



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
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TAMARA PRISOCK—ADMINISTRATOR  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
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July 19, 2019

Michael Crowley, Administrator  
River's Edge Rehabilitation & Living Center  
714 North Butte Avenue  
Emmett, ID 83617-2725

Provider #: 135020

Dear Mr. Crowley:

On **July 12, 2019**, a survey was conducted at River's Edge Rehabilitation & Living 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 29, 2019**. Failure to submit an acceptable PoC by **July 29, 2019**, may result in the imposition of penalties by **August 21, 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 **August 16, 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 **October 12, 2019**. A change in the seriousness of the deficiencies on **August 26, 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 **October 12, 2019** includes the following:

Denial of payment for new admissions effective **October 12, 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 **January 12, 2020**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, 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 **October 12, 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 29, 2019**. If your request for informal dispute resolution is received after **July 29, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

lt/lj

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

PRINTED: 08/01/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135020</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/12/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RIVER'S EDGE REHABILITATION &amp; LIVING CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>714 NORTH BUTTE AVENUE EMMETT, ID 83617</b>
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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	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification survey conducted at the facility from July 8, 2019 through July 12, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Brad Perry, LSW Sallie Schwartzkopf, LCSW</p> <p>Survey Abbreviations:</p> <p>CNA = Certified Nursing Assistant DON = Director of Nursing GM = Gram LPN = Licensed Practical Nurse MDS = Minimum Data Set mg = Milligram ml = Milliliter RN = Registered Nurse</p>	F 000		
F 550 SS=D	<p>Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)</p> <p>§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.</p> <p>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p>	F 550		8/12/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>07/26/2019</b>
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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 550	Continued From page 1  §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.  §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.  §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, resident and staff interview, it was determined the facility failed to maintain an environment that enhanced residents' dignity and respect when a catheter drainage bag was exposed. This was true for 1 of 2 residents (Resident #36) who were reviewed for dignity related to urinary catheters. This created the potential for psychosocial harm if residents experienced a lack of self-esteem or embarrassment due to exposed catheter	F 550	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River's Edge Rehabilitation and Living Center does not admit that the deficiencies listed on this form exists, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies.		

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F 550	<p>Continued From page 2 drainage bags. Findings include:</p> <p>The facility's catheter care policy, dated 1/2/08, directed staff to ensure urinary catheter collection bags were placed in a bag cover.</p> <p>Resident #36 was readmitted to the facility on 4/9/18, with multiple diagnoses including neuromuscular dysfunction of the bladder (difficulty or inability to pass urine).</p> <p>Resident #36's care plan documented he had an indwelling catheter for a neurogenic bladder and directed staff to position his catheter bag away from the entrance of his room door.</p> <p>On 7/9/19 at 9:30 AM, Resident #36 was in his recliner in his room with the door open. His catheter drainage bag was in a plastic wash basin to the left side of his recliner. His catheter bag was not covered. Resident #36 said he relied on staff to take care of his catheter and catheter bag.</p> <p>On 7/9/19 at 3:40 PM, Resident #36 was in his recliner in his new room (he moved to a larger room that day). His door was open and from the hallway, his catheter bag was not covered and was inside the basin.</p> <p>On 7/10/19 at 8:32 AM, CNA #1 said residents' catheter bags were to be placed in privacy bags on the side of their recliners or on the side of their beds.</p> <p>On 7/10/19 at 9:23 AM, CNA #2 said Resident #36 used a basin for his catheter bag while in his recliner. CNA #2 said the urine should not be</p>	F 550	<p>The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiencies.</p> <p>F550: Resident Rights/ Exercise of Rights</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Resident #36's catheter bag has been placed inside the privacy bag.</p> <p>Corrective action for resident that may be affected by this deficiency:</p> <p>The facility conducted an audit of current Residents that have urinary catheters to ensure that they are being used in accordance with the facility's policies and procedures. All catheters were found to be in cover bags and in compliance with the facility's policies and procedures.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the LNs and CNAs on the requirement to ensure Residents rights to be treated with respect and dignity in a manner and in an environment that promotes maintenance</p>		

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F 550	Continued From page 3 visible and the bag should be flipped over so the white portion of the bag was displayed instead.  On 7/10/19 at 1:02 PM, RN #1 said she was not aware Resident #36's urine should not be visible while in his room with the door opened. RN #1 said the facility used privacy covers while residents were in their wheelchairs or while in bed.  On 7/10/19 at 1:47 PM, the DON said she expected staff to make sure Resident #36's urinary catheter was covered by a privacy bag.	F 550	or enhancement of his or her quality of life, recognizing each Resident's individuality. Education will specifically include the requirement to ensure that catheter bags are kept in privacy bags to enhance the dignity and respect of the Residents in accordance with the facility's policies and procedures. Education will be completed by 8/2/19.  Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:  The DON, ED or designee will conduct audits of urinary catheters to ensure they are being maintained in accordance with the facility's policies and procedures. Audits will begin the week of 8/5/19. Audits will be done weekly for 4 weeks then monthly for 3 months.  The DON or ED will review and report The results of the audits monthly in QA committee meeting for 4 months, then further recommendations from the committee will be implemented as indicated.  Corrective action completed by: 8/12/19		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		8/12/19	

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F 578	Continued From page 4  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.  §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578			

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F 578	<p>Continued From page 5</p> <p>the information to the individual directly at the appropriate time. 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 information and assistance to exercise their right to formulate an Advance Directive. This was true for 5 of 6 residents (#13, #18, #20, #26, and #38) reviewed for Advance Directives. The deficient practice created the potential for harm should residents' wishes regarding end of life or emergent care not be honored when they were incapacitated. Findings include:</p> <p>The State Operations Manual defined an "Advance Directive" is "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." "Physician Orders for Life-Sustaining Treatment (or POLST) paradigm form" 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 policies for Advance Directives and Advance Directive Documentation dated 5/2007, documented the following:</p>	F 578	<p>F578: Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Affected Residents will be given information and offered assistance to exercise their right to formulate an advanced directive.</p> <p>Corrective action for resident that may be affected by this deficiency:</p> <p>All Residents have the potential to be Affected by this deficient practice. An Audit will be done to determine all current Residents who do not have advanced directives. Information will be provided and assistance to exercise their right to formulate an advanced directive will be offered.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the Director of Social Services on advanced directive regulation and the requirement to ensure that advanced directives are being discussed during quarterly care</p>		

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F 578	<p>Continued From page 6</p> <p>* Prior to, upon, or immediately after admission, the facility will ask residents, and/or their family members, about the existence of any advance directives</p> <p>* Should the resident indicate that he or she has issued advance directives about his/her care and treatment, the facility will request that a copy of such directive be included in the medical records</p> <p>* Provide written information to residents at the time of admission regarding their right under State Law to accept or refuse medical treatment and the right to formulate Advance Directives</p> <p>* Include documentation in the resident's health record that, at the time of admission, the residents have been provided with written information regarding the advance directives and whether the resident had executed such a document</p> <p>The facility policies were not followed.</p> <p>Examples include:</p> <p>a. Resident # 18 was admitted to the facility on 7/11/13, with multiple diagnoses which included dementia and heart failure.</p> <p>An Advance Directive care plan, dated 3/12/18, documented Resident #18 had an advance directive of DNR.</p> <p>An Idaho Physician Orders for Scope of Treatment (POST), dated 12/14/12, was under the Advance Directive tab in Resident #18's paper record. The POST, signed by Resident</p>	F 578	<p>plan reviews and that the discussion is documented. Education will be completed by 8/2/19.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The ED or designee will audit documentation of advanced directive discussions monthly. Audits will begin the week of 8/5/19.</p> <p>The ED will review and report the results of the audits monthly in QA committee meeting for 4 months, then further recommendations from the committee will be implemented as indicated.</p> <p>Corrective action completed by: 8/12/19</p>		

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F 578	<p>Continued From page 7</p> <p>#18's daughter, documented a DNR with limited additional interventions. There was not an Advance Directive in Resident #18's record.</p> <p>b. Resident #38 was admitted to the facility on 4/18/17, with multiple diagnoses which included chronic kidney disease and diabetes mellitus.</p> <p>An Advance Directive care plan, dated 3/12/18, documented Resident #38 had an advance directive of DNR. An intervention communicated, "for additional advance directives, please see POST."</p> <p>A POST, dated 1/17/17, was under the Advance Directive tab in Resident #38's paper record. The POST, signed by Resident #38, documented a DNR with comfort measures only. There was not an Advance Directive in Resident #38's record.</p> <p>c. Resident #13 was admitted to the facility on 4/18/19, with multiple diagnosis including cerebral infarction (stroke).</p> <p>Resident #13's care plan, dated 5/21/19, directed staff to obtain a DNR order or appropriate Advance Directive.</p> <p>Resident #13's record did not contain an Advance Directive nor documentation the facility offered Resident #13 or Resident #13's representative information or assistance on Advance Directives.</p> <p>d. Resident #20 was admitted to the facility on 8/3/18, with diagnosis of femur fracture and Alzheimer's disease.</p>	F 578			

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F 578	<p>Continued From page 8</p> <p>On 7/10/19 at 9:10 AM Resident #20's daughter stated she was involved in plan of care discussions, reported a DNR was in place and she was the Power of Attorney for Healthcare (POA-HC. She also stated Resident #20 had a durable power of attorney, and she did not believe he had a living will but was going to look for it.</p> <p>Resident #20's record did not contain an Advance Directive or POA-HC as mentioned by his daughter. There was no documentation the facility offered Resident #20 or Resident #20's representative information or assistance on Advance Directives.</p> <p>e. Resident #26 was admitted to the facility on 12/3/18, with multiple diagnosis including chronic kidney disease and heart failure.</p> <p>Resident #26's record did not contain an Advance Directive nor documentation the facility offered Resident #26 or Resident #26's representative information or assistance on Advance Directives.</p> <p>On 7/10/19 at 8:56 AM, the Director of Social Services (DSS) stated Advance Directives were either in the electronic medical record or in the resident paper charts under the Advance Directives tab.</p> <p>On 7/10/19 at 9:45 AM, the DSS was informed that only the POST form was found for Residents #18, #26, and #38. The DSS asked, "Isn't the POST an Advanced Directive?" The DSS stated she thought the POST was an advance directive, "They say the same thing."</p>	F 578			

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

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FORM APPROVED  
OMB NO. 0938-0391

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F 582 SS=D	<p>Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)</p> <p>§483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.</p> <p>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident</p>	F 582		8/12/19	

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F 582	<p>Continued From page 10</p> <p>representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with an Advance Beneficiary Notice (ABN) at the termination of their Medicare Part A benefits. This was true for 2 of 3 residents (#16 and #23) reviewed for ABN. This failure created the potential for residents to experience financial and psychological distress when residents were not informed of their potential liability for payment. Findings include:</p> <p>The facility's Advance Beneficiary Notice policy, dated 2018, directed facility staff to issue an ABN before services were delivered to inform the Medicare beneficiary that services may not be paid for by Medicare and they, the resident, may assume the responsibility.</p> <p>This policy was not followed.</p> <p>a. Resident #16 was admitted to the facility on 4/8/19, with multiple diagnosis including type 2</p>	F 582	<p>F582: Medicaid/Medicare Coverage/Liability Notice</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Residents #16 and #23 were provided Advance Beneficiary Notices on 7/12/19.</p> <p>Corrective action for resident that may be affected by this deficiency:</p> <p>The facility conducted an audit of current Residents that had the potential to be affected by this deficient practice. One additional Resident was identified and he was provided an Advance Beneficiary Notice on 7/12/19.</p> <p>Measures that will be put into place</p>		

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F 582	<p>Continued From page 11 diabetes mellitus.</p> <p>Resident #16's record included a Census List (list of admissions, payer change, and discharge dates) which documented his Medicare Part A benefits ended on 4/26/19, and he remained in the facility. His record did not include an ABN.</p> <p>b. Resident #23 was admitted to the facility on 2/15/19, with multiple diagnoses including right femur fracture.</p> <p>Resident #23's record also included a Census List which documented his Medicare Part A benefits ended on 4/7/2019, and he remained in the facility. His record did not include an ABN.</p> <p>On 7/11/19 at 11:05 AM the MDS Coordinator stated she did not provide the ABN to Resident #16 and Resident #23 before their Part A Medicare coverage ended.</p>	F 582	<p>to ensure that this deficiency does not recur:</p> <p>ED or designee will educate the Business Office Manager and the MDS Coordinator on the requirement to ensure that Residents receive an Advance Beneficiary Notice at the Termination of their Medicare Part A benefits in accordance with the facility's policies and procedures. Education will be completed by 8/2/19.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The ED or designee will conduct monthly audits of Residents who have their Medicare Part A benefits terminated to ensure that Advance Beneficiary Notices are Being provided in accordance with the facility's policies and procedures. Audits will begin the week of 8/5/19.</p> <p>The ED or Designee will review and report The results of the audits monthly in QA committee meeting for 4 months, then further recommendations from the committee will be implemented as indicated.</p>		

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F 582	Continued From page 12	F 582			
F 584 SS=D	<p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide-</p> <p>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature</p>	F 584	<p>Corrective action completed by: 8/12/19</p>	8/12/19	

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F 584	<p>Continued From page 13 levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a clean and homelike environment. This was true for 2 of 12 residents (#20 and #25) whose environment was observed. This deficient practice created the potential for harm if residents were embarrassed by odors and dirty equipment, and/or felt the lack of cleanliness was unacceptable, disrespectful, or undignified. Findings include:</p> <p>The facility's commode and equipment cleaning policies, dated 5/2007 and 3/2009, directed staff to clean commodes after each use, and to clean and disinfect equipment surfaces of urine and feces. This policy was not followed. Residents #20 and #25 shared a room which had a strong, foul odor whether or not they were in their room. The odor was evident on 7/8/19 at 9:30 AM, 10:37 AM, 3:25 PM, on 7/10/19 at 8:46 AM, and on 7/11/19 at 8:46 AM, 9:08 AM, and 9:20 AM.</p> <p>On 7/11/19 at 9:20 AM, Resident #20's and Resident #25's bedside commodes were both near the foot of Resident #25's bed where the odors were strongest. Resident #20's bedside commode had streaks of feces down the outside and inside of the waste container and had dried feces on the underside of the seat. Resident</p>	F 584	<p>F584: Safe/Clean/Comfortable/Homelike Environment</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Residents #20 and #25 have been moved to different rooms. The room that Residents #20 and #25 share has been deep cleaned, including the bedside commodes and the sub floor is being replaced on 7/29/19.</p> <p>Corrective action for resident that may be affected by this deficiency:</p> <p>All Residents have the potential to be affected by this deficient practice. Audits will be conducted of all Resident rooms to ensure that they are a clean and homelike environment. Audits will include bedside commodes and other equipment. Audits will also include ensuring that odors are appropriate and consistent with a clean homelike environment.</p>		

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F 584	<p>Continued From page 14</p> <p>#25's bedside commode had particles of feces and dried urine in the bottom of the waste container.</p> <p>On 7/11/19 at 9:37 AM, LPN #1 was in Resident #20's and Resident #25's shared room and said she could smell the odors and she could not identify what the smells were. LPN #1 lifted both commode seats and she said they were not clean and there was feces on the underside of Resident #20's commode seat.</p> <p>On 7/11/19 at 9:42 AM, the Housekeeping Supervisor stated the facility had already replaced the mattresses and floor mats for both Resident #20 and Resident #25 due to a urine odor. She said the next step would be to replace the floor due to urine smells coming from the floor. She said housekeeping staff had not been in to clean the room that day. The Housekeeping Supervisor lifted both bedside commode seats and she said they were not clean. She said the feces residue on Resident #20's commode was not a fresh stain. She said CNAs were expected to empty the commodes and wipe them out after each use and the housekeepers were to disinfect them every day.</p> <p>On 7/11/19 at 9:46 AM, CNA #3 said it was the CNAs' responsibility to empty and wipe down the bedside commodes. She said Resident #20's and Resident #25's commodes were not clean. CNA #3 said Resident #25 used his commode every day.</p> <p>On 7/11/19 at 9:50 AM, CNA #4 said Resident #20 did not use his commode very often and did not recall him using it in the last week. CNA #4</p>	F 584	<p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the Housekeeping Staff, Maintenance Staff and CNAs on the requirement to ensure that the facility is providing a clean homelike environment for our Residents in accordance with the facilities policies and procedures. Education will be completed by 8/2/19.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The DON, ED or designee will conduct random audits of Residents rooms to ensure that the facility is providing a clean homelike environment. Audits will begin the week of 8/5/19. Audits will be done weekly for 4 weeks then monthly for 3 months.</p> <p>The DON or ED will review and report The results of the audits monthly in QA committee meeting for 4 months, then further recommendations from the committee will be implemented as indicated.</p> <p>Corrective action completed by: 8/12/19</p>		

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F 584	Continued From page 15 said it was the CNAs' responsibility to clean out the bedside commodes.  On 7/11/19 at 12:00 PM, the Maintenance Director said he was aware of the odors in Resident #20's and Resident #25's room and he said he used a scrubber on the floor the previous month to try and rid the room of the odors without much success.	F 584			
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 and staff interview, it was determined the facility failed to ensure professional standards of practice were followed for medication administration. This was true for 2 of 2 residents (#1 and #18) reviewed for bowel care. This failed practice created the potential for residents to experience complications related to constipation if they did not receive the necessary treatment. Findings include:  a. Resident #1 was admitted to the facility on 9/11/14, with multiple diagnoses which included cerebellar ataxia (a degenerative disease of the nervous system) and constipation.	F 684	F684: Quality of Care  Corrective action for residents found to have been affected by this deficiency:  Residents #1 and #18 had bowel care protocol added to their medical records.  Corrective action for resident that may be affected by this deficiency:  All Residents have the potential to be affected by this deficient practice. The facility conducted an audit of	8/12/19	

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F 684	<p>Continued From page 16</p> <p>A quarterly MDS assessment, dated 6/20/19, documented Resident #1 was cognitively intact, dependent on 2 plus staff members for toileting assistance, and was occasionally incontinent of bowel.</p> <p>Resident #1's physician's orders, dated 9/11/14, included Dulcolax suppository every 8 hours as needed for constipation and Fleets enema every 8 hours as needed for constipation if Dulcolax was ineffective after 8 hours.</p> <p>Resident #1's physician's orders, dated 1/24/17, included Docusate Sodium 100 mg one time daily for constipation and Senna tablet, 2 tablets daily for constipation. The order included Milk of Magnesia as needed for constipation after 3 days with no bowel movement.</p> <p>Resident #1's bowel monitoring for June 2019, had no bowel movements documented for 6 days, from 6/23/19 through 6/28/19.</p> <p>Resident #1's Medication Administration Record for June 2019, documented she received Milk of Magnesia on 6/22/19 and 6/28/19. The Dulcolax suppository and Fleets enema were not administered as ordered by her physician.</p> <p>b. Resident #18 was admitted to the facility on 7/11/13, with multiple diagnoses which included gastrointestinal hemorrhage.</p> <p>A quarterly MDS assessment, dated 5/14/19, documented Resident #18 had moderately impaired cognition, required extensive one-person assistance with toileting, and was occasionally incontinent of bowel.</p>	F 684	<p>current Residents to determine Residents that did not have a bowel protocol in their medical records. Bowel protocol was added to all Residents' routine standing orders.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the LNs on bowel protocol. Education will be completed by 8/2/19.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The DON or designee will audit bowel documentation to ensure facility is following the bowel protocol. Audits will begin the week of 8/5/19. Audits will be done weekly for 4 weeks then monthly for 3 months.</p> <p>The DON or ED will review and report the results of the audits monthly in QA committee meeting for 4 months, then further recommendations from the committee will be implemented as indicated.</p> <p>Corrective action completed by: 8/12/19</p>		

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F 684	Continued From page 17  Resident #18's physician's orders, dated 4/14/14, included Milk of Magnesia daily as needed for constipation after 3 days with no bowel movement, Dulcolax suppository every 8 hours as needed for constipation and Fleets enema every 8 hours as needed for constipation if Dulcolax was ineffective after 8 hours.  On 11/5/18, a physician's order directed staff to provide Resident #18 with Colace daily for hard stool.  Resident #18's bowel monitoring for June 2019, had no bowel movement documented for 5 days, from 6/24/19 through 6/28/19.  Resident #18's Medication Administration Record for June 2019, documented she received Milk of Magnesia on 6/28/19. The Dulcolax suppository or Fleets enema were not administered as ordered by her physician.  On 7/10/19 at 12:40 PM, the DON stated the nurses completed a list of residents who have not had a bowel movement daily. The DON stated she was not sure how Resident #1 and Resident #18 were missed.	F 684			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		8/12/19	

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F 761	<p>Continued From page 18</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, it was determined the facility failed to securely store controlled medications. This was true for 1 of 1 resident (Resident #7) whose medication was observed during the inspection of the medication storage room. This failed practice created the potential for harm if the controlled medication was diverted because it was not secured. Findings include:  The facility's policy Pharmacy Services and Procedures, dated 5/2007, directed staff to store medications listed as Schedules II, III, IV, and V under double lock in a locked cabinet or safe designated for that purpose.  On 7/11/19 at 8:57 AM, an inspection of the locked medication storage room was completed</p>	F 761	<p>F761: Label/Store Drugs and Biologicals</p> <p>Corrective action for residents found to have been affected by this deficiency:  A lock was placed on the refrigerator where Resident # 7's medication being stored on 7/11/19.</p> <p>Corrective action for resident that may be affected by this deficiency:  All Residents have the potential to be affected by this deficient practice. An audit was done to ensure that all schedule II, III, IV, and V medications</p>		

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F 761	Continued From page 19 with the DON present. The medication storage room had an unlocked refrigerator for the storage of temperature-controlled medications. Among the medications in the refrigerator was a bottle of Lorazepam solution, 2 mg/ml. Lorazepam is a class of medications called benzodiazepines, which is a Schedule IV medication. The pharmacy label identified the medication was for Resident #7 who was admitted to the facility on 4/21/16. The refrigerator had 2 individually locked boxes filled with various controlled medications. The DON stated there was no room for any more medication in the locked boxes.	F 761	<p>are stored under double lock in a locked cabinet or safe designated for that purpose.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the LNs on the Facility's Pharmacy Services policy and procedure and the requirement to ensure that all schedule II, III, IV, and V medications are stored under double lock in a locked cabinet or safe designated for that purpose.</p> <p>Education will be completed by 8/2/19.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The DON or designee will conduct monthly audits of medication storage to ensure they are being stored in accordance with the facility's policies and procedures. Audits will be done monthly for 4 months. Audits will begin the week of 8/5/19.</p> <p>The DON or ED will review and report The results of the audits monthly in QA committee meeting for 4 months, then further recommendations from the committee will be implemented as</p>		

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F 761	Continued From page 20	F 761	indicated.		
F 880 SS=D	<p>Infection Prevention &amp; 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 persons in the facility;</p>	F 880	<p>Corrective action completed by: 8/12/19</p>	8/12/19	

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F 880	<p>Continued From page 21</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the</p>	F 880	F880: Infection Prevention & Control		

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F 880	<p>Continued From page 22</p> <p>facility failed to ensure urinary catheter bags were not placed on the floor. This was true for 1 of 1 resident (Resident #36) reviewed for urinary catheter use. This deficient practice placed residents at risk of infection and cross-contamination. Findings include:</p> <p>The facility's catheter care policy, dated 1/2/08, directed staff to ensure proper care of catheters was provided to prevent infection.</p> <p>Resident #36 was readmitted to the facility on 4/9/18, with multiple diagnoses including neuromuscular dysfunction of the bladder (difficulty or inability to pass urine) caused by neurologic damage.</p> <p>On 7/10/19 at 8:17 AM and 8:30 AM, Resident #36 was in his recliner in his room. His catheter drainage bag was on the floor with part of the upper bag positioned on top of the tray table leg. At 8:30 AM, CNA #1 was in Resident #36's room to remove his breakfast tray, and left the room without moving the catheter bag off the floor.</p> <p>On 7/10/19 at 9:20 AM, Resident #36's catheter bag was on the floor and on top of the tray table leg.</p> <p>On 7/10/19 at 9:23 AM, CNA #2 was shown Resident #36's catheter bag on the floor and she said it should have been in the plastic wash basin and not on the floor. CNA #2 looked around the recliner and said the basin was underneath the recliner and said she would fix the catheter bag.</p> <p>On 7/10/19 at 12:11 PM, Resident #36 was back from his appointment and was in his recliner in</p>	F 880	<p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Resident #36's catheter bag has been placed inside a privacy bag and placed in a manner consistent with the facility's policy and procedure related to catheter care.</p> <p>Corrective action for resident that may be affected by this deficiency:</p> <p>The facility conducted an audit of current Residents that have urinary catheters to ensure that they are being used in accordance with the facility's policies and procedures.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>DON, SDC or designee will educate the LNs and CNAs on facility's policies procedures related to proper catheter care to prevent infections. Education will be completed by 8/2/19.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The DON, SDC or designee will</p>		

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F 880	<p>Continued From page 23</p> <p>his room. His catheter bag was on the floor and it was sandwiched between his recliner and his trash can, touching all three surfaces.</p> <p>On 7/10/19 at 1:02 PM, RN #1 said Resident #36's catheter bag should not have been left on the floor due to infection control concerns. RN #1 said Resident #36's catheter bag was to be in the basin because he moved around a lot in his recliner and the basin helped protect the bag from getting a hole in it.</p> <p>On 7/10/19 at 1:47 PM, the DON said she expected staff to keep Resident #36's catheter bag off of the floor.</p>	F 880	<p>conduct audits of urinary catheters to ensure they are being maintained in accordance with the facility's policies and procedures. Audits will begin the week of 8/5/19. Audits will be done weekly for 4 weeks then monthly for 3 months.</p> <p>The DON or ED will review and report The results of the audits monthly in QA committee meeting for 4 months, then further recommendations from the committee will be implemented as indicated.</p> <p>Corrective action completed by: 8/12/19</p>		

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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiency was cited during the state licensure survey conducted at the facility from July 8, 2019 through July 12, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Edith Cecil, RN, Team Coordinator Brad Perry, LSW Sallie Schwartzkopf, LCSW</p>	C 000		
C 664	<p>02.150,02,a Required Members of Committee</p> <p>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 staff interview and review of Infection Control Committee (ICC) attendance records, it was determined the facility failed to ensure the Pharmacist and a housekeeping/maintenance services representative participated in ICC meetings at least quarterly. This failure created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings include:</p> <p>On 7/12/19 at 9:30 AM, the facility's Infection Control Program was reviewed with the Administrator. The Administrator stated the ICC met monthly.</p> <p>Review of the ICC sign-in sheets from July 2018 to June 2019, provided by the facility showed the Pharmacist and a housekeeping/maintenance services representative did not attend at least one meeting during the second quarter from</p>	C 664	<p>C664: Required Members of Committee</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>No specific Residents were affected by this deficient practice.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>ED or designee will educate the Infection Control Committee (ICC) Members on the requirement to have the Pharmacist and a housekeeping/maintenance services representative</p>	8/12/19

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  07/26/19
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C 664	<p>Continued From page 1</p> <p>October 2018 to December 2018.</p> <p>A housekeeping/maintenance services representative did not attend at least one meeting during the third quarter from January 2019 to March 2019.</p> <p>The Pharmacist and a housekeeping/maintenance services representative did not attend at least one meeting during the fourth quarter from April 2019 to June 2019.</p> <p>On 7/12/19 at 9:30 AM, the facility's Infection Control Program was reviewed with the Administrator. The Administrator stated the ICC met monthly. The Administrator stated he did not believe the required committee members always attended the Infection Control Committee meetings at least quarterly.</p>	C 664	<p>attend an ICC meeting at least quarterly. The Maintenance Director and Housekeeping Supervisor have been invited to join the ICC and will do so beginning 7/30/19. Education will be completed by 8/2/19.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The ED or designee will audit the ICC meetings monthly to ensure the required attendees are participating in the meetings. Audits will begin the week of 8/5/19. Audits will be done monthly for 4 months.</p> <p>The DON or ED will review and report The results of the audits monthly in QA committee meeting for 4 months, then further recommendations from the committee will be implemented as indicated.</p> <p>Corrective action completed by: 8/12/19</p>	