



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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June 21, 2019

Melissa Truesdell, Administrator
Owyhee Health & Rehabilitation Center
PO Box A
Homedale, ID 83628-2040

Provider #: 135087

Dear Ms. Truesdell:

On **June 7, 2019**, a survey was conducted at Owyhee Health & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 1, 2019**. Failure to submit an acceptable PoC by **July 1, 2019**, may result in the imposition of penalties by **July 24, 2019**.

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

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

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 12, 2019 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 7, 2019**. A change in the seriousness of the deficiencies on **July 22, 2019**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **September 7, 2019** includes the following:

Denial of payment for new admissions effective **September 7, 2019**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 7, 2019**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **September 7, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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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 **July 1, 2019**. If your request for informal dispute resolution is received after **July 1, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

lt/lj

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

PRINTED: 07/22/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/07/2019
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NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted from June 3, 2019 through June 7, 2019. The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator Brad Perry, LSW Sallie Schwartzkopf, LCSW Survey Abbreviations: CNA = Certified Nursing Assistant DNS = Director of Nursing Services I&A = Incidents and Accidents LPN = Licensed Practical Nurse MDS = Minimum Data Set RN = Registered Nurse	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		6/26/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 07/01/2019
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	<p>Continued From page 1</p> <p>resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure a) Residents were provided accurate information regarding Advance Directives upon admission, and if necessary they were assisted to formulate Advance Directives, b) Residents' records included a copy of the Advance Directives, or documentation of their decision not to formulate an Advance Directive, c) Residents' Advance Directives were recognized and honored, and d) The physician's order regarding code status was consistent with the resident's wishes documented in the record. This was true for 4 of 4 residents (#7 #13, #40 and #148) reviewed for Advance Directives.</p>	F 578	<p>Corrective Action: The facility IDT and admissions staff have been educated regarding the requirement of F578. Orders and/or care plans have been audited to ensure accuracy between the resident's wishes and the documentation in the medical record. Residents affected were provided information regarding advanced directive implementation and assistance offered.</p> <p>Residents affected: The deficiency had the potential to affect all residents.</p> <p>Systematic Changes: The facility has</p>		

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F 578	<p>Continued From page 2</p> <p>These failures created the potential for harm should residents not have their decisions documented, honored, and respected when they were unable to make or communicate their health care preferences. Findings include:</p> <p>The State Operations Manual, Appendix PP, defines an Advanced Directive as "...a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." The State Operations Manual also states a Physician Orders for Life-Sustaining Treatment (POLST) is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an Advance Directive.</p> <p>The facility's policy for Advance Directive Documentation, revised May 2007, documented the following:</p> <p>* At the time of admission, the facility provided written information to residents regarding "Their right under State Law to accept or refuse medical treatment and the right to formulate Advance Directives such as the Natural Death Act, Durable Power of Attorney for Health Care Decision, or living will, in accordance with the Resident Self Determination Act."</p>	F 578	<p>updated their admissions packet to include documentation of conversations surrounding advanced directives and the facility's efforts in educating and assisting with implementation of such directives. Advanced Directives will be reviewed on admission and quarterly during scheduled care plan conferences and assistance offered to formulate if not presently in place.</p> <p>Monitor of Compliance: The director of Nursing and/or designee will complete an audit of all resident records to ensure conversations have taken place surrounding advanced directives and options for implementing. Weekly audits will occur on all new admissions x12 weeks. The QAPI Committee will review until it is determined that systems are effective.</p>		

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F 578	<p>Continued From page 3</p> <ul style="list-style-type: none"> * The facility included documentation in the resident's record that written information was provided upon admission regarding Advance Directives and whether the resident had completed an Advance Directive. * The facility provided education to staff and residents related to Advance Directives. * The Admission Coordinator, Social Service Director or designee inquired whether the resident completed an Advance Directive and provided the "Concerning Life Prolonging Procedures" form if an Advance Directive did not exist. * When an Advance Directive was completed, it was reviewed to ensure it was signed and dated by the resident and it reflected their wishes. If the resident was no longer capable of making decisions independently, the Advance Directive was accepted. * Copies of the Advance Directive and conservatorship/guardianship were obtained and placed in the resident's record. * A written order was obtained from the physician to carry out the Advance Directive. * If the resident was capable of making decisions independently, assistance was provided to complete the desired documents if they wanted to complete an Advance Directive. * If the resident was not capable of making decisions independently, their decision maker was asked to document their wishes regarding 	F 578			

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F 578	<p>Continued From page 4 initiating an Advance Directive for the resident.</p> <p>* All Advance Directive orders were reconfirmed monthly in the physician's orders.</p> <p>On 6/7/19 at 11:02 AM, the DNS said the facility was trying to get rid of the POST (Physician Orders for Scope of Treatment, Idaho's version of POLST) form, so a new form was put in place by the facility, titled Request Concerning Life-Prolonging Procedures form. The top portion of the form included space for the resident's or the resident's legal guardian's name and date. It stated the resident or legal guardian requests "the following care in the event that the attending physician determines that [the resident's] condition (be it injury, disease or illness) is terminal, incurable and irreversible, and that death is imminent)." The form stated "You must indicate Yes or No for each listed procedure. Yes means to do the procedure, No means DO NOT do procedure." The procedures listed for which the resident or resident representative was to indicate yes or no to, included:</p> <ul style="list-style-type: none"> *Cardiopulmonary resuscitation (CPR) *Use of respirators or ventilators *Blood transfusion *Administration of medications other than those necessary to prevent infection, provide comfort, or alleviate pain *Transfer to an acute care hospital *Other, with two lines to document specific information <p>The form documented "I fully understand the impact and potential consequences of this document and wish to emphasize my desire to</p>	F 578			

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F 578	<p>Continued From page 5</p> <p>have the procedures performed or withheld (as indicated above) if death is imminent." The bottom portion of the form included spaces for the dated signature of the resident or guardian, physician, and a witness, and space for the attending physician's comments.</p> <p>The form addressed residents' wishes when death was imminent. It did not address residents' healthcare wishes if they were to become incapacitated and death was not imminent. The form did not address the right to establish a Living Will and/or Durable Power of Attorney for Healthcare.</p> <p>Idaho Code, Title 39, Chapter 45, The Medical Consent and Natural Death Act, specifies the required contents of a Living Will and/or Durable Power of Attorney in Idaho. It states the following: "Any competent person may execute a document known as a Living Will and Durable Power of Attorney for Health Care. Such document shall be in substantially the following form, or in another form that contains the elements set forth in this chapter." The facility's Request Concerning Life-Prolonging Procedures form did not address residents' wishes regarding the administration of artificial or non-artificial hydration and nutrition, an element required for a living will under Idaho Code, Title 39, Chapter 45, The Medical Consent and Natural Death Act.</p> <p>1. Resident #40 was admitted to the facility on 11/21/18, with multiple diagnoses including stage 3 chronic kidney disease.</p> <p>Resident #40's Request Concerning Life-Prolonging Procedures form, dated 11/21/18,</p>	F 578			

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F 578	<p>Continued From page 6</p> <p>documented his code status was DNR and he did not want respirators, ventilators, blood transfusions, or sent to an acute care hospital.</p> <p>Resident 40's record included a Living Will and Durable Power of Attorney for Health Care, dated 12/6/18. Resident #40's Living Will documented his code status was DNR.</p> <p>On 6/5/19 at 4:02 PM, the SSD said the facility copied residents' living wills and power of attorney documents and they were kept in the residents' records. She said the facility's Request Concerning Life-Prolonging Procedures form superseded residents' Living Wills and DPOA documents. The SSD said residents and their families had been educated that the Request Concerning Life-Prolonging Procedures form was the Advanced Directive.</p> <p>Resident #40's Living Will and Durable Power of Attorney for Health Care, were not recognized by the facility as his Advance Directives.</p> <p>2. Resident #148 was admitted to the facility on 5/28/19, with multiple diagnoses including an old myocardial infarction (heart attack).</p> <p>Resident #148's physician orders documented CPR/Full Code was ordered on 5/28/19.</p> <p>Resident #148's care plan documented he wished his code status to be Full Code, initiated on 5/28/19.</p> <p>Resident #148's Request Concerning Life-Prolonging Procedures form, dated 5/28/19, documented he wished to receive CPR, blood</p>	F 578			

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F 578	<p>Continued From page 7</p> <p>transfusion, medications other than those necessary to prevent infection, provide comfort, or alleviate pain, and transfer to the hospital. He did not wish to receive respirators or ventilators. The form was signed by Resident #148 on 5/28/19.</p> <p>Resident #148's Social Services Assessment/Evaluation, dated 6/4/19 at 1:30 PM, documented his Advance Directive wishes included Full Code.</p> <p>Resident #148's record did not contain documentation an Advance Directive was offered, explained, or discussed with him. An Advance Directive was not present in Resident #148's medical record.</p> <p>On 6/5/19 at 4:15 PM, the SSD said the Request Concerning Life-Prolonging Procedures form was the documentation of Advance Directive information for Resident #148, and his code status was documented on the Social Services Assessment.</p> <p>3. Resident #7 was admitted to the facility on 3/22/18, with multiple diagnoses including dementia and moderate intellectual disability. Resident #7's annual MDS assessment, dated 3/8/19, documented she had severe cognitive impairment.</p> <p>Resident #7's POST documented her code status was Full Code (resuscitate), and it was signed by her legal guardian on 1/25/12.</p> <p>On 6/4/19 at 11:55 AM, Resident #7's physician orders documented CPR (cardiopulmonary</p>	F 578			

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F 578	<p>Continued From page 8 resuscitation)/Full Code was ordered on 3/22/18.</p> <p>Resident #7's record did not contain documentation an Advance Directive was offered, explained, or discussed with her legal guardian.</p> <p>A Progress Note, dated 5/2/19 at 3:23 PM, documented a care plan conference was held via phone call to Resident #7's guardian. Her code status was reviewed and it was Full Code at that time. A Request Concerning Life-Prolonging Procedures form was sent to her guardian by e-mail to replace her POST. Resident #7's Request Concerning Life-Prolonging Procedures form, dated 5/6/19, documented no CPR and was signed by her guardian on 5/6/19.</p> <p>Resident #7's record did not contain documentation an Advance Directive was offered, explained, or discussed with her legal guardian.</p> <p>On 6/5/19 at 4:09 PM, the Social Services Designee (SSD) said after the Request Concerning Life-Prolonging Procedures form was completed, she thought the nurse may have overlooked the need to update the physician's order to change Resident #7's code status to Do Not Resuscitate (DNR).</p> <p>On 6/7/19 at 11:02 AM, the DNS said Resident #7's form came back to the facility after being completed by her guardian, and the physician's order regarding her code status was not changed until 6/6/19.</p> <p>Resident #7's legal guardian was not provided</p>	F 578			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 578	<p>Continued From page 9</p> <p>information regarding Advance Directives and Resident #7's physician's orders were not updated in a timely manner to reflect her current code status of DNR.</p> <p>4. Resident #13 was admitted to the facility on 3/29/18, with multiple diagnoses including type 2 diabetes.</p> <p>Resident #13's Request Concerning Life-Prolonging Procedures form, dated 3/29/18, documented her code status was Full Code.</p> <p>Resident #13's POST, dated 11/12/18, documented her code status was DNR.</p> <p>Resident #13's physician orders, dated 11/13/18, and her care plan, documented her code status was DNR.</p> <p>On 6/5/19 at 3:24 PM, Resident #13 said when she came to the facility she wanted to be resuscitated but had since changed her mind and wanted to her code status to be DNR.</p> <p>Resident #13's record did not include an Advanced Directive.</p> <p>On 6/4/19 at 2:45 PM, RN #1 said she would find residents' Advanced Directives in the electronic medical record under the documents tab. RN #1 demonstrated how she looked for residents' Advanced Directives and navigated to where the Request Concerning Life-Prolonging Procedures form was located.</p> <p>On 6/5/19 at 4:02 PM, the SSD said Resident #13's record should have contained a new</p>	F 578			

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F 578	Continued From page 10 Request Concerning Life-Prolonging Procedures form when she changed her code status from Full Code to DNR. The SSD said the POST was not an Advanced Directive and staff should have filled out a new Request Concerning Life-Prolonging Procedures form for Resident #13. The facility failed to ensure residents' and residents' representatives were educated that their living wills and powers of attorney were Advance Directives and failed to educate them on what an Advance Directive was. The facility failed to honor residents' Advance Directives when they were directed to complete the Request Concerning Life-Prolonging Procedures form as the facility's recognized Advanced Directive.	F 578			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		6/25/19	

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F 623	<p>Continued From page 11</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and</p>	F 623			

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

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F 623	<p>Continued From page 12</p> <p>telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by:</p>	F 623			

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F 623	<p>Continued From page 13</p> <p>Based on record review, policy review, and resident, resident representative, and staff interview, it was determined the facility failed to ensure transfer notices were provided in writing to the residents and residents' representatives. This was true for 2 of 2 residents (#13 and #29) reviewed for transfers. This created the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include:</p> <p>The facility's transfer and discharge policy, revised 11/2016, documented residents' records were to include the reason for transfers. The policy did not document that residents or residents' representatives were to receive a written notification of the reason for transfers.</p> <p>a. Resident #13 was admitted to the facility on 3/29/18, with multiple diagnoses including type 2 diabetes.</p> <p>Resident #13's Nurse's Progress Notes documented she was transferred to the hospital for evaluation on 3/9/19 and was readmitted to the facility on 3/14/19, with diagnoses of sepsis (a systemic infection) and stroke. Resident #13's record did not include a written notice of transfer to her or her representative.</p> <p>On 6/3/19 at 2:16 PM, Resident #13 said she did not remember receiving a transfer notice when she was transferred to the hospital.</p> <p>b. Resident #29 was admitted to the facility on 6/13/17, with multiple diagnoses including Alzheimer's disease.</p>	F 623	<p>Corrective Action: The facility IDT and nursing staff have been educated regarding the requirement of F623 indicating that a transfer for urgent medical care does constitute a facility initiated transfer and therefore requires written notice to the residents and/or their representative.</p> <p>Residents Affected: The deficiency had the potential to affect all residents.</p> <p>Systematic Changes: The facility transfer form has been modified to include urgent medical need as a reason for transfer. The notice will be delivered to the resident and/or resident's representative as soon as practicable in the event of a transfer related to an urgent medical need.</p> <p>Monitor of Compliance: Medical records will audit compliance on all facility discharges weekly x12 weeks. The QAPI Committee will review until it is determined that systems are effective.</p>		

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F 623	Continued From page 14 Resident #29's Nurse's Progress Notes documented she was transferred to the hospital for evaluation on 5/26/19 and was readmitted to the facility on 5/28/19, with a diagnosis of urinary tract infection. Resident #29's record did not include a written notice of transfer to her or her representative. On 6/5/19 at 10:13 AM, Resident #29's representative said the facility notified him via phone of the hospitalization. On 6/6/19 at 9:18 AM, RN #1 said when residents were transferred to the hospital their representatives were notified via phone, and they were not provided a written notice of transfer. On 6/6/19 at 9:37 AM, the Administrator said when residents were transferred to the hospital, the facility had not been providing written transfer notices to residents or their representatives.	F 623			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a resident was appropriately assessed by	F 684	Corrective Action: An inservice was held with all nursing staff to review revised protocols requiring neurological	6/27/19	

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F 684	<p>Continued From page 15</p> <p>a nurse after it was reported they had a seizure. This was true for 1 of 12 residents (Resident #4) reviewed for quality of care. This failure created the potential for harm should residents experience undetected changes in neurological status related to their disease process. Findings include:</p> <p>The Lippincot Manual of Nursing Practice, tenth edition, documented after a seizure a patient should be assessed for the degree of memory of recent events and coordination, paralysis, or weakness. The Lippincot Manual also stated the nurse needs to assess the length of time of the postictal state (the time after a seizure until the condition returns to normal) and pupil reaction.</p> <p>Resident #4 was readmitted to the facility on 7/22/17, with multiple diagnoses including epilepsy and repeated falls.</p> <p>Resident #4's quarterly MDS assessment, dated 2/27/19, documented the following he had moderate cognitive impairment, required extensive assistance of 2 persons with bed mobility and transfers, and had two or more falls since admission or the prior assessment, with one fall resulting in injury.</p> <p>Resident #4's care plan documented the following:</p> <p>* He had a seizure disorder related to epilepsy. Interventions, initiated on 7/22/17, included assessing "asap" (as soon as possible) if seizure activity occurred, and "after seizures check vital signs and neurological assessments."</p>	F 684	<p>assessments following both witnessed and unwitnessed falls as well as seizure activity protocols.</p> <p>Residents affected: The deficiency had the potential to affect all residents.</p> <p>Systematic changes: The facility has updated their policy to include neurological assessment on any unwitnessed fall with or without evidence of head trauma. Policy and procedure for monitoring seizure activity reviewed.</p> <p>Monitor of Compliance: Director of Nursing and/or designee will audit all falls and post seizure activity documentation to determine appropriate neurological assessments were completed per facility policy weekly x8 weeks. The QAPI Committee will review until it is determined that systems are effective.</p>		

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F 684	<p>Continued From page 16</p> <p>Resident #4's physician orders documented he took two medications to prevent seizure activity, as follows:</p> <p>* Kepra (medication to control seizures) 750 mg daily and 1000 mg at bedtime, ordered on 4/11/18.</p> <p>* Lamotrigine (medication to control seizures) 150 mg twice a day, ordered on 4/11/18.</p> <p>An I&A Report, dated 6/1/19 at 5:34 AM, documented Resident #4 had "seizure like activity" which caused him to land on his hands and knees on the ground next to his bed.</p> <p>A Nursing Progress Note, dated 6/1/19 at 5:35 AM, documented Resident #4 complained of dizziness and nausea. The nurse told him she would return with medication to help the dizziness and nausea. When the nurse returned to the room, Resident #4 was on his hands and knees on the floor, and he stated he had "a really bad seizure."</p> <p>A Nursing Progress Note, dated 6/1/19 at 9:51 AM, more than 4 hours after the reported seizure activity, documented Resident #4 did not have further seizure activity. There was no documentation his condition was monitored or assessed after the reported seizure until that time.</p> <p>There was no documentation in Resident #4's record a neurological assessment or physical assessment was completed after he was found on his hands and knees and reported to the nurse he had a seizure on 6/1/19.</p>	F 684			

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F 684	Continued From page 17 On 6/5/19 at 10:16 AM, RN #1 said neurological assessments were done only if a resident hit their head when they fell. On 6/5/19 at 11:18 AM, the DNS said if a resident was not able to say whether they hit their head, then neurological assessments should be done, but if the resident said they did not hit their head then she probably would not do neurological assessments. The DNS said Resident #4 was able to tell staff whether he hit his head, and if he said he did not hit his head she would not do neurological assessments. On 6/5/19 at 2:06 PM, the DNS presented the policy for Neurological Assessment, dated 8/22/97, and said that was the way the nurses were trained. The DNS said neurological assessments should be done if there was evidence of head trauma or if the resident said they hit their head, and otherwise neurological assessments were not needed.	F 684			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure fall prevention interventions were consistently implemented	F 689	Corrective Action: All nursing staff inserviced and educated regarding charting requirements and interventions for high fall risk residents. All staff	6/27/19	

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F 689	<p>Continued From page 18</p> <p>following resident falls. This was true for 2 of 2 residents (#4 and #45) reviewed for falls. This failure created the potential for harm should residents experience injuries from falling. Findings include:</p> <p>The facility's policy for Fall Protocol, revised May 2007, documented "if any significant, pertinent measures to reduce risk for falls have not been taken, and in a timely manner, then deficient practice may exist."</p> <p>1. Resident #4 was readmitted to the facility on 7/22/17, with multiple diagnoses including dementia, muscle weakness, abnormalities of gait and mobility, psychotic disorder with delusions, schizophrenia, Parkinson's disease (a progressive nervous system disorder that affects movement), epilepsy, cerebral palsy (a disorder that affects a person's ability to move and maintain balance), repeated falls, and dizziness.</p> <p>Resident #4's quarterly MDS assessment, dated 2/27/19, documented the following:</p> <ul style="list-style-type: none"> * He had moderate cognitive impairment. * He required extensive assistance of 2 persons with bed mobility and transfers. * He had two or more falls since admission or the prior assessment, with one fall resulting in injury. <p>Resident #4's physician orders included the following:</p> <ul style="list-style-type: none"> * Keppra (medication to control seizures) 750 mg daily and 1000 mg at bedtime, ordered on 	F 689	<p>educated on 4p hourly rounds and when those should be charted. The kardex was reviewed with all staff and how to check listed interventions to ensure those things are in place where and when they should be. Resident #4's care plan was thoroughly reviewed and updated and all care plan interventions are in place.</p> <p>Residents affected: The deficiency had the potential to affect all residents.</p> <p>Systematic Changes: All 4p hourly rounds were removed from electronic charting to paper charting to allow for real time documentation rather than end of shift. Nurse to monitor completion of round sheets throughout shift. All care plans reviewed to ensure documented interventions are presently in place and effective and will continue to be reviewed and implemented as changes occur.</p> <p>Monitor of Compliance: Director of Nursing and/or designee will audit all 4p hourly round sheets daily x2 weeks, then weekly x8 weeks. The QAPI Committee will review until it is determined that systems are effective.</p>		

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F 689	<p>Continued From page 19 4/11/18.</p> <p>* Lamotrigine (medication to control seizures) 150 mg twice a day, ordered on 4/11/18.</p> <p>Resident #4's care plan documented he was at risk for falls related to a history of falling, generalized weakness, unsteady gait and balance, impulsive behaviors, and poor safety judgment. Interventions included the following:</p> <p>* One person assistance with transfers, initiated on 2/5/19 and revised on 5/6/19.</p> <p>* 4-P hourly rounds (hourly checks for pain, position, potty, and possessions), and ask if any assistance was needed, initiated on 10/31/17.</p> <p>* He wished for simple signs to remind him to call nursing for assistance, initiated on 5/16/18.</p> <p>* Non-skid strips in front of the toilet in the bathroom, initiated on 7/30/17 and revised on 9/19/17.</p> <p>* Safety notes that he could read to be posted in his room, initiated on 2/20/18.</p> <p>Resident #4's Fall Risk Evaluations documented he was at high risk for falls on 2/2/19 at 6:04 AM, 2/4/19 at 4:27 PM, 5/21/19 at 12:25 PM, and 6/2/19 at 2:23 PM.</p> <p>Resident #4's I&A Reports documented the following falls:</p> <p>* On 2/1/19 at 9:15 PM, he was found on the floor in his room. He attempted to self-transfer to get</p>	F 689			

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F 689	<p>Continued From page 20 to the bathroom.</p> <p>* On 2/3/19 at 9:40 PM, he slipped and fell when attempting to self-transfer. Resident #4's care plan was updated to include one person assistance with transfers on 2/5/19.</p> <p>* On 2/21/19 at 1:00 AM, he was found on the floor in his room. He lost his balance when he self-transferred to the bathroom, and sustained abrasions to his forehead and right wrist. Additional interventions were not added to Resident #4's care plan following the fall.</p> <p>* On 6/1/19 at 5:34 AM, he was found on the floor on his hands and knees after the nurse told him she would return with medication for nausea. It was determined he had "seizure like activity" which caused him to land on his hands and knees on the ground. Resident #4's care plan was not updated to include new fall prevention interventions.</p> <p>Resident #4 was observed in his room self-transferring from his wheelchair to his recliner or bed on 6/3/19 at 2:02 PM, 2:25 PM, and 2:30 PM.</p> <p>On 6/5/19 at 9:34 AM, Resident #4 was in his room leaning far forward in his wheelchair as he grabbed his recliner chair and moved it. Resident #4 leaned toward the floor, looked around the floor and room, and attempted to get behind the recliner while in his wheelchair. A male staff member entered the room and asked Resident #4 if he needed help. Resident #4 said he was trying to find the remote control for his television.</p>	F 689			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135087	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/07/2019
NAME OF PROVIDER OR SUPPLIER OWYHEE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 108 WEST OWYHEE HOMEDALE, ID 83628		
(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 689	<p>Continued From page 21</p> <p>The 4-P hourly rounds were documented once per shift on Resident #4's ADL (Activities of Daily Living) flowsheet section with a staff member's initial and time. The flowsheet did not contain documentation of the time each round was completed.</p> <p>Resident #4's Fall Prevention Devices flowsheet documented visual checks were completed by staff on two occasions from 5/8/19 through 6/6/19, on 5/26/19 at 10:05 AM and 6/2/19 at 3:29 PM.</p> <p>The non-skid strips were not present in Resident #4's bathroom, and safety notes were not posted in his room, as directed in his care plan, on 6/5/19 at 10:47 AM.</p> <p>On 6/5/19 at 10:52 AM, CNA #2 said she checked on Resident #4 "a lot," and she was always looking to see where he was and reminding him to call if he needed anything. CNA #2 said Resident #4 usually tried to self-transfer into his recliner. CNA #2 said she checked on residents who were at risk for falls every hour, and Resident #4 was to be checked every 30 minutes or hourly.</p> <p>On 6/5/19 at 10:57 AM, RN #1 said Resident #4 was on every 15 minute checks in the past, but at the present time there was no direction regarding how often he should be checked. RN #1 said staff constantly walked by Resident #4's room to see what he was doing, and he knew how to use his call light but sometimes he would not use it. RN #1 said there were no posted signs or notes in Resident #4's room.</p>	F 689			

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F 689	<p>Continued From page 22</p> <p>On 6/5/19 at 11:18 AM, the DNS said the facility did just about everything they could think of to prevent Resident #4 from falling, including signs in his room to call the nurse for assistance. The DNS said staff were to do hourly 4-P checks, place his bed in low position, and keep slick blankets off his bed. The DNS said Resident #4 required one person assistance with transfers and he was not safe to self-transfer. The DNS said if staff saw Resident #4 go to his room they would try to catch him, but he may try to do what he wanted to do and he moved fast. The DNS said Resident #4 may not have signs in his room anymore because sometimes he took the signs down, and the facility was told signs could not be placed if resident information was displayed. The DNS said she did not know what to say about the non-skid strips not being in Resident #4's bathroom, there may have been a room change and the non-skid strips did not get moved. On 6/5/19 at 11:34 AM, the DNS said it was documented once a shift that Resident #4's hourly 4-P checks were done.</p> <p>On 6/5/19 at 12:07 PM, RN #1 said she was just reminded Resident #4 was on hourly 4-P checks, and the CNAs documented it.</p> <p>On 6/5/19 at 12:12 PM, CNA #2 said she was just informed by RN #1 that staff were to check on Resident #4 hourly, and they were to document it. CNA #2 said the hourly checks should not be documented just at the end of the shift, and they were previously documented on a sheet of paper but now it was entered in the computer. CNA #2 said there was no documentation of the times the hourly checks were completed for Resident #4.</p>	F 689			

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F 689	Continued From page 23	F 689			
F 880 SS=D	<p>On 6/6/19 at 3:16 PM, the DNS said it was not possible to document hourly checks in the electronic medical record, so it was set up to document it each shift.</p> <p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</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: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other</p>	F 880		6/27/19	

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F 880	<p>Continued From page 24</p> <p>persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. 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, policy review, and staff</p>	F 880	<p>Corrective Action: An inservice has</p>		

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F 880	<p>Continued From page 25</p> <p>interview, it was determined the facility failed to ensure staff performed appropriate hand hygiene during medication administration. This was true for 1 of 12 residents (Resident #32) reviewed for infection control. This failure placed residents at risk of infection from cross-contamination. Findings include:</p> <p>The facility's policy for Hand Washing, revised May 2007, documented hand washing was the most important procedure to prevent facility-acquired infections.</p> <p>The Center for Disease Control and Prevention website, accessed 6/10/19, documented hand hygiene should be performed after touching a patient or their immediate environment, after contact with blood, body fluids, or contaminated surfaces, and immediately after removing gloves.</p> <p>On 6/6/19 at 11:41 AM, LPN #1 administered eye drops to Resident #32, removed her gloves, and did not perform hand hygiene. LPN #1 then picked up a blood glucose meter (a machine used to check the resident's blood sugar level) from Resident #32's bedside tray and returned to the medication cart. LPN #1 obtained an alcohol wipe from the medication cart and returned to Resident #32's room with the blood glucose meter. LPN #1 placed the blood glucose meter on the bedside table on a paper towel, cleansed the blood glucose meter with a disinfectant wipe, removed her gloves, and did not perform hand hygiene. LPN #1 applied new gloves and performed a blood glucose test on Resident #32's right third finger. The blood glucose meter read "error." LPN #1 removed her gloves, did not perform hand hygiene, applied new gloves,</p>	F 880	<p>been held educating all staff regarding facility infection control policies and procedures and best practices regarding washing between gloving.</p> <p>Residents affected: The deficiency had the potential to affect all residents, new admissions, staff including new hires, and visitors may be affected.</p> <p>Systematic Changes: Skills checklists are implemented to include universal precautions and will be completed for all present and newly hired staff. Checklists are conducted on a routine basis to prevent deficient practice.</p> <p>Monitor of Compliance: Director of Nursing and/or designee will spot check handwashing and gloving on a minimum of 1-2 randomly selected direct care staff alternating shifts daily x4 weeks, then weekly x8 weeks. The QAPI Committee will review until it is determined that systems are effective.</p>		

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F 880	Continued From page 26 obtained a new blood glucose test strip, and performed a blood glucose test on Resident #32's left index finger. At the end of the observation, LPN #1 said she did not perform hand hygiene after removing her gloves in Resident #32's room. On 6/6/19 at 2:40 PM, the DNS said she expected staff to perform hand hygiene with any contact with a resident when they might contact bodily fluids, before applying gloves, and after removing gloves.	F 880			

Bureau of Facility Standards

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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the state licensure survey conducted from June 3, 2019 through June 7, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Cecilia Stockdill, RN, Team Coordinator Brad Perry, LSW Sallie Schwartzkopf, LCSW</p>	C 000		
C 422	<p>02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas</p> <p>vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not provide one tub or shower for every 12 licensed beds. Findings include:</p> <p>On 6/3/19 at 8:54 AM, the Administrator stated the facility's census was 45 residents.</p> <p>On 6/7/19 at 8:50 AM, the Administrator said the previously existing nursing unit had 40 beds and 3 tubs, one of which was a double stall. No additional tubs were added to the previously existing nursing unit. The administrator said a</p>	C 422	<p>The facility requests the continuance of the waiver that has existed for many years in this facility. To ensure there is no negative impact of resident the facility employs dedicated bath aides to ensure that all showers and baths are scheduled and executed for each resident according to their choice and preference. We discuss during resident council. No residents have been negatively affected by the number of shower rooms.</p>	6/21/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 07/01/19
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C 422	Continued From page 1 new nursing unit was added to the building, which had 18 beds, and each room on the new unit had its own shower. The administrator said staff occasionally took residents from the previously existing nursing unit and showered them in an unoccupied room on the new nursing unit. There were no concerns regarding showers during interviews with multiple residents and resident representatives. The administrator requested to continue the waiver for the bathing facilities on the previously existing nursing unit.	C 422		
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of the facility's Infection Control Program and staff interview, it was determined the facility failed to ensure the required members of the Infection Control Committee attended the infection control meetings. This had the potential to affect all residents in the facility who were vulnerable to nosocomial infections. Findings include: On 6/6/19 at 2:53 PM, the facility's Infection Control program was reviewed with the DNS (Director of Nursing Services), who was covering for the Infection Control Nurse. The DNS said the Infection Control Committee met at least quarterly during their QAPI (Quality Assessment and Performance Improvement) meetings. The DNS said the Infection Control Committee consisted of the Medical Director, DNS, Infection	C 664	Corrective Action: All IDT members have been educated regarding C664 and the requirements for committee meeting attendance. Future meetings will be represented by the Medical Director, Administrator, Pharmacist, Dietary Services, Director of Nursing, Housekeeping, and Maintenance or appropriate designees from those departments. Residents Affected: The deficiency had the potential to affect all residents, new admissions, staff including new hires, and visitors. Systematic Changes: The policy/procedure for infection control	6/27/19

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C 664	<p>Continued From page 2</p> <p>Control Nurse, Dietary Manager, Administrator, a CNA (Certified Nursing Assistant), and a therapy team member. The DNS said antibiotics were reviewed with the pharmacist during the QAPI/Infection Control meetings. Upon review of the Infection Control meeting minutes, the pharmacist and maintenance representative did not attend the meetings on 1/16/19 and 5/15/19.</p> <p>On 6/6/19 at 4:16 PM, the DNS said the pharmacist and maintenance representative did not attend the QAPI/Infection Control meetings on 1/16/19 and 5/15/19. The DNS said the pharmacist would often call in to the meeting for the portion of the meeting that was pertinent, and she thought he called in for one of the previously mentioned meetings.</p>	C 664	<p>meeting attendance has been reviewed and updated. All committee members will be notified in advance for scheduled meetings. Appropriate designees will be in attendance in the event of an absence. In the event that a department can't be appropriately represented the meeting will be rescheduled for a different time.</p> <p>Monitor of Compliance: The facility administrator will monitor attendance on an ongoing basis.</p>	
C 882	<p>02.203,02,a Resident Identification Requirements</p> <p>a. Patient's/resident's name and date of admission; previous address; home telephone; sex; date of birth; place of birth; racial group; marital status; religious preference; usual occupation; Social Security number; branch and dates of military service (if applicable); name, address and telephone number of nearest relative or responsible person or agency; place admitted from; attending physician; date and time of admission; and date and time of discharge. Final diagnosis or cause of death (when applicable), condition on discharge, and disposition, signed by the attending physician, shall be part of the medical record.</p>	C 882		6/26/19

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C 882	<p>Continued From page 3</p> <p>This Rule is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to obtain a physician-signed cause of death for residents who expired in the facility. This was true for 1 of 1 resident (Resident #46) reviewed for death in the facility. Findings include:</p> <p>Resident #46 was admitted to the facility on 2/11/19, with multiple diagnoses including stroke. His nurse's progress notes documented he expired on 3/26/19. The record did not document the cause of death.</p> <p>On 6/7/19 at 10:47 AM, the Administrator said she could not find the cause of death in Resident #46's record and she would contact the physician.</p> <p>On 6/7/19 at 11:05 AM, the Administrator provided a faxed physician's note, dated 6/7/19, which documented the cause of death as sequelae of left posterior artery cerebrovascular accident (stroke). The Administrator said the physician had completed the note, based on Resident #46's death certificate, on that day.</p>	C 882	<p>Corrective Action: Facility physicians and nursing staff have been educated regarding regulation C882. Residents who expire within the facility will have a cause of death documented by a physician.</p> <p>Residents Affected: The deficiency had the potential to affect all residents.</p> <p>Systematic Changes: Cause of death listed in the medical record has been added to the medical records audit tool</p> <p>Monitor of Compliance: Medical Records will audit compliance on all facility deaths weekly x12 weeks to determine compliance. The QAPI Committee will review until it is determined that systems are effective.</p>	
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