological assessments were started by staff beginning on 5/10/19 at 12:59 PM. The Neurological Assessment flow sheet for Resident #51 was missing documentation as follows:</p>	F 684			

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F 684	<p>Continued From page 10</p> <p>* An I&amp;A report, dated 5/10/19, documented Resident #51 fell at 12:50 PM and there were no injuries noted at that time. No neurological assessment data was documented on 5/10/19 at 2:30 PM, 3:00 PM, 3:30 PM, 4:00 PM, and 5:00 PM.</p> <p>* There was no documentation of level of consciousness, pupil response, motor functions, pain response, or vital signs on 5/11/19 at 12:00 PM.</p> <p>* Vital signs were not documented for the day shift on 5/12/19 or the evening shift on 5/13/19.</p> <p>On 5/23/19 at 8:58 AM, LPN #4 said neurological assessments should be done for 72 hours after an unwitnessed fall.</p> <p>On 5/23/19 at 9:38 AM, RCM #3 said neurological assessments should be done for unwitnessed falls, altered level of consciousness, and any kind of head injury, and they should be done for 72 hours.</p> <p>On 5/23/19 at 10:03 AM, the DON said neurological assessments should be initiated immediately, and she needed to look at the protocol on the Neurological Assessment Flow Sheet to see the time frame. The DON said there was documentation missing on Resident #51's Neurological Assessment Flow Sheet. The DON said she did not know if Resident #51 refused the neurological assessments, but if she did it was not documented.</p> <p>4. Resident #19 was re-admitted to the facility on</p>	F 684			

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F 684	Continued From page 11 7/23/18, with multiple diagnoses including abnormalities of gait and mobility.  An I&A Report documented Resident #19 fell on 2/4/19 at 2:00 AM, when she became lightheaded and fell in the bathroom. The Neurological Assessment Flow Sheet did not include documentation of her level of consciousness, pupil response, motor functions, or pain response on 2/4/19 at 4:30 AM and 5:00 AM. The pupil response was not documented on 2/4/19 at 6:00 and 7:00 AM.  On 5/23/19 at 2:17 PM, the DON said Resident #19's Neurological Assessment Flow Sheet was not completed.	F 684			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)  §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and  §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.	F 688		7/10/19	

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F 688	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents received treatment and services to prevent further decrease or loss of range of motion (ROM) for 1 of 2 residents (Resident #25) who were reviewed for restorative nursing services. This deficient practice placed residents at risk of experiencing a decrease in mobility and function due to lack of passive ROM (PROM) services. Findings include:</p> <p>Resident #25 was admitted to the facility on 12/14/15, with multiple diagnoses which included congenital hydrocephalus (excess fluid in cavities of the brain), hemiplegia (loss of function on one side of the body), high blood pressure, hand contracture (a condition of chronic loss of joint and muscle motility), and congenital malformations (deformity defects at birth) of the upper limbs.</p> <p>A quarterly MDS assessment, dated 3/25/19, stated Resident #25 was severely cognitively impaired and had functional limitation in ROM to his upper extremity on one side which included the shoulder, elbow, wrist, and hand.</p> <p>Resident #25's record included a restorative nursing order, dated 12/12/16, for him to receive PROM to maintain ROM to the left elbow 6 times per week for 15 minutes a day and to use slow, prolonged stretches for 1 to 2 minutes at a time.</p> <p>A care plan, revised 3/28/19, identified contractures to Resident #25's left arm and to maintain ROM to the left elbow and wrist.</p>	F 688	<ol style="list-style-type: none"> <li>1. Resident #25's restorative plan was re-evaluated for effectiveness. Restorative Aide was educated on the importance of restorative plan being done as written.</li> <li>2. Residents on restorative plans were re-evaluated for need and effectiveness. Restorative Aide was educated on the importance of restorative plan being done as written.</li> <li>3. RCM and DNS will assure that residents with restorative plans are receiving their programming by checking with Restorative Aide on completion of restorative plans. RCMs to check restorative flow sheets daily in MACC meeting.</li> <li>4. RCMs will audit 2 random residents on restorative plans on their unit for completion in MACC week for 4 weeks; then biweekly for one month; then monthly until the QAPI team feels this is no longer needed. The Director of Nursing or designee will review RCM audits to ensure compliance and accuracy. Results will be presented monthly at QAPI.</li> </ol>		

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F 688	<p>Continued From page 13</p> <p>Interventions included restorative nursing to provide PROM and stretches 6 times per week for 15 minutes a day, and to use slow, prolonged stretches for 1 to 2 minutes at a time.</p> <p>Resident #25 did not receive PROM as ordered. Examples include:</p> <p>a. The restorative nursing flow sheet for 3/1/19 to 3/31/19, documented Resident #25 did not receive PROM on 3/1/19, 3/4/19, 3/5/19, 3/11/19 to 3/17/19, 3/21/19, 3/24/19 to 3/26/19, and 3/29/19.</p> <ul style="list-style-type: none"> <li>- The week of 3/3/19 to 3/9/19, Resident #25 did not receive PROM on 2 days out of 6.</li> <li>- The week of 3/10/19 to 3/16/19, he did not receive PROM 6 days out of 6.</li> <li>- The week of 3/17/19 to 3/23/19, Resident #25 did not receive PROM 2 days out of 6.</li> <li>- The week of 3/24/19 to 3/30/19, he did not receive PROM 2 days out of 6.</li> </ul> <p>b. The restorative nursing flow sheet for 4/1/19 to 4/30/19, documented Resident #25 did not receive PROM on 4/3/19, 4/6/19, 4/7/19, 4/11/19, 4/13/19, 4/15/19, 4/18/19, 4/20/19, 4/21/19, 4/23/19, 4/25/19, 4/26/19, 4/28/19, and 4/29/19.</p> <ul style="list-style-type: none"> <li>- The week of 3/31/19 to 4/6/19, Resident #25 did not receive PROM on 3 days out of 6.</li> <li>- The week of 4/7/19 to 4/13/19, he did not receive PROM on 3 days out of 6.</li> <li>- The week of 4/14/19 to 4/20/19, Resident #25 did not receive PROM on 3 days out of 6.</li> <li>- The week of 4/21/19 to 4/27/19, he did not receive PROM on 4 days out of 6.</li> </ul>	F 688			

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F 688	Continued From page 14 c. The restorative nursing flow sheet for 5/1/19 to 5/23/19, documented Resident #25 did not receive PROM on 5/1/19, 5/3/19 to 5/5/19, 5/7/19 to 5/9/19, 5/11/19, 5/12/19, 5/15/19, 5/16/19, 5/18/19, and 5/20/19 to 5/22/19.  - The week of 4/28/19 to 5/4/19, Resident #25 did not receive PROM on 5 days out of 6. - The week of 5/5/19 to 5/11/19, he did not receive PROM on 5 days out of 6. - The week of 5/12/19 to 5/18/19, Resident #25 did not receive PROM on 3 days out of 6.  On 5/24/19 at 11:45 AM, CNA #1, who was a full-time restorative aide, said she not have time to complete all assigned therapies because there was only 1 restorative aide staffed each day.  On 5/24/19 at 11:47 AM, the DON said the facility had 2 restorative aides, 1 worked full-time and the other worked part-time. She said a restorative aide was staffed 7 days a week. The DON stated she was not aware of how many residents received restorative nursing or the amount of missed restorative nursing sessions that were not performed for Resident #25.	F 688			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		7/10/19	

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F 689	<p>Continued From page 15</p> <p>by:</p> <p>Based on observation, record review, review of I&amp;A reports, policy review, and resident and staff interview, it was determined the facility failed to provide adequate supervision to prevent falls. This was true for 2 of 4 residents (#51 and #52) who were reviewed for falls. Resident #51 sustained a fracture related to a fall, and Resident #51 and Resident #52 were at risk for injury from further falls. Findings include:</p> <p>The facility's Fall Risk policy, revised February 2019, documented the following:</p> <ul style="list-style-type: none"> <li>* All residents were assessed for fall risk upon admission, at least quarterly, after any fall, and upon any significant change in condition.</li> <li>* A plan for fall prevention was initiated based on residents' risk for falling.</li> <li>* The MDS assessment was used to further assess residents' risk for falls. The History and physical was reviewed to indicate residents' fall history, contributing diagnoses and other risk factors. This information was used to form individualized interventions to reduce their fall risk and to identify the need for referrals to other disciplines.</li> <li>* The fall risk care plan was reviewed at least quarterly and after a fall.</li> </ul> <p>1. Resident #51 was admitted to the facility on 4/29/19, with multiple diagnoses including repeated falls, displaced fracture of the left humerus (long bone in the upper arm), Type 2 diabetes mellitus with diabetic neuropathy (nerve</p>	F 689	<ol style="list-style-type: none"> <li>1. Resident #51 is no longer a resident of the facility. Resident 52's medications were reviewed by pharmacist and medical director to decrease or discontinue any unnecessary medications that may lead to falls, none were adjusted as resident had a GDR of Abilify on 5/31 from 10mg QD to 5mg QD. Care plans will be reviewed to reflect additional interventions for falls.</li> <li>2. Residents with high risk for falls per MDS/H&amp;P/frequent previous falls were evaluated for risk for falls and current interventions. Residents with high risk for falls had medication review by Pharmacist for possible GDRs of medications that may increase risk for falls. PIP initiated for falls in QAPI meeting.</li> <li>3. RCM and DNS will assure that residents with high risk for falls have their care plans reviewed and updated as needed.</li> <li>4. RCMs will audit 2 all new resident falls care plans/interventions/assessments/risk managements on their unit for completion in MACC week for 4 weeks; then biweekly for one month; then monthly until the QAPI team feels this is no longer needed. The Director of Nursing or designee will review RCM audits to ensure compliance and accuracy. Results will be presented monthly at QAPI.</li> </ol>		

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F 689	<p>Continued From page 16 damage), severe obesity, depression, anxiety, myocardial infarction (heart attack), atrial fibrillation (irregular heart rhythm), and heart failure (condition in which the heart cannot pump enough blood to meet the body's needs).</p> <p>Resident #51's physician orders, dated 4/29/19, included the following medications:</p> <ul style="list-style-type: none"> <li>* Bupropriion (antidepressant medication) extended release 450 mg once a day.</li> <li>* Venlafaxine (antidepressant medication) extended release 225 mg once a day.</li> <li>* Abilify (antipsychotic medication) 30 mg at bedtime.</li> <li>* Cyclobenzaprine (muscle relaxer) 10 mg three times a day.</li> <li>* Gabapentin (medication to relieve nerve pain) 900 mg four times a day.</li> <li>* Morphine (narcotic pain medication) extended release 15 mg three times a day.</li> <li>* Hydrocodone-acetaminophen (narcotic pain medication) 10-325 mg four times a day as needed.</li> <li>* Lorazepam (anti-anxiety medication) 1 mg twice a day as needed, which was reordered on 5/22/19.</li> </ul> <p>According to Drugs.com a nationally recognized reference for medications, website accessed on 6/7/19, listed the common side effects for</p>	F 689			

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F 689	<p>Continued From page 17 Resident #51's medications as follows:</p> <ul style="list-style-type: none"> <li>- Gabapentin: clumsiness or unsteadiness and lack or loss of strength</li> <li>- Venlafaxine: lack or loss of strength</li> <li>- Bupopriion: dizziness</li> <li>- Abilify: loss of balance</li> <li>- Cyclobenzaprine: dizziness, drowsiness, lightheadedness</li> <li>- Morphine Extended Release: drowsiness, sleepiness</li> <li>- Hydrocodone: sedation, lethargy (a lack of energy and enthusiasm)</li> <li>- Lorazepam: drowsiness, sleepiness</li> </ul> <p>Resident #51's Fall Risk Assessment, dated 4/29/19 at 1:15 PM, documented she was at low risk for falls. The Fall Risk Assessment documented Resident #51 scored 50 on the Morse Fall Scale Acuity Tool. According to the U.S. Department of Health &amp; Human Services Agency for Healthcare Research and Quality (AHRQ), website accessed 6/6/19, the Morse Fall Scale is used to identify risk factors for falls in hospitalized patients. The AHRQ also stated "The total score may be used to predict future falls, but it is more important to identify risk factors using the scale and then plan care to address those risk factors." The Morse Fall Scale tool uses 6 items with a score for each answer and a total score of &gt;45 means the patient is at high risk for falls.</p> <p>A care plan, dated 5/1/19, identified Resident #51's psychosocial well-being, mood related to major depression and anxiety, and return to the community. The care plan did not include her risk for falling, ADLs, or use of a wheelchair for</p>	F 689			

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F 689	<p>Continued From page 18 mobility.</p> <p>Resident #51's admission MDS assessment, dated 5/6/19, documented she was cognitively intact and she required extensive assistance of 2 or more staff for bed mobility and transfers. The assessment also documented she was not steady on her feet and was only able to stabilize with human assistance when moving from a seated to a standing position and surface to surface transfers, and she required the use of a wheelchair. The MDS documented Resident #51 fell within the last month prior to admission, and she had a fracture related to a fall within six months prior to admission.</p> <p>Resident #51's progress notes documented the following:</p> <p>* A progress note, dated 4/29/19 at 2:18 PM, documented Resident #51 was admitted to the facility and she had a cast on her left arm up past her elbow. RCM #2 also documented Resident #51 had all the toes on her left foot amputated and there was an "area of concern" under 3 to 4 toes on her right foot. RCM #2 documented Resident #51 required the assistance of 2 staff to stand.</p> <p>* A progress note, dated 5/1/19 at 2:17 AM, documented Resident #51 was up to the restroom twice with the assistance of 2 staff and she wanted to stay in her wheelchair for several hours during the night. Progress notes dated 5/4/19 and 5/5/19, documented Resident #51 spent most of the day in her wheelchair.</p> <p>* A progress note, dated 5/7/19 at 12:30 PM,</p>	F 689			

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F 689	<p>Continued From page 19</p> <p>documented Resident #51 was transferring herself in her room and she was reminded to get assistance from staff. The note documented Resident #51 agreed to request assistance but later transferred herself without assistance.</p> <p>* A progress note, dated 5/10/19 at 1:56 PM, documented Resident #51 slid from her chair to the floor onto her bottom. The progress note stated there were no witnesses and no injuries noted at that time and the physician was notified.</p> <p>* A progress note, dated 5/11/19 at 12:48 AM, documented Resident #51 was complaining of pain in her right upper arm and wrist around dinnertime. The progress note documented there was no redness, bruising, or marks noted on her arm. Resident #51 stated her left arm was also hurting, and the nurse administered Norco with "some relief. " The progress note documented a family member called to demand Resident #51 should be sent to the hospital for x-rays, but Resident #51 declined going to the hospital at that time.</p> <p>* A progress note, dated 5/12/19 at 5:23 PM, documented Resident #51 said she was unable to use her right arm or move it. The RN lifted her arm and "had her hold it up with encouragement." Resident #51 wanted tissues to blow her nose, and the nurse "encouraged her to get the tissues in which she did 3 times." Resident #51 wanted water and the nurse encouraged her to pick up her water pitcher, which she did. The nurse educated her it was important to build up her strength and "try to do as much as possible."</p> <p>* A progress note, dated 5/13/19 at 6:33 AM,</p>	F 689			

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F 689	<p>Continued From page 20</p> <p>documented "Resident [Resident #51] continues to try and get every one [sic] to wait on her as if she was a Queen. She wants to be fed, explained to her she needs to use her hands and arms or she will loose [sic] the ability to be able to use her hands and arms, will loose [sic] her strength and physical therapy will hurt more."</p> <p>* A progress note, dated 5/13/19 at 10:05 AM, documented Resident #51 " ...needed encouraged [sic] to use [right] arm. [S]tates bruising prevents her from using her [right] arm very much." There was no documentation describing where the bruising was or how it affected Resident #51 from moving her right arm.</p> <p>* A progress note, dated 5/14/19 at 12:01 PM, documented Resident #51 wanted to call 911 due to concerns the x-rays to her right arm would not get done. The progress note documented the nurse informed her the x-rays were ordered and " ...they would be in as soon as they could ..." Resident #51 requested anti-anxiety medication and it was administered by the nurse.</p> <p>* A progress note, dated 5/14/19 at 12:38 PM, documented Resident #51 had bruising covering the inside of her arm from the elbow to the shoulder, and some bruising around her ribs. The progress note documented an order was received for x-rays of the shoulder, elbow, and wrist. Resident #51 was able to use her hand with no weakness, but she complained of pain with movement from her elbow to her wrist.</p> <p>* A progress note, dated 5/15/19 at 8:20 AM, documented it was a late entry for 5/11/19, and Resident #51 was complaining of pain in her right</p>	F 689			

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F 689	<p>Continued From page 21</p> <p>arm. The progress note documented staff explained an x-ray could be done, but not until the following week because the mobile x-ray did not come in on weekends. The note documented Resident #51 refused to go to the emergency room for x-rays over the weekend and wanted to wait and see if she improved with pain medication.</p> <p>* A progress note, dated 5/15/19 at 12:53 PM, documented Resident #51 required the assistance of 3 staff for transferring because she was "...refusing to assist ..."</p> <p>* A progress note, dated 5/15/19 at 7:01 PM, documented Resident #51 had a fracture of the right humerus which was noted by the orthopedic physician, and he wanted to see her in one week.</p> <p>An I&amp;A report, dated 5/10/19, documented Resident #51 fell the same day at 12:50 PM when she slid from her chair to the floor and there were no injuries at the time of the fall. The investigation section of the I&amp;A report documented Resident #51 tended to lean to the right in her wheelchair, and fell asleep this way, and fell out of her wheelchair. The investigation section documented Resident #51 had a previous fracture to her left arm and sustained a fracture of the right arm. The investigation section of the I&amp;A report documented the fall was related to positioning, and Resident #51 was confused and fatigued. The investigation section documented an x-ray was obtained of her right arm due to bruising and Resident #51 complaining of pain two days after the fall, and the x-ray identified a fracture of the right humerus.</p>	F 689			

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F 689	Continued From page 22  An Investigation Summary, undated, related to the incident on 5/10/19, documented Resident #51 was admitted to the facility on 4/29/19, after hospitalization for a fracture to the left elbow as the result of a fall at another facility. On 5/10/19, a nurse noted Resident #51 had slipped out of her wheelchair onto her buttocks. The summary documented there were no signs of injury at the time of the initial nursing assessment after the fall and then at dinnertime on the same day, Resident #51 reported to another nurse she had pain in her right upper arm and wrist. The Investigation Summary stated there was no redness or bruising, and her left arm was also hurting, and pain medication was administered to Resident #51 with "some effectiveness." The Investigation Summary documented a family member called and wanted Resident #51 taken to the hospital for evaluation and x-rays and Resident #51 declined going to the hospital at that time. The summary documented on 5/14/19, Resident #51 complained of pain in her right arm and agreed to have x-rays and the x-ray results documented an acute fracture of the right humerus.  A Radiology Report, dated 5/14/19, documented Resident #51 had "Acute comminuted fracture involving right humeral neck with moderate angulation and displacement" (a fracture of a portion on the humerus into several pieces that was not in alignment).  Resident #51's care plan was updated/revised on 5/21/19, 11 days after she fell and 6 days after the fracture of the right humerus was identified. The care plan revisions included the following:	F 689			

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F 689	<p>Continued From page 23</p> <p>* Impaired Activities of Daily Living (ADL) function related to increased weakness. Interventions included mechanical lift for all transfers, Occupational and Physical Therapy evaluate and treat, wheelchair used for transportation, and assistance of one staff for mobility related to fracture.</p> <p>* Fall out of wheelchair in room, interventions included "Assess and document the cause of incident, sitting in [wheelchair], leans to the R (right), falls asleep," assess and document changes in mental status and functional level, assess and document for signs and symptoms of injury: for non-injury, every shift for 24 hours, for injury, every shift for 72 hours "or as indicated," treat injury as indicated, sling to right arm for fracture.</p> <p>Resident #51 was interviewed and observed as follows:</p> <p>* On 5/21/19 at 9:27 AM, Resident #51 was sitting in her wheelchair in her room. She was leaning forward and to the right and appeared drowsy. A cast was on her left arm and a sling was on her right arm. Her right arm was hanging down over the side of the wheelchair, partially out of the sling.</p> <p>* On 5/21/19 at 12:53 PM, Resident #51 was leaning over to her right side in her wheelchair with her eyes closed and head down towards her chest. She said she did not want lunch, and she appeared drowsy.</p> <p>* On 5/21/19 at 2:55 PM, Resident #51 was in</p>	F 689			

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F 689	<p>Continued From page 24</p> <p>her wheelchair in her room, leaning forward and to the right. She was awake off and on, her right arm was out of the sling hanging over the side of the wheelchair, and there were red/purple bruises on the inside of her right arm. She said she felt tired and "drugged out" and was tired of sitting in the chair.</p> <p>* On 5/22/19 at 1:16 PM, Resident # 51 said she fell out of her chair and broke her left arm at another facility. She said she fell out of her chair again in her current room and broke her right arm. She was leaning forward and to the right in her wheelchair with her right arm hanging down over the side of the wheelchair.</p> <p>* On 5/22/19 at 1:58 PM, Resident #51 said she took a lot of pain medicine and some of it made her sleepy. She said she felt like she got too much medicine.</p> <p>* On 5/23/19 at 8:48 AM, Resident #51 said she fell because the night before the fall the facility gave her 600 mg of a medication, the name of which she could not recall, and she was previously taking 50 mg, and it made her "so loopy." She said she was favoring her right arm because it hurt. She was sitting in her wheelchair, leaning forward and to the right with her right arm hanging down over the side of the wheelchair.</p> <p>On 5/22/19 at 3:57 PM, the LSW said Resident #51 was admitted to the facility with one fracture, and then she fell out of her wheelchair as she was sleeping and sustained another fracture. The LSW said the facility received an order to x-ray Resident #51's right shoulder, elbow, and wrist,</p>	F 689			

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F 689	<p>Continued From page 25</p> <p>and the results showed a fracture of the right humerus.</p> <p>On 5/22/19 at 4:23 PM, the DON said Resident #51 came to the facility from the hospital with a cast on her left arm, and then she fell in the facility. The DON said the mobile x-ray did not come to the facility on weekends, and Resident #51 initially declined going to the hospital for x-rays. The DON said once Resident #51 started complaining of pain an order for an x-ray was obtained and it showed a fractured humerus. The DON said on the day Resident #51 fell she had just finished lunch, the aide got her ready for therapy, and she was waiting for the therapist to come in. The DON said a nurse went by the room and saw Resident #51 sitting on her buttocks on the floor, and she said she must have fallen asleep.</p> <p>On 5/22/19 at 4:46 PM, the DON said Resident #51's medications could be making her a little sleepy, and it was going to be addressed in the next medication review meeting. The DON said the pharmacist usually reviewed residents' medications at their next visit to the facility, and the pharmacist was in the facility during the survey. The DON said residents' medications were also reviewed at the pharmacy level, the pharmacy would let the facility know if there were any concerns, and if the facility noticed anything concerning regarding residents' medications they could ask the pharmacy.</p> <p>2. Resident #52 was admitted to the facility on 7/30/13, with multiple diagnoses including paranoid schizophrenia (a severe mental disorder which can result in hallucinations,</p>	F 689			

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F 689	<p>Continued From page 26</p> <p>delusions, and disordered thinking and behavior), muscle weakness, pain, heart failure, obesity, depression, anxiety, convulsions, and parkinsonism (a movement disorder).</p> <p>Resident #52's quarterly MDS assessment, dated 5/7/19, documented she had severe cognitive impairment and required extensive assistance of 2 or more persons for bed mobility and transfers, and she required use of a wheelchair for mobility. The MDS stated she had two or more falls since the prior MDS assessment.</p> <p>Resident #52's care plan documented she had insomnia, garbled speech, and was at high risk for falls related to a history of falling out of bed and lowering herself to the floor, cognition, obesity with generalized muscle weakness, seizure disorder, decreased mobility and impulsivity, and receiving antipsychotic medication. Resident #52's care plan also documented she experienced hallucination and spoke to the voices in her head via a nonfunctional phone she carried with her. Interventions related to falls included the following:</p> <p>* When she is heard talking into her phone while in bed, get her up in her wheelchair because she will attempt to get up by herself, initiated on 1/25/17.</p> <p>* She had been witnessed attempting to place herself on the floor from her wheelchair. Encourage her to call for assistance and urge her not to get on the floor. Attempt to determine the reason she wants to be on the floor. If unsuccessful, use extensive assistance of two</p>	F 689			

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F 689	<p>Continued From page 27</p> <p>persons to guide her to the floor. Ensure the area around her is free of clutter, provide a blanket and pillow as she wishes. Staff must remain with her to ensure her safety, initiated on 3/10/17.</p> <p>* Periodically observe her positioning in bed, if she is too close to the edge of the bed verbally encourage her to reposition herself, initiated on 2/28/18.</p> <p>* Ensure floor is clear of clutter, liquids, and foreign objects, initiated on 4/6/18.</p> <p>* Bed to be placed in highest position when she is not in it to discourage her from attempting to transfer herself back into bed without assistance, and bed in lowest position when in bed, initiated on 4/6/18.</p> <p>* Floor mats on the side of bed when she is in bed and remove the mat from the side of the bed where she enters/exits when she is out of bed, initiated on 4/6/18.</p> <p>* Retrieve items that she drops on the floor, initiated on 4/6/18.</p> <p>* Keep her books in the upper drawers so she can get them while she is in bed, initiated on 4/6/18.</p> <p>* Keep personal items and frequently used items where they can be easily reached, initiated on 4/6/18.</p> <p>* Ensure she has properly fitted, non-skid footwear in place when she is out of bed, initiated on 4/6/18.</p>	F 689			

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F 689	<p>Continued From page 28</p> <ul style="list-style-type: none"> <li>* Remind her not to attempt to ambulate or transfer without assistance, initiated on 4/6/18.</li> <li>* Keep wheelchair close to her while she is in bed, initiated on 6/7/18.</li> <li>* Pharmacy review monthly at psychotropic meeting and as needed, gradual dose reduction as indicated, initiated on 9/15/18.</li> <li>* Encourage her to use a pencil pouch to prevent pencils from falling on the floor resulting in her reaching to pick them up, initiated on 10/29/18.</li> <li>* Check call light function regularly, initiated on 1/3/19.</li> <li>* Answer her call light promptly, if possible, attempt morning cares shortly before 4:00 AM, initiated on 2/25/19.</li> <li>* Keep a large numbered clock at the bedside to facilitate her seeing the current time, initiated on 3/25/19.</li> </ul> <p>Resident #52's Fall Risk Assessment, dated 5/10/19 at 5:25 PM, documented she was at high risk for falls.</p> <p>Resident #52 had I&amp;A reports documenting 9 falls between 12/25/18 and 5/17/19. Examples include:</p> <ul style="list-style-type: none"> <li>* Resident #52 fell on 12/25/18 at 8:55 AM. She dropped a colored pencil, leaned over to pick it up and fell out of her chair, hitting the back of her head on the dresser. She had a large raised area</li> </ul>	F 689			

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F 689	<p>Continued From page 29</p> <p>on the back of her head. Neurological assessments were performed and her eyes were "pinpoint." She later complained of a headache and was medicated for pain. Interventions initiated were to "Monitor remind resident to ask for staff assistance [sic]." Reminding Resident #52 not to attempt to transfer without assistance had been added to her care plan on 4/6/18 and had not been effective in preventing further falls. It was not documented whether she had the pencil pouch available per her care plan or if staff attempted to pick up the pencil off the floor for her.</p> <p>* Resident #52 fell on 1/31/19 at 4:10 AM. She was found by a CNA sitting on a fall mat in her room. She was restless and experiencing hallucinations. Recommendations included showing the resident the clock in her room and getting her up if she requested to get up. Resident #52 was hallucinating at the time of the fall. There was no documentation as to how showing Resident #52 the clock would prevent her from falling out of bed while hallucinating.</p> <p>* Resident #52 fell on 2/9/19 at 11:00 PM. It was "presumed" she purposely slid off her bed and onto the fall mat because she went from her bed to her closet and put on a pair of pants without assistance. She was barefoot and did not have non-skid footwear in place as per her care plan. It was recommended that staff answer her call light in a timely manner and remind her to have assistance with transfers. Reminding Resident #52 not to attempt transfer without assistance had been added to her care plan on 4/6/18 and had not been effective in preventing further falls. The I&amp;A, dated 2/9/19, documented Resident</p>	F 689			

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F 689	<p>Continued From page 30</p> <p>#52's call light was not on at the time of the fall. Call light response time was not a factor in Resident #52's fall. It was unclear how it was determined answering Resident #52's call light promptly would have prevented the fall.</p> <p>* Resident #52 fell on 2/19/19 at 3:40 AM. She was found by a CNA sitting on a fall mat. She had no footwear, and it was care planned to get her up around 4:00 AM. The Root Cause section of the 2/19/19 I&amp;A, documented "(Resident #52) will continue to self transfer if call light is not answered promptly. Due to cognitive deficits (Resident #52) believes she can still walk and will attempt to do so and will continue to fall." Staff were to answer her call light promptly or attempt to complete her morning cares shortly before 4:00 AM. These interventions were added to the care plan on 2/25/19.</p> <p>* Resident #52 fell on 3/1/19 at 2:25 AM. She was found sitting in her room. She had no footwear on, and a new bed was in place that was narrower than her previous bed. Recommendations included reminding her to use the call light and wait for assistance, and staff were to get her up if she was requesting to get up. Reminding Resident #52 not to attempt to transfer without assistance had been added to her care plan on 4/6/18 and had not been effective in preventing further falls.</p> <p>* Resident #52 fell on 3/11/19 at 3:05 AM. She was found lying on the floor on a fall mat. No footwear was in place. She was impulsive and would not wait for staff when she wanted to get up. Staff were to monitor her closely and get her up if she requested to get up. Getting Resident</p>	F 689			

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F 689	<p>Continued From page 31</p> <p>#52 up when she wanted to get up was recommended in response to her 3/1/19 fall and had not prevented her 3/11/19 fall. It was unclear how often staff were to monitor Resident #52.</p> <p>* Resident #52 fell on 3/22/19 at 2:00 AM. She was found sitting on the mat with her back against the bed. No footwear was in place. Recommendations included rearranging her room, placing a large digital clock next to her bed, and educating her to wait for assistance. Reminding Resident #52 not to attempt to transfer without assistance had been added to her care plan on 4/6/18 and had not been effective in preventing further falls. Resident #52's care plan was updated on 3/25/19 to include use of the large clock.</p> <p>* Resident #52 fell on 5/11/19 at 3:30 PM. She was found on the floor by a CNA, and she said she was trying to get up and slid out of bed. Recommendations included frequent checks by staff and re-educating her on using her call light and to call for assistance. Reminding Resident #52 not to attempt to transfer without assistance had been added to her care plan on 4/6/18 and had not been effective in preventing further falls. It was unclear how often staff were to monitor Resident #52.</p> <p>* Resident #52 fell on 5/17/19 at 1:15 PM. She was found on the floor by a CNA, and she said she was trying to get up and slid out of bed. Recommendations included "Monitor" and "Her room is in a well-traveled area, glance in when she is in bed when walking by room." Close monitoring of Resident #52 was to be in place prior to the 5/17/19 fall. The I&amp;A, dated 5/17/19,</p>	F 689			

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F 689	Continued From page 32 documented Resident #52 "often self transfers, almost always resulting in falls. She is inconsistent with using her call light."  On 5/24/19 at 11:12 AM, the DON said Resident #52 had a lot of falls, and most of the falls occurred because she slid out of bed. The DON said staff watched her and got her up if she wanted to get up, and staff took her to the toilet if it was noticed she was awake. The DON said most of Resident #52's falls happened on night shift, so staff were to make sure to get her up.  On 5/24/19 at 12:00 PM, the DON said Resident #52 was to have increased supervision due to her falls, which meant more frequent checks and staff made it a habit to stop by more often. The DON said there was no specified time intervals or documentation of frequent checks.	F 689			
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)  §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and  §483.25(g)(5) A resident who is fed by enteral	F 693		7/10/19	

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F 693	<p>Continued From page 33</p> <p>means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure enteral feeding and flushing of a feeding tube were administered appropriately for 1 of 1 resident (Resident #32) reviewed for the use of a feeding tube. This created the potential for harm if complications developed from improper tube feeding practices. Findings include:</p> <p>The facility's policy for Medication Administration, dated August 2018, documented the following steps for administering medications through a feeding tube:</p> <ul style="list-style-type: none"> <li>* Place 15 mls (milliliters) or a prescribed amount of warm purified or sterile water in the syringe and flush the tubing by gravity flow. Clamp the tubing when the syringe is empty, allowing water to remain in the tubing.</li> <li>* Pour the dissolved/diluted medication in the syringe, unclamp the tubing, and allow the medication to flow by gravity.</li> </ul> <p>The facility's policy for Administration of Tube Feedings, undated, documented the following:</p> <ul style="list-style-type: none"> <li>* Clamp the feeding tube, connect the syringe to the feeding tube.</li> </ul>	F 693	<ol style="list-style-type: none"> <li>1. All LNs were educated on how to appropriately administer Resident #32's gravity fed feeding solution.</li> <li>2. LNs were educated on administering medication via gravity feed through feeding tube per Prestige policy and procedure and MD order.</li> <li>3. In-service has been added to all new hire LNs education to be done by SDC upon hire.</li> <li>4. SDC will audit new LN hire in-servicing on administering medication through a feeding tube policy and procedure for 4 weeks; then biweekly for one month; then monthly until the QAPI team feels this is no longer needed. The Director of Nursing or designee will review SDC audits to ensure compliance and accuracy. Results will be presented monthly at QAPI.</li> </ol>		

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F 693	<p>Continued From page 34</p> <p>* Pour the feeding solution into the syringe.</p> <p>* Unclamp the feeding tube.</p> <p>* Hold the syringe 12 inches above the abdomen and allow the feeding solution to infuse "slowly by gravity."</p> <p>Resident #32 was admitted to the facility on 4/5/19, with multiple diagnoses including dysphagia (difficulty swallowing) and adult failure to thrive.</p> <p>Resident #32's physician orders documented the following:</p> <p>* 2Kal (a feeding solution) via nasogastric tube (a feeding tube) 240 milliliters (ml) three times a day, ordered on 5/4/19.</p> <p>Resident #32's care plan documented she received tube feedings three times per day, initiated on 5/3/19.</p> <p>On 5/23/19 starting at 12:14 PM, RN #4 was observed administering tube feeding solution to Resident #32. RN #4 administered 30 mls of water through Resident #32's feeding tube by pushing on the plunger of the syringe. RN #4 then administered 240 mls of feeding solution by pushing on the plunger of the syringe, followed by flushing the feeding tube with 60 mls of water in the same manner. RN #4 did not allow the feeding solution to flow by gravity.</p> <p>On 5/23/19 at 12:23 PM, RN #4 said staff used to administer Resident #32's feeding solution by</p>	F 693			

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F 693	Continued From page 35 gravity, then they switched to pushing it through the syringe because she was tolerating it. RN #4 said she did not know what the facility's policy said regarding administering tube feedings.  On 5/23/19 at 12:28 PM, the DON said tube feedings should go in by gravity.  On 5/23/19 starting at 4:16 PM, RN #5 was observed administering fluconazole 10 mls through Resident #32's feeding tube. RN #5 administered 15 mls of water through Resident #32's feeding tube by pushing on the plunger of the syringe. RN #5 then administered the fluconazole by gravity flow, followed by 30 mls of water administered by pushing on the plunger of the syringe. RN #5 did not flush the feeding tube by gravity flow.  On 5/23/19 at 4:28 PM, RN #5 said she administered the water through Resident #32's feeding tube by pushing on the plunger of the syringe because she really wanted "to get it in there." RN #5 said she did not know what the facility's policy said regarding administering medication through a feeding tube.	F 693			
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)  § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		7/10/19	

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F 695	<p>Continued From page 36</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, the facility failed to label and date respiratory care equipment and place nebulized mist treatment (NMT) set-ups (a delivery system to deliver medications via inhalation) in a bag to protect them from environmental elements. This was true for 5 of 5 residents (#9, #23, #33, #43, and #53) reviewed for respiratory care. This failure created the potential for outdated respiratory supplies to be used and cross contamination of NMT set-ups. Findings include:</p> <p>The facility's Respiratory Treatment policy, revised February 2019, documented the oxygen cannula, mask, nebulizer and tubing were dated and initialed when changed weekly by the night shift. The licensed nurse was directed to rinse the nebulizer with water after each use, allow it to air dry, and store it in a plastic bag when not in use.</p> <p>This policy was not followed.</p> <p>On 5/20/19 at 3:15 PM and 5/21/19 at 9:30 AM and 3:00 PM, the oxygen tubing for residents #9, #33, #43, and #53 were not dated or labeled. On 5/22/19 at 1:30 PM and 5/23/19 at 8:30 AM, the oxygen tubing for residents #9, #33, #43, and #53 were not dated or labeled.</p> <p>On 5/20/19 at 3:15 PM, 5/21/19 at 9:30 AM and 3:00 PM, 5/22/19 at 1:30 PM, and 5/23/19 at 8:30 AM, the NMT set ups for Residents #9, #23, #43 and #53 were not dated or placed in a bag to protect them from environmental factors. The</p>	F 695	<ol style="list-style-type: none"> <li>1. oxygen cannulas, masks, nebulizers and tubing were dated and bagged for residents #9, #23, #33, #43, &amp; #53.</li> <li>2. Residents on oxygen or respiratory treatments were assessed to assure that oxygen cannulas, masks, nebulizers and tubing were dated and bagged.</li> <li>3. LNs were in-serviced that oxygen cannulas, masks, nebulizers and tubing are to be dated and bagged.</li> <li>4. SDC will audit 5 random residents on oxygen or respiratory treatments to assure their oxygen cannulas, masks, nebulizers and tubing are dated and bagged for 4 weeks; then biweekly for one month; then monthly until the QAPI team feels this is no longer needed. The Director of Nursing or designee will review SDC audits to ensure compliance and accuracy. Results will be presented monthly at QAPI.</li> </ol>		

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F 695	Continued From page 37 NMT set ups for these residents were intact with the mask or mouthpiece and medication cup still attached. Condensation was observed in the medication cups.  On 5/23/18 at 11:00 AM, the DON stated she was not aware the oxygen tubing and NMT set ups were not labeled or dated. The DON also stated the expectation for the nursing staff was to follow the policy and keep NMT set ups in a bag when not in use, and the nurses were to change the oxygen tubing and NMT set ups on the night shift.	F 695			
F 757 SS=G	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)  §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-  §483.45(d)(1) In excessive dose (including duplicate drug therapy); or  §483.45(d)(2) For excessive duration; or  §483.45(d)(3) Without adequate monitoring; or  §483.45(d)(4) Without adequate indications for its use; or  §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or  §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 757		7/10/19	

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F 757	<p>Continued From page 38</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents were free from unnecessary drugs. This was true for 1 of 5 residents (Resident #51) reviewed for unnecessary medications. This failure resulted in harm to Resident #51 when she fell and sustained a fracture from oversedation. Findings include:</p> <p>The facility's policy for Medication Regimen Review, undated, documented the following:</p> <ul style="list-style-type: none"> <li>* The consultant pharmacist performed a comprehensive medication regimen review (MRR) at least monthly.</li> <li>* The MRR included "the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy." Medication irregularities included unnecessary drugs and pertinent recommendations were reported to the DON, attending physician, and medical director and/or administrator.</li> <li>* The consulting pharmacist incorporated federally mandated standards of care and other professional standards.</li> <li>* A written diagnosis, indication, or documented objective information supported each medication order.</li> <li>* Indication for use and therapeutic goals were</li> </ul>	F 757	<ol style="list-style-type: none"> <li>1. Resident #51 is no longer a resident in this facility.</li> <li>2. Residents medications will be reviewed by pharmacist to decrease or discontinue any unnecessary medications. The DNS has re-inserviced LNs on the use of psychotropics and that they have side effects. Staff also reviewed the Psychotropic Drug policy and procedure. Emphasis was placed on the need to find root cause of falls and if the resident is displaying side effects, a referral to the physician must be made to discuss continued use of the psychotropic.</li> <li>3. Monthly residents medications will be reviewed by pharmacist to decrease or discontinue any unnecessary medications. Residents with high risk for falls had medication review by Pharmacist for possible GDRs of medications that may increase risk for falls as well.</li> <li>4. RCMs will audit 5 random residents <input type="checkbox"/> drug regimen for possible decrease or discontinuation of unnecessary medications for 4 weeks; then biweekly for one month; then monthly until the QAPI team feels this is no longer needed. The Director of Nursing or designee will review RCM audits to ensure compliance and accuracy. Results will be presented monthly at QAPI.</li> </ol>		

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F 757	<p>Continued From page 39 consistent with current medical writings and clinical practice guidelines.</p> <p>* Duplicated medication orders included a written rationale and evidence of monitoring for efficacy and adverse medication effects.</p> <p>* The administration schedule was appropriate for the resident, keeping in mind side effects (such as sedation), compatibility with other medications, and manufacturer's recommendations.</p> <p>* The resident's medical condition and response to medication therapy were evaluated to ensure the appropriateness of the medication regimen.</p> <p>* Resident irregularities or clinically significant risks related to medications were documented in the resident's record and reported to the DON, attending physician, and medical director as appropriate.</p> <p>Resident #51 was admitted to the facility on 4/29/19, with multiple diagnoses including repeated falls, displaced fracture of the left humerus (long bone in upper arm), Type 2 diabetes mellitus with diabetic neuropathy (nerve damage), chronic pain, and fibromyalgia (a condition where there is widespread musculoskeletal pain).</p> <p>Resident #51's physician orders documented the following medications were ordered on 4/29/19:</p> <p>* Cyclobenzaprine (muscle relaxer) 10 mg three times a day.</p>	F 757			

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F 757	<p>Continued From page 40</p> <ul style="list-style-type: none"> <li>* Gabapentin (medication to relieve nerve pain) 900 mg four times a day.</li> <li>* Morphine (narcotic pain medication) extended release 15 mg three times a day.</li> <li>* Hydrocodone-acetaminophen (narcotic pain medication) 10-325 mg four times a day as needed.</li> <li>* Lorazepam (anti-anxiety medication) 1 mg twice a day as needed.</li> </ul> <p>According to Drugs.com a nationally recognized reference for medications, website accessed on 6/7/19, listed the common side effects for Resident #51's medications as follows:</p> <ul style="list-style-type: none"> <li>- Gabapentin: clumsiness or unsteadiness and lack or loss of strength</li> <li>- Venlafaxine: lack or loss of strength</li> <li>- Bupropion: dizziness</li> <li>- Abilify: loss of balance</li> <li>- Cyclobenzaprine: dizziness, drowsiness, lightheadedness</li> <li>- Morphine Extended Release: drowsiness, sleepiness</li> <li>- Hydrocodone: sedation, lethargy (a lack of energy and enthusiasm)</li> <li>- Lorazepam: drowsiness, sleepiness</li> </ul> <p>An I&amp;A report documented Resident #51 fell on 5/10/19 at 12:50 PM, when she slid from her chair to the floor. The report documented Resident #51 leaned to the right in her wheelchair, fell asleep, and fell out of her wheelchair. The I&amp;A stated there were no injuries at that time. Resident #51 had a previous fracture</p>	F 757			

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F 757	<p>Continued From page 41</p> <p>to her left arm and sustained a fracture of the right arm at the time of the report. The report documented the fall was related to positioning, and Resident #51 was confused and fatigued. It was believed she fell onto her buttocks, but an x-ray was obtained of her right arm due to bruising and the resident's complaints of pain two days after the fall. The x-ray showed a fracture of the right humerus.</p> <p>Resident #51's Progress Notes documented the following:</p> <p>* On 5/1/19, the attending physician documented on an admission examination of Resident #51, she was on a very high dose of Abilify (antipsychotic medication) but that would be left up to her primary care physician. The note did not address other concerns or issues regarding her medications.</p> <p>* On 5/1/19, an Infectious Disease physician documented Resident #56 "reports she is just tired from all the stuff recently. Patient is very drowsy and falls to sleep quickly...Per [physician name], advised to go to ER for eval and possible [N]arcan, but patient refuses repeatedly and requests ride back to nursing home. Called nursing home to verify patient's meds [medications] and drowsiness." Narcan is a medication to reverse effects of narcotic medications.</p> <p>* On 5/10/19 at 1:56 PM, an RN documented Resident #51 slid from her chair to the floor onto her bottom.</p> <p>* On 5/15/19 at 7:01 PM, an RN documented a</p>	F 757			

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F 757	<p>Continued From page 42</p> <p>fracture of the right humerus was noted by the orthopedic physician, and he wanted to see her in one week.</p> <p>* On 5/16/19 at 2:05 AM, an LPN documented Resident #51 rated her pain as 6 out of 10, but she did not want to take a narcotic pain medication because it made her "too out of it."</p> <p>* On 5/16/19 at 1:54 PM, an RN documented Resident #51 continued leaning forward and to the right in her chair. Her right arm was "outside of the armrest, causing impaired circulation to her arm and twisting her shoulder at an odd angle. She appears to be ready to fall out of her chair and is reminded to sit back and sit up."</p> <p>* On 5/18/19 at 1:54 PM: An LPN documented Resident #51 was very drowsy and falling asleep in her chair. Resident #51 was educated "several times" about keeping her arm in the sling; she said it was "annoying and hurts" so removed it and threw it on the floor when she wanted to sleep. She "seemed really down...having a hard time not being able to use her arms."</p> <p>Resident #51 was interviewed and observed as follows:</p> <p>* On 5/21/19 at 9:27 AM, Resident #51 was sitting in her wheelchair in her room. She was leaning forward and to the right and appeared drowsy.</p> <p>* On 5/21/19 at 12:53 PM, Resident #51 was observed leaning over to the right side in her wheelchair with her eyes closed and head down towards her chest. She said she did not want</p>	F 757			

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F 757	<p>Continued From page 43 lunch, and she appeared drowsy.</p> <p>* On 5/21/19 at 2:55 PM, Resident #51 was in her wheelchair in her room, leaning forward and to the right. She was awake off and on, her right arm was out of the sling hanging over the side of the wheelchair, and there were red/purple bruises on the inside of her right arm. She said she felt tired and "drugged out" and was tired of sitting in the chair.</p> <p>* On 5/22/19 at 1:58 PM, Resident #51 said she took a lot of pain medicine and some of it made her sleepy. She said she felt like she got too much medicine.</p> <p>* On 5/23/19 at 8:48 AM, Resident #51 said she fell because the night before the facility gave her 600 mg of a medication, the name of which she could not recall, and she was previously taking 50 mg, and it made her "so loopy."</p> <p>On 5/22/19 at 4:23 PM, the DON said on the day Resident #51 fell, she just finished lunch, the aide got her ready for therapy, and she was waiting for the therapist to come in. A nurse came by and saw Resident #51 sitting on her buttocks on the floor, and she said she must have fallen asleep.</p> <p>On 5/22/19 at 4:46 PM, the DON said Resident #51's medications could be making her a little sleepy, and it was going to be addressed in the next medication review meeting. The DON said the pharmacist usually reviewed residents' medications at their next visit to the facility, and the pharmacist was in the facility during the survey. The DON said residents' medications</p>	F 757			

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F 757	Continued From page 44 were also reviewed by the pharmacy, and they would let the facility know if there were any concerns. She said if the facility noticed anything concerning residents' medications they could ask the pharmacy.  On 5/23/19 at 3:01 PM, the pharmacist said he just reviewed Resident #51's medications the previous evening. The pharmacist said he made some recommendations pertaining to Resident #51's psychoactive medications but did not make recommendations regarding her other medications. The pharmacist said Resident #51 had a lot of pain medication ordered, but he did not recommend anything different. The pharmacist said the facility was going to have a psychoactive medication meeting during the week of survey and they planned to discuss Resident #51's medications, but the he could not be there. The pharmacist said Resident #51 was a complicated case because of her diabetic neuropathy, pain, and psychiatric history.  On 5/24/19 at 9:03 AM, the DON said the pharmacist addressed Resident #51's antidepressant medications, and it was planned to have a psychotropic drug meeting the day before and discuss her medications, but it did not happen "because of everything going on." The DON said the pharmacist said something about Resident #51's gabapentin (medication for nerve pain) but she needed the medication. The DON said the initial pharmacist's review did not mention concerns about Resident #51's medications, and the physician saw her but did not mention anything about her medications.	F 757			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		7/10/19	

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F 758	Continued From page 45  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehensive assessment of a resident, the facility must ensure that---  §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;  §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;  §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and  §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758			

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F 758	<p>Continued From page 46</p> <p>beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents received appropriate monitoring while receiving psychotropic medications. This was true for 2 of 5 residents (#10 and #51) who were reviewed for psychotropic medications. This failure created the potential for harm should residents experience adverse reactions or lack of efficacy from psychotropic medications. Findings include:</p> <p>The facility's policy for Psychoactive Medications, dated February 2018, documented the following:</p> <ul style="list-style-type: none"> <li>* Residents' medication regimen would be free from unnecessary drugs and would help to "promote or maintain the resident's highest practicable mental, physical, and psychosocial well being. "</li> <li>* The resident's medication regimen was reviewed on admission by Social Services and Nursing for psychoactive medication orders.</li> <li>* Risks and benefits of the drug and informed consent was obtained by nursing from the resident or their family/responsible party before</li> </ul>	F 758	<ol style="list-style-type: none"> <li>1. Resident #51 is no longer a resident in this facility. Resident #10s medications will be reviewed by pharmacist and medical director to decrease or discontinue any unnecessary medications per the pharmacist and medical director. Resident #10's care plan and behavior monitor has been updated to reflect resident's medication Donepezil to allow direct caregivers to have accurate information available to them to properly care for their residents.</li> <li>2. Resident's who receive psychotropic medication that have exhibited side effects such as lethargy, unsteady gait or weakness who also receive narcotics or medications to relive neuropathic pain have had their medications reviewed as well as their fall history for the past 30 days to determine if medications should be adjusted by the physician and appropriate referral to the physician made. Orders updated as needed.</li> <li>3. Monthly resident's psychotropic medications will be reviewed by</li> </ol>		

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F 758	<p>Continued From page 47</p> <p>administration of any psychoactive drug.</p> <p>* The resident was placed on the 24 hour report and charting related to the new admission and monitoring behaviors.</p> <p>* Behavior monitoring was initiated and specific behavior interventions were documented on the behavior monitor log prior to initiating PRN (as needed) psychoactive medications.</p> <p>* The RCM completed a psychoactive drug assessment for each medication and the care plan was developed.</p> <p>* Residents receiving psychoactive drugs were reviewed by the Psychoactive Drug Committee. Social Services or their designee were responsible to prepare a list of all residents on psychoactive medications before the monthly Psychoactive Drug Committee meeting.</p> <p>This policy was not followed.</p> <p>1. The Nursing 2019 Drug Handbook documented nursing considerations for donepezil (an Alzheimer's medication) included monitoring for evidence of gastrointestinal bleeding and monitor for bradycardia (low heart rate). Adverse reactions included headache, insomnia, seizures, dizziness, fatigue, depression, somnolence (drowsiness), pain, hallucinations, and abnormal dreams. It also documented to use with caution in residents who had urinary outflow impairment.</p> <p>Resident #10 was admitted to the facility on 11/21/18 with multiple diagnoses, including dementia with behavioral disturbance and benign</p>	F 758	<p>pharmacist and the Psychotropic Drug Meeting IDT Team to decrease or discontinue any unnecessary psychotropic medications.</p> <p>4. SSD will audit 5 random residents <input type="checkbox"/> drug regimen for possible decrease or discontinuation of unnecessary psychotropic medications for 4 weeks; then biweekly for one month; then monthly until the QAPI team feels this is no longer needed. The Administrator or designee will review SSD audits to ensure compliance and accuracy. Results will be presented monthly at QAPI.</p>		

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F 758	<p>Continued From page 48</p> <p>prostatic hyperplasia (an enlarged prostate gland, which can obstruct the outflow of urine).</p> <p>Resident #10's quarterly MDS assessment, dated 2/28/19, documented he had a severe cognitive impairment.</p> <p>Resident #10's physician orders included donepezil 10 mg (an Alzheimer's medication) at bedtime, ordered on 11/21/18, for dementia with behavioral disturbance.</p> <p>Resident #10's care plan documented he had a cognition problem related to dementia with behavioral disturbance.</p> <p>Resident #10's record did not include documentation of monitoring for side effects or behavior monitoring related to the donepezil, and there was no consent for the donepezil.</p> <p>On 5/24/19 at 12:26 PM, the DON said side effects and behaviors were not monitored for Resident #10 related to the donepezil and they did not monitor residents who received that medication.</p> <p>On 5/24/19 at 12:38 PM, the LSW said if a resident had targeted behaviors she would monitor them. The LSW said if the resident was stable and had not exhibited those behaviors, she would not have them on a behavior monitor.</p> <p>On 5/24/19 at 12:49 PM, RCM #1 said donepezil was not a medication the facility followed in their medication review meetings. RCM #2 said the LSW mentioned donepezil at the beginning of their medication review meetings, but they did</p>	F 758			

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F 758	Continued From page 49 not follow it and did not monitor for side effects or behaviors related to donepezil.  2. Resident #51 was admitted to the facility on 4/29/19, with multiple diagnoses including anxiety disorder and major depression.  Resident #51's Admission MDS assessment, dated 5/6/19, documented she was cognitively intact, and she received anti-anxiety medication on 1 of the past 7 days.  Resident #51's care plan documented she had a mood problem related to major depression and anxiety.  Resident #51's physician orders documented lorazepam (anti-anxiety medication) 1 mg twice a day as needed, which was reordered on 5/22/19.  Resident #51's Medication Administration Record (MAR) documented the lorazepam was started on 4/29/19, and it was administered on 4/30/19 at 12:21 PM.  Resident #51's record did not include documentation of monitoring for side effects or behaviors related to the lorazepam.  On 5/24/19 at 9:03 AM, the DON said the facility did not document side effect or behavior monitors related to lorazepam.	F 758			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		7/10/19	

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F 880	<p>Continued From page 50</p> <p>designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <ul style="list-style-type: none"> <li>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</li> <li>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</li> <li>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</li> <li>(iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> <li>(A) The type and duration of the isolation, depending upon the infectious agent or organism</li> </ul> </li> </ul>	F 880			

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F 880	<p>Continued From page 51 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. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, 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). This was true for 1 of 16 residents (Resident #5) observed for infection prevention practices. This failure created the potential for harm by potentially exposing residents to the risk of infection and cross contamination. Findings include:</p> <p>The facility's Infection Control Program, dated</p>	F 880	<ol style="list-style-type: none"> <li>1. C.N.A.'s #2 and #3 were educated on proper hand hygiene.</li> <li>2. SDC will in-service staff members on proper hand hygiene.</li> <li>3. SDC will in-service new staff members on proper hand hygiene upon hire and staff members quarterly at monthly all-staff meetings.</li> <li>4. SDCs will randomly audit hand hygiene</li> </ol>		

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F 880	<p>Continued From page 52</p> <p>November 2016, documented the facility employees will follow Standard Precautions (practices used to prevent transmission of diseases) when interacting with residents to manage body fluids and other potentially infectious material.</p> <p>The CDC website, accessed on 5/30/19, 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> <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>Resident #5 was admitted to the facility on 5/9/19, with multiple diagnoses including mood disorder, high blood pressure, cerebrovascular disease (affects blood vessels and blood supply to the brain), hydrocephalus (excess fluid in cavities of the brain), and muscle weakness.</p> <p>An MDS assessment, dated 5/14/19, documented Resident #5 required extensive assistance by 2 staff for incontinence care.</p>	F 880	<p>performed by 5 staff members weekly for 4 weeks; then biweekly for one month; then monthly until the QAPI team feels this is no longer needed. The Director of Nursing or designee will review SDC audits to ensure compliance and accuracy. Results will be presented monthly at QAPI.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/24/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRESTIGE CARE &amp; REHABILITATION - THE ORCHARDS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1014 BURRELL AVENUE LEWISTON, ID 83501</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 880	Continued From page 53  On 5/21/19 at 9:42 AM, CNA #2 and CNA #3 were observed performing peri-care for Resident #5. The two CNAs did not remove their gloves and perform hand hygiene after removing Resident #5's soiled incontinence brief.  On 5/21/19 at 9:52 AM, CNA #2 and CNA #3 stated they did not perform hand hygiene after removing their gloves.	F 880			



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

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August 9, 2019

Brandi Jeffries, Administrator  
Prestige Care & Rehabilitation - The Orchards  
1014 Burrell Avenue,  
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Jeffries:

On **May 24, 2019**, an unannounced on-site complaint survey was conducted at Prestige Care & Rehabilitation - The Orchards. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008047**

ALLEGATION #1:

Resident call lights were not answered in a timely manner.

FINDINGS #1:

An unannounced complaint survey and recertification survey was conducted on 5/20/19 to 5/24/19. During the survey, resident records were reviewed, facility grievances were reviewed, observations were conducted, and a group interview with residents was conducted.

Observations of call lights demonstrated they were answered in a timely manner throughout the facility. Staff were observed to interact with residents appropriately and in a dignified manner. The environment was clean and there were no odors that would indicate a lack of hygiene/personal care for the residents.

Brandi Jeffries, Administrator  
August 9, 2019  
Page 2 of 5

During interviews with residents no complaints were voiced regarding long wait times for their call lights to be answered.

A resident group meeting was held with seven alert and oriented residents in attendance, and no concerns were voiced in regard to call lights.

Record review of the past three months of resident grievances did not document any concerns about call light wait times.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The facility failed to ensure residents' medications were managed appropriately.

#### FINDINGS #2:

During the survey resident records and facility grievances were reviewed, and staff were interviewed. Medication administration was also observed.

Seventeen resident records were reviewed for medications. One resident's closed record documented he was on 15 medications during his stay. Medications included those for hypertension (high blood pressure), diabetes, and edema (swelling). Changes were made to the resident's diuretic (a medication to decrease excess fluid and swelling) per his request. According to the clinical record, blood pressure medications were not given prior to vital signs being taken.

The Resident Care Manager was interviewed and stated the above resident appeared pale and was complaining of dizziness at the time of a care conference. The resident's blood pressure and blood sugar were checked and were within acceptable parameters. The resident requested to be sent to the emergency room and was transported to the hospital per his request. The hospital record was not available for review. The resident did not return to the facility by choice.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility failed to ensure food was served at appropriate temperatures and palatability.

FINDINGS #3:

During the survey, resident records and facility grievances were reviewed. A group meeting was conducted with residents during the survey. Observation of the kitchen area, meal service, and food preparation were completed.

A resident group meeting was held with seven alert and oriented residents in attendance, and no concerns were voiced in regards to the food. Record review of the past three months of resident grievances did not document any concerns about food.

The facility's kitchen was observed and inspected and food temperatures were within acceptable parameters. A meal tray was obtained and tested by the surveyor, which revealed hot, palatable food.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to ensure residents' personal items were available for use.

FINDINGS #4:

During the survey, resident records and facility grievances were reviewed and a group interview was conducted with residents.

Seventeen resident records were reviewed for documentation regarding missing personal items. One resident's record included an Inventory of Personal Effects form, and there was no documentation regarding missing personal items. The resident was transferred to the hospital and did not return. There was no documentation in the other resident records of missing personal items.

A group interview was conducted with seven residents in attendance. There were no concerns voiced regarding missing personal items. Residents at the interview stated if an item went missing it was located by staff and returned. Facility grievances were reviewed and there were

Brandi Jeffries, Administrator  
August 9, 2019  
Page 4 of 5

no concerns related to missing personal items not being available for use or missing without return.

The Director of Nursing (DON) and Licensed Social Worker (LSW) stated the above resident's family member came and packed up his belongings. The LSW stated there had been no complaints from the resident prior to his transfer about missing personal items.

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 given appropriate notice before being discharged.

#### FINDINGS #5:

Staff were interviewed regarding discharge policies and procedures and resident records were reviewed.

One resident's record documented they were sent to the hospital for evaluation and did not return to the facility after discharge from the hospital. The Director of Nursing (DON) and Licensed Social Worker (LSW) were interviewed and both stated the resident's family member came in and packed up his belongings. The DON stated it was at this time the facility was made aware the resident was not returning to the facility but was going to another facility. The LSW stated there had been no complaints from the resident prior to his transfer to the hospital and they were surprised he was not returning. The LSW stated the resident's family member signed the facility Notification of Transfer or Discharge when she packed up his personal belongings. The notice stated "...I agree to move and understand that I am waiving my right to 30-day notice ..." The LSW stated the resident's family member would not state the reason for his discharge, only that he would not be returning.

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Brandi Jeffries, Administrator  
August 9, 2019  
Page 5 of 5

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

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson".

LAURA THOMPSON, RN, Supervisor  
Long Term Care Program

LT/slj



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August 22, 2019

Brandi Jeffries, Administrator  
Prestige Care & Rehabilitation - The Orchards  
1014 Burrell Avenue  
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Jeffries:

On **May 20, 2019** through **May 24, 2019**, an unannounced on-site complaint survey was conducted in conjunction with a recertification survey at Prestige Care & Rehabilitation - The Orchards. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008025**

ALLEGATION #1:

The facility did not ensure staff met residents' needs and the facility was not kept clean.

FINDINGS #1:

Fourteen residents were reviewed, three closed records were reviewed, and facility grievances were reviewed. Call lights were monitored, and observations of resident care were made throughout the survey. A resident group meeting was conducted with seven residents during the survey, and residents and staff were interviewed.. The resident activities calendar and schedule were reviewed.

During the survey the environment was observed to be clean and there were no odors indicating a lack of hygiene/personal care for the residents.

During observations of residents throughout the survey, residents were coming out of their room and engaged in individual and group activities. Housekeeping staff were engaged in daily cleaning of the facility and resident rooms.

In interviews with residents, no complaints were voiced regarding activities at the facility or residents being kept in their room. Residents did not voice any complaints regarding the cleanliness of the facility or their treatment by staff.

A resident group meeting was held on 5/23/19 with seven residents in attendance, and no concerns were voiced regarding facility cleanliness, activities, or how residents were treated by staff.

Review of the past three months of resident grievances did not include concerns about facility cleanliness, staff treatment or activities.

The Licensed Social Worker stated in an interview some residents were moved to different rooms during the past year due to facility remodeling..

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

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

The facility did not ensure residents were discharged appropriately.

#### FINDINGS #2:

Resident records were reviewed and the Licensed Social Worker was interviewed.

During the interview, he Licensed Social Worker stated one resident was transferred to a facility that had a secure dementia unit, which was more appropriate for her continued care needs. The Licensed Social Worker said the resident's Power of Attorney was involved throughout the process and understood the need for the transfer.

Review of the resident's record documented the resident had escalating behaviors with facility staff and other residents.

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

Brandi Jeffries, Administrator  
August 22, 2019  
Page 3 of 3

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,

A handwritten signature in cursive script, appearing to read "Belinda Day".

Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj



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BRAD LITTLE – Governor  
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August 27, 2019

Brandi Jeffries, Administrator  
Prestige Care & Rehabilitation - The Orchards  
1014 Burrell Avenue  
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Jeffries:

On May 20, 2019 through **May 24, 2019**, an unannounced on-site complaint survey was conducted at Prestige Care & Rehabilitation - The Orchards. The complaint survey was done in conjunction with the annual recertification survey. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00008112**

ALLEGATION #1:

The facility failed to ensure residents were free from abuse.

FINDINGS #1:

During the investigation, 14 residents were observed and their records were reviewed, the residents or their representatives were interviewed, six staff members were interviewed, Incident and Accident (I &A) reports and grievances were reviewed for the prior 6 months, and a resident group interview was performed.

Review of 14 residents' records, I&A reports, and grievances did not document any concerns about abuse. No concerns regarding abuse were expressed by interviewed residents and resident representatives. During observation of residents being transferred by mechanical lift, three of three residents were transferred appropriately. Staff interacted appropriately with residents during all observations of resident care throughout the investigation.

Brandi Jeffries, Administrator  
August 27, 2019  
Page 2 of 2

One resident's record documented she sustained a fracture to her arm when she fell from her wheelchair. The resident stated she fell from her wheelchair and injured her arm, and she said staff did not transfer her inappropriately. Six of six interviewed staff members said the resident injured her arm when she fell, and they were unaware of any other incidents resulting in injury to the identified resident.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



Belinda Day, RN, Supervisor  
Long Term Care Program

BD/lj