



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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3232 Elder Street
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Boise, Idaho 83720-0009
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August 6, 2019

Cole Clarke, Administrator
McCall Rehabilitation And Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

Dear Mr. Clarke:

On **July 26, 2019**, a survey was conducted at McCall Rehabilitation And Care 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.

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 **August 16, 2019**. Failure to submit an acceptable PoC by **August 16, 2019**, may result in the imposition of penalties by **September 8, 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 30, 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 26, 2019**. A change in the seriousness of the deficiencies on **September 9, 2019**, may result in a

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change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 26, 2019** includes the following:

Denial of payment for new admissions effective **October 26, 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 26, 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 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 26, 2019** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

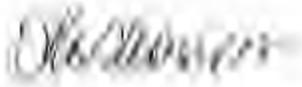
- BFS Letters (06/30/11)

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

This request must be received by **August 16, 2019**. If your request for informal dispute resolution is received after **August 16, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

lt/dr

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

PRINTED: 08/23/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/26/2019
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MCCALL, ID 83638		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted from July 22, 2019 through July 26, 2019. The surveyors conducting the survey were: Cecilia Stockdill, RN Team Coordinator Jenny Walker, RN Sallie Schwartzkopf, LCSW Survey Abbreviations: CNA = Certified Nursing Assistant DNS = Director of Nursing Services LSW = Licensed Social Worker MDS = Minimum Data Set RN = Registered Nurse	F 000			
F 578 SS=D	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	F 578		8/26/19	

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

TITLE

(X6) DATE

Electronically Signed

08/15/2019

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

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F 578	<p>Continued From page 1</p> <p>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 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the resident or the resident's representative received information and assistance to exercise their right to formulate an Advance Directive. This was true for 1 of 4 residents (Resident #15) reviewed for an Advance Directive. The deficient practice created the potential for harm should resident's wishes regarding end of life or emergent care not be honored when they were incapacitated. Findings include:</p>	F 578	<p>1. Resident #15's Guardian has been sent information on Advanced Directives and contacted over the phone to offer assistance in completing the documents.</p> <p>2. All residents' records were reviewed to ensure documentation of Advance Directives and that advanced directives were explained to resident/guardian and assistance offered to help with completing the forms as needed.</p> <p>3. The requirements for explaining and</p>		

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F 578	Continued From page 2 Resident #15 was admitted to the facility on 4/22/14, with multiple diagnoses including vascular dementia and cognitive communication deficit. Resident #15's record did not contain an Advance Directive or documentation the facility provided Resident #15 or Resident #15's representative information on an Advance Directive, and offered assistance to develop an Advance Directive if desired. On 7/23/19 at 3:48 PM, the Admission Coordinator reviewed Resident #15's record and said it did not include an Advance Directive. The Admission Coordinator said Resident #15's record did not include documentation the facility discussed with Resident #15 or Resident #15's representative Advance Directives or assistance to complete an Advance Directive.	F 578	documenting Advance Directives have been reviewed with the Social Services Director. Discussion with the resident/guardian about advance directives during the admission process will be documented by Social Services Director or designee. All care conferences will include a discussion/review on completing advance directives if they are not already in place. The "Care Plan Conference Summary" for used at care conferences has been updated to include a section to document discussion on Advance Directives. 4. To monitor performance and ensure corrective action was effective and compliance sustained, DNS or designee will report in QAPI monthly for the next 3 months on the audits of new admissions/quarterly care plan conferences to confirm that this discussion has taken place and assistance offered in completing the Advanced Directive forms as needed. If compliance is achieved for three months, the audits will be discontinued.		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		8/26/19	

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F 580	<p>Continued From page 3</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations</p>	F 580			

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F 580	<p>Continued From page 4 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure a resident's representative was notified in a timely manner of a resident's significant change in condition which required hospitalization. This was true for 1 of 4 residents (Resident #30) reviewed for notification of changes. This placed the resident at risk of inappropriate care and treatment due to lack of advocacy and involvement by their representative. Findings include:</p> <p>Resident #30 was admitted to the facility on 10/10/18, with multiple diagnoses including dementia with behaviors.</p> <p>A Nurse's Progress Note, dated 5/20/19 at 5:24 PM, documented Resident #30 was attempting to exit the building. The facility staff were attempting to redirect him and Resident #30 became physically and verbally abusive to a staff member. The police, Emergency Medical Services (EMS), and the physician were notified of the behaviors and Resident #30 was sent to the ER (emergency room) for an evaluation. Resident #30 was admitted to the hospital.</p> <p>A Nurse's Progress Note, dated 5/21/19 at 4:50 PM, documented the LSW notified Resident #30's spouse he was admitted to the hospital for the incident that happened on 5/20/19.</p> <p>On 7/25/19 at 3:28 PM, the DNS was unable to provide additional documentation Resident #30's spouse was notified he was sent to the ER on</p>	F 580	<ol style="list-style-type: none"> 1. The family of resident #30 was notified of the residents' discharge to the hospital on 5/21/19. He is no longer a resident at the facility. 2. All residents that had transferred to the hospital had the potential to be affected by this issue. No other residents are know to have been affected by this practice. 3. All licensed staff will be in-serviced on timely reporting to family/representative upon a transfer to the hospital or other setting. Transfers out of the facility will be reviewed 5 day/week x 4 and then monthly x 3 in stand up to confirm that notification calls were made. 4. To monitor performance and ensure corrective action was effective and compliance sustained, the Administrator or designee will review audits weekly x 4 and then monthly x 3 to ensure that all the necessary calls have been made for any transfers out of the facility. Results of audits will be reviewed monthly in QAPI. If compliance is achieved for three months, the audits will be discontinued. 		

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F 580	Continued From page 5 5/20/19. The DNS stated the facility should have notified Resident #30's spouse he was sent to the hospital the day of the incident on 5/20/19. On 7/25/19 at 3:35 PM, the LSW stated she did not notify Resident #30's spouse he was sent to the hospital until 5/21/19. The LSW stated the facility staff thought his spouse was in the facility visiting when he was sent to the ER. On 7/25/19 at 3:41 PM, the Administrator stated Resident #30 was verbally upset towards his spouse on 5/20/19 and she left the facility. The Administrator stated the physician was notified of Resident #30's behavior, and per the physician's orders, police and EMS were called. The Administrator stated Resident #30's spouse had left the facility and was not aware he was sent to the hospital.	F 580			
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		8/26/19	

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F 655	<p>Continued From page 6</p> <p>(C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.</p> <p>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-</p> <p>(i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).</p> <p>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <p>(i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a resident's code status was documented on their baseline care plan. This was true for 1 of 2 residents (Resident #130) reviewed for baseline care plans. This failure created the potential for harm should a residents' wishes not be followed regarding their code status due to lack of information on the baseline care plan. Findings include:</p>	F 655	<p>1. Resident #130 is no longer residing in the facility.</p> <p>2. All residents of the facility have the potential to be affected by this practice. All residents' records have been reviewed to ensure that their current code status has been documented on their care plan.</p> <p>3. Code status has been added to the</p>		

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F 655	Continued From page 7 Resident #130 was admitted to the facility on 7/16/19, with multiple diagnoses including cognitive communication deficit, history of stroke, and left bundle branch block (a delay or blockage in the electrical impulse traveling through the heart). Resident #130's physician orders documented Do Not Resuscitate (DNR), dated 7/17/19. Resident #130's Preferred Intensity of Care form documented she was a DNR, and it was signed by her representative on 7/16/19. Resident #130's Initial Care Plan, dated 7/16/19, did not include documentation regarding her code status. On 7/25/19 at 2:50 PM, the DNS said Resident #130's code status was not documented on the baseline care plan. The DNS said the facility typically documented the code status on the initial care plan within 48 hours.	F 655	checklist completed by the admission nurse. All nurses doing admissions will be in-serviced on ensuring that the code status for each resident is completed at admission. 4. To monitor performance and ensure corrective action was effective and compliance sustained, LSW or designee will audit weekly x 4 and then monthly x 3 all admissions to ensure that code status has been documented on the base line care plan. Results of these audits will be reported in the monthly QAPI meeting. If compliance is achieved for three months, the audits will be discontinued.		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		8/26/19	

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F 657	<p>Continued From page 8 resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and resident, resident family member, and staff interview, it was determined the facility failed to ensure care plans were revised and updated as care needs changed. This was true for 1 of 13 residents (Resident #13) whose care plans were reviewed. This failure created the potential for harm if cares and/or services were provided based on inaccurate information on the care plan. Findings include:</p> <p>The facility's policy for Comprehensive Person-Centered Care Planning, revised August 2017, documented each resident's care plan was reviewed and/or revised by the Interdisciplinary Team (IDT) after each assessment.</p> <p>Resident #13 was admitted to the facility on 5/2/16, with multiple diagnoses including cerebrovascular disease (a medical condition</p>	F 657	<ol style="list-style-type: none"> The care plan of resident #13 has been revised and updated to reflect her current code status. All other residents are potentially at risk. All residents' care plans he been reviewed to ensure that the correct code status is documented. Code status will be discussed at all care conferences. All licensed nurses and IDT members involved in car planning have been educated on revising and updating care plans as resident needs change. To monitor performance and ensure corrective action was effective and compliance sustained, DON/designee will conduct change of condition audits 5 		

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F 657	<p>Continued From page 9</p> <p>that affects blood vessels of the brain), aphasia (the loss of ability to understand or express speech), and cognitive communication deficit.</p> <p>Resident #13's care plan documented she was not to be resuscitated, Do Not Resuscitate (DNR), and to provide comfort measures and limited interventions, initiated on 6/18/19. The care plan also documented Resident #13 wanted cardiorespiratory resuscitation (CPR) and was a Full Code, initiated one day later on 6/19/19.</p> <p>Resident #13's Care Plan Conference Summary, dated 6/18/19, documented she changed her code status from DNR to Full Code.</p> <p>Resident #13's record included a physician order, dated 6/18/19, for Full Code and her Preferred Intensity of Care form documented she wished for all efforts at revival in the event of sudden death (Full Code).</p> <p>On 7/23/19 at 3:35 PM, LPN #1 said Resident #13's code status was no longer DNR, she recently went to the doctor and it was changed to Full Code.</p> <p>On 7/23/19 at 4:11 PM, the LSW said Resident #13 recently had a care conference and she updated her code status. The LSW said the information on the care plan that documented DNR was an error.</p> <p>On 7/23/19 at 4:26 PM, the DNS said Resident #13 recently had a care conference and she changed her code status to Full Code. The DNS said Resident #13's care plan included previous information that was not correct regarding her</p>	F 657	<p>days/week x 4 and then monthly x 3 to ensure changes of condition are identified and care plans updated. Audit results will be reported monthly in QAPI. If compliance is achieved for three months, the audits will be discontinued.</p>		

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F 657	Continued From page 10 code status.	F 657			
F 676 SS=D	<p>Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)</p> <p>§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:</p> <p>§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...</p> <p>§483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:</p> <p>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,</p> <p>§483.24(b)(2) Mobility-transfer and ambulation, including walking,</p> <p>§483.24(b)(3) Elimination-toileting,</p> <p>§483.24(b)(4) Dining-eating, including meals and snacks,</p> <p>§483.24(b)(5) Communication, including (i) Speech,</p>	F 676		8/26/19	

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F 676	<p>Continued From page 11</p> <p>(ii) Language, (iii) Other functional communication systems. 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 provide showers and communication assistance as needed. This was true for 2 of 12 residents (#13 and #18) whose activities of daily living were reviewed. This failure placed the residents at risk of psychosocial distress related to embarrassment and/or isolation from not receiving showers and not being able to communicate. Findings include:</p> <p>1. The facility's policy for Restorative Care, revised 11/2017, documented objectives for providing direct nursing care services that maintained "optimum physical and mental health for the resident and meet all his medical treatment needs," and "Participate in the retraining of the resident in self-care activities." Residents would be evaluated on their ability to carry out activities of daily living (ADLs), including the ability to understand speech and talk.</p> <p>Resident #13 was admitted to the facility on 5/2/16, with multiple diagnoses including cerebrovascular disease (a medical condition that affects blood vessels of the brain), aphasia (the loss of ability to understand or express speech), and cognitive communication deficit.</p> <p>Resident #13's quarterly MDS assessment, dated 5/27/19, documented she had unclear speech and was rarely/never understood, she usually understood others, and she was severely cognitively impaired.</p>	F 676	<p>1. The care plan for resident #18 has been reviewed and updated to reflect the residents' preference for shower times. Resident #13's care plan has been revised to reflect her preference for communication.</p> <p>2. All residents had the potential to be affected by this practice of failing to provide showers as scheduled and use of appropriate communication devices. Showers are being provided per the schedule and documented. All residents assessed for hygiene, mobility, toileting, dining, bathing, and communication ADL's and care plans updated as indicated.</p> <p>3. In order to ensure that this practice doesn't reoccur, all nursing staff have been in-serviced on the importance of providing hygiene, bathing, mobility, toileting, dining and communication per the plan of care.</p> <p>4. To monitor performance and ensure corrective action was effective and compliance sustained, DNS or designee will review the shower schedule 3 times per week x 4 and then monthly x 3. New admits with communication deficits will have speech therapy screen for the need of a communication device. Compliance to this requirement will be reported monthly to the QAPI committee. If</p>		

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F 676	<p>Continued From page 12</p> <p>Resident #13's care plan documented she had a computerized communication device, a Dynavox, and communication cards and staff were to use these communication tools as recommended by Speech Therapy (ST), initiated on 1/24/19.</p> <p>An ST discharge summary, signed by the Speech Therapist on 1/22/19, documented Resident #13 required daily assistance and encouragement from staff to use her communication device, the Dynavox. The discharge summary stated Resident #13 wanted and was able to use the communication device but did not have the staff support or knowledge. The summary also stated staff needed continued encouragement and familiarization with the ST tools and this should be done with the Restorative Program. The ST discharge summary stated a communication program was established with the restorative aide.</p> <p>A progress note, dated 3/27/19 at 10:47 AM, documented "Will discontinue program for now as Resident [sic] is not showing improvement...doesn't retain how to use Dynavox, one worded questions work best at this time. She tends to get overwhelmed which seems to upset her."</p> <p>A Care Plan Conference summary, dated 6/18/19, documented Resident #13 had a Dynavox for communication and communication was a barrier. There was no further documentation in the summary about Resident #13's barriers to communication or how it was going to be addressed.</p>	F 676	<p>compliance is achieved for three months, the audits will discontinued.</p>		

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F 676	<p>Continued From page 13</p> <p>A Care Conference note, dated 6/18/19 at 4:58 PM, stated Resident #13 continued to experience frustration regarding not being able to communicate, and she attempted to write her responses but was unsuccessful.</p> <p>On 7/23/19 at 3:52 PM, Resident #13's family member said he never saw Resident #13 use the Dynavox or staff attempt to use it with her. When asked if she liked the Dynavox, Resident #13 shook her head side-to-side indicating "no."</p> <p>On 7/23/19 at 4:01 PM, a Dynavox was observed on the counter in Resident #13's room and it was plugged into the wall outlet. CNA #1 said it was hard to communicate with Resident #13 and her yes/no questions were "confused." CNA #1 said Resident #13 had a communication device, but she never saw it being used. CNA #1 said she did not know how to use the communication device.</p> <p>On 7/23/19 at 4:46 PM, LPN #2 said Resident #13 had pictures on her wall (used as communication aids) but she did not use them. LPN #2 said she had never seen Resident #13 use the Dynavox and staff did not touch it. LPN #2 said she thought Resident #13 used to be on a Restorative Program.</p> <p>On 7/24/19 at 8:52 AM, CNA #2 said the Speech Therapist previously trained her on Resident #13's Dynavox. CNA #2 said Resident #13 did not like to use the Dynavox very much and she became a little overwhelmed with it. CNA #2 said the last time Resident #13 used the Dynavox was about 2 weeks ago, and it was not part of her Restorative Program. CNA #2 said other staff</p>	F 676			

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F 676	<p>Continued From page 14</p> <p>knew Resident #13 did not like to use the Dynavox, and she did not know if it was discontinued. CNA #2 said the speech therapist was informed Resident #13 did not like to use the Dynavox, and she said to use whatever Resident #13 was most comfortable with.</p> <p>On 7/24/19 at 10:47 AM, the DNS said the staff received training to help Resident #13 use the Dynavox. The DNS said it was supposed to be an option for Resident #13 to use the Dynavox, but staff had to initiate it. The DNS said she had not observed Resident #13 use the Dynavox.</p> <p>On 7/25/19 at 9:44 AM, the Speech Therapist said she was not sure if Resident #13 still used the Dynavox, staff would have to initiate it, and she had not observed it being used recently. The Speech Therapist said Resident #13 did not have "a lot of therapy" because "there was no payment method for that." The Speech Therapist said she had not followed up with Resident #13 and did not know if she was still on a Restorative Program.</p> <p>2. Resident #18 was admitted to the facility on 4/6/18, with multiple diagnoses including type 2 diabetes mellitus with diabetic neuropathy (nerve damage including pain and numbness).</p> <p>Resident #18's care plan documented Resident #18 required supervision/set-up with the assistance of 1 staff member for showering.</p> <p>Resident #18's Care Plan Conference summary, dated 7/2/19, documented Resident #18 preferred evening showers.</p>	F 676			

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

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F 676	<p>Continued From page 15</p> <p>On 7/24/19 at 3:30 PM, Resident #18 said she did not remember the last time she had a shower.</p> <p>The daily shower schedule forms for July 2019 documented Resident #18 received showers on 6/30/19, 7/17/19, and 7/21/19. The forms for July 2019 documented Resident #18 did not receive a shower for 17 days between 6/30/19 and 7/17/19.</p> <p>The bathing schedule in the electronic record for June 2019 and July 2019 documented Resident #18 did not receive a shower for 21 days between 6/30/19 and 7/21/19.</p> <p>The facility's tool to track the residents' showering schedule, and completion of showers, was a paper form that was posted. It identified the date and shift, which residents were to get showers that shift, and which CNA was assigned to the residents. The shower schedule, dated 7/10/19, initiated by the DNS, documented Resident #18's showers were to be provided every Sunday and Wednesday evening. Those residents with a change in their scheduled showers had the day/shift identifiers circled, if they refused or did not receive a shower that day. Resident #18's day/shift identifier was not circled on the days and shifts she did not receive a schedule.</p> <p>On 7/24/19 at 4:03 PM, LPN #1 said staff knew to shower a resident by reading the daily shower schedule form that was posted. LPN #1 said staff procedure was to offer the resident assistance with a shower 3 times during the scheduled shift, and if the resident refused 3 times they wrote the</p>	F 676			

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F 676	Continued From page 16 resident's name on the next day's shower schedule form. On 7/24/19 at 4:03 PM, the DNS said on 7/10/19 she implemented the policy of re-scheduling a resident on the next day's shower schedule with the date the original shower was offered and refused and this was to be repeated until a shower was provided. The DNS said the electronic record has priority over the paper shower schedule which was posted daily. On 7/24/19 at 4:10 PM, the DNS said she reviewed Resident #18's electronic record and said it documented Resident #18 was provided a shower on 6/30/19, had refused a shower on 7/3/19 and 7/14/19, and her next shower was on 7/21/19. The DNS was unable to provide documentation Resident #18 was provided a shower on 7/17/19. The DNS said Resident #18 did not get a shower for 21 days.	F 676			
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interviews, it was determined the facility failed to ensure neurological	F 684	1. Resident #'s 5,19,21,22,27 are clinically stable and have shown no adverse neurological issues. Resident #7	8/26/19	

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F 684	<p>Continued From page 17</p> <p>assessments were performed after unwitnessed falls and/or incidents involving a potential head injury, and medications were administered consistent with physician orders. This was true for 5 of 5 residents (#5, #19, #21, #22, and #27) reviewed for falls, and 1 of 8 residents (Resident #7) reviewed for medication administration. These failures created the potential for harm should residents experience undetected changes in neurological status and adverse effects from medications that were administered contrary to physician orders. Findings include:</p> <p>The facility's policy for Neurological Evaluation, revised May 2007, documented the following:</p> <ul style="list-style-type: none"> * All incidents involving head trauma result in a comprehensive neurological assessment for a minimum of 72 hours. * A neurological assessment flowsheet was used for all residents who sustained head trauma due to falls or other incidents. * Any resident who had an injury involving the head or an observed fall required neurological checks and vital signs at least every 8 hours for 24 hours or per specific facility policy or physician's order. * Comprehensive neurological assessments were done every 15 minutes times 4 (one hour), every 30 minutes times 4 (two hours), every hour times 4 (four hours), and every shift times 72 hours. <p>This policy did not include consistent instructions to staff when to conduct a neurological assessment, how frequently a resident should be assessed, and the duration of time for the neurological assessments.</p>	F 684	<p>has had her insulin orders updated to reflect her time preference for receiving insulin.</p> <p>2. All other residents that fall are potentially at risk of not having a neuro check done. None have been identified. All residents on insulin are at risk of receiving insulin at the wrong time. No other residents have been identified as not receiving insulin as prescribed.</p> <p>3. All licensed staff and nurse aides were in-serviced on completing neuro checks after an unwitnessed fall, or witnessed falls where the head was involved. The risk management tool has been updated to include neuro checks. All residents receiving insulin have been audited to ensure that insulin orders are correct and being followed. All licensed nurses have been in-serviced on administering medications per MD orders. All new orders will be reviewed five times per week in stand-up meeting.</p> <p>4. To monitor performance and ensure corrective action was effective and compliance sustained, DON or designee will audit 5 times per week x 4 and then monthly x3 in stand up0 meeting when a fall occurs to ensure that neuro checks are initiated and completed. New insulin orders will be reviewed for accuracy by the DON or designee. Licensed nurses will be randomly audited for compliance with medication pass weekly x 4 and then monthly x 3. Results of these audits will</p>		

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F 684	<p>Continued From page 18</p> <p>Neurological assessments were not completed as follows:</p> <p>a. Resident #5 was admitted to the facility on 5/6/08, with multiple diagnoses including dementia and a stroke.</p> <p>The quarterly MDS assessment, dated 4/26/19, documented Resident #5 was severely cognitively impaired and required extensive assistance from two staff members for bed mobility and transfers.</p> <p>- An Incident and Accident Report, dated 7/8/19 at 3:13 PM, documented Resident #5 was found lying on the floor to the right of her door. The report stated Resident #5 had no injuries from the fall. There was no documentation in Resident #5's record neurological assessments were completed after the fall.</p> <p>- An Incident and Accident Report, dated 7/12/19 at 5:29 PM, documented Resident #5 experienced an unwitnessed fall out of bed and was found on the floor on a mat next to her bed. The report stated Resident #5 had no injuries from the fall. There was no documentation in Resident #5's record neurological assessments were completed after the fall.</p> <p>- An Incident and Accident Report, dated 7/18/19 at 6:05 AM, documented Resident #5 experienced an unwitnessed fall out of bed and was found on the floor on a mat next to her bed. The report stated Resident #5 had no injuries from the fall. There was no documentation in Resident #5's record neurological assessments were completed after the fall.</p>	F 684	<p>be reported in the monthly QAPI meeting. If compliance is achieved for three months, the audits will be discontinued.</p>		

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F 684	<p>Continued From page 19</p> <p>- An Incident and Accident Report, dated 7/22/19 at 10:46 AM, documented Resident #5 experienced an unwitnessed fall out of bed and was found on the floor on mat next to the bed. There was no documentation in Resident #5's record neurological assessments were completed after the fall.</p> <p>On 7/24/19 at 9:25 AM, the DNS stated Resident #5's record did not include neurological assessments for the falls on 7/8/19, 7/12/19, 7/18/19, or 7/22/19.</p> <p>b. Resident #21 was admitted to the facility on 1/2/19, with multiple diagnoses including dementia with behavioral disturbance, abnormalities of gait and mobility, and muscle wasting and atrophy.</p> <p>Resident #21's quarterly MDS assessment, dated 6/2019, documented he was severely cognitively impaired and required extensive assistance of two persons with bed mobility and transfers.</p> <p>Resident #21 had two falls which resulted in injuries to his head and neurological assessments were not completed as follows:</p> <p>- An Incident and Accident Report, dated 1/19/19 at 6:00 AM, documented he had an unwitnessed fall with a hematoma (swelling of clotted blood in the tissue) and two abrasions to his forehead. There was no documentation in Resident #21's record neurological assessments were completed after the fall.</p> <p>- An Incident and Accident Report, dated 7/17/19</p>	F 684			

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F 684	<p>Continued From page 20</p> <p>at 9:37 PM, documented Resident #21 bumped his right temple area on the wall in the shower room when he stood up from his wheelchair and attempted to bite a CNA as she attempted to transfer him to the toilet. There was no documentation in Resident #21's record neurological assessments were completed after he bumped his head.</p> <p>On 7/24/19 at 10:55 AM, the DNS said neurological assessments should have been done after Resident #21's falls on 1/21/19 and 7/17/19. The DNS said if he hit his head there should have been further assessment.</p> <p>c. Resident #19 was admitted to the facility on 1/29/09, with multiple diagnoses including abnormalities of gait and mobility, and dementia with behavioral disturbance.</p> <p>Resident #19's quarterly MDS assessment, dated 6/11/19, documented he was severely cognitively impaired and required extensive assistance of two persons with bed mobility and transfers.</p> <p>An Incident and Accident Report, dated 7/9/19 at 3:50 PM, documented Resident #19 was found on the floor next to his bed. There was no documentation in Resident #19's record neurological assessments were completed after he fell.</p> <p>On 7/24/19 at 10:55 AM, the DNS said neurological assessments should be done if it was unsure whether the resident hit their head, there were visible signs and symptoms they hit their head, or the resident said they hit their head.</p>	F 684			

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F 684	Continued From page 21 d. Resident #27 was admitted to the facility on 5/21/19, with multiple diagnoses including muscle wasting and abnormalities of gait and mobility. Resident #27's quarterly MDS assessment, dated 7/1/19, documented he was cognitively intact and required physical assistance from one person for bed mobility and transfers. An Incident and Accident Report, dated 5/19/19 at 5:55 AM, documented Resident #27 was found lying on his left side between the wall and his bed. The report stated Resident #27 had a hematoma on the left of his forehead. The LPN documented neurological assessments were initiated and were within normal limits. There was no documentation in Resident #27's record neurological assessments were completed after he fell. On 7/24/19 at 5:30 PM, the DNS said she could not find neurological assessments in Resident #27's record after his fall on 5/19/19. e. Resident #22 was readmitted to the facility on 6/14/19, with multiple diagnoses including dementia. A readmission MDS assessment, dated 6/21/19, documented Resident #22 was severely cognitively impaired and required extensive assistance with two staff members for bed mobility and transfers. An Incident and Accident Report, dated 7/11/19 at 3:15 AM, documented Resident #22 experienced an unwitnessed fall out of bed. The	F 684			

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F 684	<p>Continued From page 22</p> <p>report stated Resident #22 had no injuries from the fall. There was no documentation in Resident #22's record neurological assessments were completed after he fell.</p> <p>On 7/25/19 at 8:40 AM, the DNS stated Resident #22's record did not include neurological assessments for his unwitnessed fall on 7/11/19. The DNS stated Resident #22 had an unwitnessed fall and neurological assessments should have been implemented.</p> <p>2. The facility's policy for the Six Rights of Medication Administration, revised May 2007, documented one of the "Six Rights" included the right time-"Medications are administered within prescribed time frames."</p> <p>Resident #7 was admitted to the facility on 1/26/18, with multiple diagnoses including type 2 diabetes mellitus.</p> <p>Resident #7's physician orders included Humalog (insulin) 12 units subcutaneously (injected into the skin) twice a day after lunch and dinner, ordered on 7/4/19.</p> <p>On 7/24/19 at 4:47 PM, RN #1 administered the Humalog to Resident #7 in her left upper abdomen. No meal was served at that time, and dinner was not scheduled to be served until 5:30 PM (almost 45 minutes later). RN #1 said Resident #7 wanted the Humalog before dinner or right at dinner because she received another 28 units at bedtime, and she did not want them given too close together or her blood sugar could get too low. RN #1 said she did not administer the Humalog after dinner as ordered by Resident</p>	F 684			

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F 684	<p>Continued From page 23 #7's physician.</p> <p>On 7/24/19 at 5:30 PM, the DNS said, the Humalog should be given to Resident #7 after dinner, and if Resident #7 wanted to receive the medication earlier due to the reasons described above, her physician should have been contacted.</p> <p>5. Resident #5 was admitted to the facility on 5/6/08, with multiple diagnoses including dementia and a stroke.</p> <p>The quarterly MDS assessment, dated 4/26/19, documented Resident #5 was severely cognitively impaired and required extensive assistance from two staff member for bed mobility and transfers.</p> <p>a. An Incident and Accident Report, dated 7/8/19 at 3:13 PM, documented Resident #5 was found lying on the floor on her right side in her room next to bed. Resident #5 had no injuries from the fall.</p> <p>Neurological assessments following Resident #5's unwitnessed fall were not found in her record.</p> <p>b. An Incident and Accident Report, dated 7/12/19 at 5:29 PM, documented Resident #5 experienced an unwitnessed fall out of bed. Resident #5 had no injuries from the fall.</p> <p>Neurological assessments following Resident #5's unwitnessed fall were not found in her record.</p>	F 684			

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F 684	<p>Continued From page 24</p> <p>c. An Incident and Accident Report, dated 7/18/19 at 6:05 AM, documented Resident #5 experienced an unwitnessed fall out of bed. Resident #5 had no injuries from the fall.</p> <p>Neurological assessments following Resident #5's unwitnessed fall were not found in her record.</p> <p>d. An Incident and Accident Report, dated 7/22/19 at 10:46 AM, documented Resident #5 experienced an unwitnessed fall out of bed and sustained a bruise and skin tear to the outer part of her right eyebrow. A neurological assessment was documented on the Incident and Accident Report.</p> <p>Neurological assessments following Resident #5's unwitnessed fall were not found in her record.</p> <p>On 7/24/19 at 9:25 AM, the DNS stated Resident #5's record did not include neurological assessments for the falls on 7/8/19, 7/12/19, 7/18/19, or 7/22/19. The DNS stated she spoke to the LPN regarding Resident #5's unwitnessed fall and she did initiate neurological checks, but she did not implement them per the facility's policy on a neurological assessment flow sheet.</p> <p>6. Resident #22 was readmitted to the facility on 6/14/19, with multiple diagnoses including dementia.</p> <p>A readmission MDS assessment, dated 6/21/19, documented Resident #22 was severely cognitively impaired and required extensive assistance with two staff members for bed</p>	F 684			

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F 684	Continued From page 25 mobility and transfers. An Incident and Accident Report, dated 7/11/19 at 3:15 AM, documented Resident #22 experienced an unwitnessed fall out of bed. Resident #22 had no injuries from the fall. Neurological assessments following Resident #22's unwitnessed fall were not found in his record. On 7/25/19 at 8:40 AM, the DNS stated Resident #22's record did not include neurological assessments for his unwitnessed fall on 7/11/19. The DNS stated Resident #22 had an unwitnessed fall and neurological assessments should have been implemented.	F 684			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably	F 688		8/26/19	

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F 688	<p>Continued From page 26</p> <p>unavoidable.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident and staff interview and record review, it was determined the facility failed to ensure residents received restorative services through the restorative nursing program as needed. This was true for 2 of 2 residents (#9 and #13) reviewed for the restorative nursing program. This failure created the potential for residents to experience a decline in Range of Motion (ROM). Findings include:</p> <p>1. Resident #9 was admitted to the facility on 2/5/19, with multiple diagnoses including age related physical disability, osteoarthritis, muscle wasting, and atrophy (a breakdown of tissues).</p> <p>A quarterly MDS assessment, dated 5/13/19, documented Resident #9 was to receive active ROM and walking therapy through the restorative nursing program.</p> <p>Resident #9's care plan, revised on 5/9/19, documented the restorative program was to provide active ROM exercises 5-6 times a week for 15 minutes. Resident #9's care plan, revised 6/26/19, documented the restorative program was also to provide walking assistance 5-6 times a week, and Resident #9 tended to walk better first thing in the morning, typically around 7 AM.</p> <p>Resident #9 received restorative nursing services 4 days a week for the last 3 weeks of June 2019, and he received restorative nursing services 2 to 3 days a week in July 2019, from 7/1/19 to 7/22/19.</p>	F 688	<p>1. Resident #'s 9 & 13 are receiving restorative services per orders.</p> <p>2. All other residents on a restorative program have the potential to be affected by this practice. All residents are receiving restorative services as prescribed.</p> <p>3. C.N.A.s have been in-serviced on Range of Motion. RNA's and MDS nurse were in-serviced on completion of RNA programs 5 - 6 times per week per the care plan. A weekly restorative meeting is being held to coordinated schedules and address any issues.</p> <p>4. To monitor performance and ensure corrective action was effective and compliance sustained, MDS nurse or designee will audit 2 times per week x 4 and then monthly x 3 to ensure RNA programs are being followed. Results of these audits will be reported in QAPI. If compliance is achieved for three months, the audits will be discontinued.</p>		

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

PRINTED: 08/23/2019
FORM APPROVED
OMB NO. 0938-0391

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F 688	<p>Continued From page 27</p> <p>A progress note, dated 7/17/19 at 10:06 AM, documented Resident #9 received restorative nursing for active ROM and ambulation, and Resident #9 participated well with active ROM and ambulation, and the plan of care was to be continued.</p> <p>On 7/22/19 at 11:02 AM, Resident #9 said he was waiting to be walked and had not walked since last Wednesday, 7/17/19.</p> <p>The restorative nursing schedule, dated 7/23/19, documented Resident #9 was in the ROM and ambulation program and was to ambulate in the morning. There was no documentation Resident #9 was ambulated by restorative nursing staff on 7/23/19.</p> <p>On 7/24/19 at 9:45 AM, the DNS said times/dates for restorative nursing were recorded under the care plan in the residents' records. Resident #9's record documented Resident #9 received restorative nursing 3-4 days the last three weeks of June 2019 and received restorative nursing 2-3 days a week in July 2019.</p> <p>On 7/24/19 at 11:13 AM, the MDS Coordinator said the goal was to provide restorative nursing for Resident #9 6-7 days a week and to staff someone who could provide these services on weekends, and without weekend staff the goal was reduced to 5-6 days a week. The MDS coordinator reviewed both electronic record and hard copy documentation and said Resident #9 had not received ROM or restorative nursing rehab since 7/17/19.</p> <p>On 7/24/19 at 11:37 AM, the DNS said the</p>	F 688			

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F 688	<p>Continued From page 28</p> <p>restorative nursing goal for Resident #9 was 5 days a week and weekend coverage on one weekend day with a total of 6 days a week.</p> <p>Resident #9 was not provided restorative nursing therapy the 5-6 days a week as directed in the care plan.</p> <p>2. Resident #13 was admitted to the facility on 5/2/16, with multiple diagnoses including hemiplegia and hemiparesis (weakness and paralysis on one side of the body) affecting the right side, cerebrovascular disease (medical conditions that affect blood vessels of the brain), aphasia (the loss of ability to understand or express speech, resulting from brain damage), cognitive communication deficit, and history of falling.</p> <p>Resident #13's quarterly MDS assessment, dated 5/27/19, documented she was severely cognitively impaired, required extensive assistance of two persons for bed mobility, transfers, dressing, and toileting, and she received restorative program services on 4 of the past 7 days.</p> <p>Resident #13's physician orders documented "May receive Restorative Nursing Services," ordered on 2/6/18.</p> <p>Resident #13's care plan directed restorative nursing be provided as follows:</p> <p>* Bed mobility 15 minutes, 5-6 times per week, initiated on 5/20/19.</p> <p>* Passive range of motion (ROM) 15 minutes, 5-6 times per week, initiated on 5/20/19.</p>	F 688			

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F 688	<p>Continued From page 29</p> <p>Resident #13's restorative program schedule documented she received restorative services four times a week 6/1/19 to 6/7/19, 6/8/19 to 6/15/19, 6/16/19 to 6/22/19, and 6/23/19 to 6/30/19. She received Restorative Nursing four times a week 7/1/19 to 7/8/19 and 7/9/19 to 7/15/19, and two times between 7/16/19 and 7/22/19. Resident #13 did not receive Restorative Nursing during the week of 7/6/19 to 7/11/19 and 7/18/19 to 7/22/19.</p> <p>On 7/23/19 at 3:52 PM, Resident #13's family member said he had not seen staff provide therapy or exercises to her.</p> <p>On 7/24/19 at 8:52 AM, CNA #2 said Resident #13 was supposed to receive restorative services for ROM and bed mobility every day, Monday through Friday. CNA #2 said she was injured earlier in the month, and another CNA was helping to try to "get back on track." CNA #2 said the goal was for Resident #13 to receive restorative services 6 days a week. CNA #2 said Resident #13 missed some restorative nursing services this month, and she only received it four times a week in June.</p> <p>On 7/24/19 at 10:47 AM, the DNS said there were some issues with restorative nursing services since the restorative CNA was injured, and they had trouble getting someone to fill in but it was worked out. The DNS said goal was to have restorative nursing services five to six days a week.</p>	F 688			



IDAHO DEPARTMENT OF
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September 30, 2019

Kurt Holm, Administrator
McCall Rehabilitation And Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

Dear Mr. Holm:

On **July 22 2019** through **July 26, 2019**, an unannounced on-site complaint survey was conducted at McCall Rehabilitation and Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008117

ALLEGATION #1:

Residents were being place in saturated adult briefs.

FINDINGS #1:

During the survey twelve resident records were reviewed, observations were conducted, and residents and staff were interviewed.

During the survey, six residents were observed for incontinence and their briefs were not saturated for extended periods of time. Four CNAs were observed providing incontinence care and changing residents' adult briefs according to their needs and their care plans.

Two residents stated the staff provide incontinence care and check and change their adult briefs regularly and had no concerns about being left in saturated adult briefs. Four CNAs stated they check and change residents who are incontinent and wear adult briefs every two or three hours and as needed. The DNS stated residents were checked and changed according to their needs and were not left or placed in saturated adult briefs.

During the review of records one resident, admitted October 2018, with multiple diagnoses including dementia with behaviors. The resident's record documented the resident was frequently incontinent of bowel and bladder and the staff provided incontinence care per the care plan.

It could not be established the facility failed to provide incontinence care to residents who require assistance with adult briefs.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility was adjusting residents psychoactive medications without informing the family representatives.

FINDINGS #2:

During the survey seven resident records were reviewed.

Seven out of seven resident records were reviewed for psychoactive medications and the family representatives were informed and signed the consent for the prescribed medications.

One resident's record documented they were prescribed two antipsychotic medications and the resident's spouse signed the consent forms prior to the administration of the medications.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents were transferred to the hospital without informing the family representative.

Kurt Holm, Administrator
September 30, 2019
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FINDINGS #3:

During the survey resident records were reviewed and staff were interviewed.

Three resident records were reviewed for hospitalization. Two of the three residents' families or emergency contact were notified of the residents' change of condition and that they were hospitalized.

One resident's record documented the spouse was the primary emergency contact person. The person was not notified of the resident being sent to the emergency room and admitted to the hospital until 24 hours later by the facility's licensed social worker. The DNS and the Administrator stated the spouse was at the facility earlier that day when the resident became verbally aggressive, but left the facility prior to the resident requiring hospitalization.

Based on the investigative findings, the allegation was substantiated. A deficiency was cited at F580 as it related to the failure of the facility to ensure residents' family representatives were notified of changes of condition in a timely manner.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
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January 10, 2020

Kurt Holm, Administrator
McCall Rehabilitation and Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

Dear Mr. Holm:

On **July 22, 2019** through **July 26, 2019**, an unannounced on-site complaint survey was conducted at McCall Rehabilitation and Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008091

ALLEGATION #1:

The facility failed to ensure residents' personal belongings were secure.

FINDINGS #1:

The facility's grievance logs were reviewed for the past 6 months, 13 resident records were reviewed, 5 residents and one family member were interviewed, a resident council interview was conducted with 8 residents in attendance, and 2 facility staff members were interviewed.

One resident's record contained no documentation regarding missing personal items.

The facility's record of grievances contained no documentation regarding residents' missing items.

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Five of 5 interviewed residents and 1 family member reported no problems with missing personal items.

During a resident council interview, there were no reported problems with missing personal items for 8 of 8 residents.

The laundry supervisor was interviewed, and she verbalized an appropriate system for attempting to locate missing items and to replace items if not found.

The social worker was interviewed and stated she was not aware of any issues with missing items for a resident.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to ensure medications were administered appropriately.

FINDINGS #2:

Thirteen resident records were reviewed. The facility's grievance logs were reviewed for the past 6 months. Medication error reports were reviewed for the past 6 months. Three nurses were observed administering medications to 7 different residents, for a total of 29 medications administered. Observations were made of 11 residents throughout the survey.

Review of one resident's record did not find documentation of any medication errors.

Review of grievances found documentation of 3 grievances involving medications found sitting at the bedside for 2 different residents, and pills were found in one resident's bed.

Review of medication error reports did not find documentation of medications not taken due to being left at the resident's bedside. One resident received an incorrect form of insulin.

During observation of medications being passed, 7 of 7 residents received the correct medication and no medications were left at the bedside. Three of 3 nurses observed each resident to ensure the medications were taken before leaving the resident's room.

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Upon resident observations throughout the facility, no residents were found with medications left at the bedside.

Based on the investigative findings, the complaint was substantiated; however, no citations were issued due to no observed deficient practice.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility failed to ensure residents' needs were accommodated in regards to their room and roommate.

FINDINGS #3:

Thirteen resident records were reviewed. Five residents and 1 family member were interviewed. A Resident Council interview was conducted with 8 residents in attendance. The facility's grievance logs for the past six months were reviewed.

Review of 1 resident's record found documentation the resident was upset due to her roommate keeping her television on all night. The resident requested to be moved to a different room, and the facility accommodated her request on the same day. There was no documentation of further issues with the resident's room or roommate. It was documented the resident seemed happier with her new roommate.

Five of 5 interviewed residents and 1 resident's family member had no concerns with their needs being accommodated as it related to their room or roommate.

During the Resident Council interview, there were no expressed concerns regarding residents' needs being accommodated as it related to their room or roommate.

Review of the facility's grievance logs found no documentation of concerns regarding residents' needs being accommodated as it related to their room or roommate.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The facility failed to ensure residents were free from being oversedated by medications.

FINDINGS #4:

Thirteen resident records were reviewed. Five residents were reviewed for unnecessary medications. Eleven residents were observed for signs and symptoms of oversedation throughout the survey. Five residents and 1 resident's family member were interviewed. The facility's grievance logs for the past 6 months were reviewed.

Upon review of 1 resident's record, there was no documentation of concerns, signs, or symptoms of oversedation. Review of the Medication Administration Record (MAR) found potentially sedating drugs as follows: an antidepressant medication once a day, a medication to relieve nerve pain twice a day, and a medication to prevent seizures twice a day. A narcotic pain medication was ordered every 4 hours as needed, and it was administered 2 to 4 times a day with at least 4 hours in between doses. There was no documentation on the MAR of observed side effects, such as sedation, for those medications being monitored as being potentially sedating.

Five of 5 resident records reviewed for unnecessary medications documented appropriate medication regimens and monitoring.

Eleven of 11 residents observed throughout the survey demonstrated no signs or symptoms of oversedation.

Five of 5 interviewed residents and 1 resident's family member had no concerns relating to oversedation from medications.

Review of the facility's grievance logs found no documentation of concerns relating to oversedation from medications.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility failed to ensure residents were provided incontinence care in a timely manner.

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FINDINGS #5:

Thirteen resident records were reviewed. Six residents and one resident's family member were interviewed. Eleven residents were observed throughout the survey for signs of being left in urine or feces after incontinence episodes. The facility's grievance logs were reviewed for the past six months. A Resident Council interview was conducted with 8 residents in attendance.

Six of six interviewed residents and one resident's family member had no concerns regarding residents being left in urine or feces for an extended period of time.

Observation of 11 of 11 residents found no signs of being left in urine or feces for an extended time, and staff were observed frequently providing incontinence care to residents.

Review of the facility's grievance logs found no documented concerns regarding residents being left in urine or feces after incontinence episodes.

During a Resident Council interview, 8 of 8 residents had no expressed concerns about residents being left in urine or feces after incontinence episodes.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

One of the allegations was substantiated, but not cited. Therefore, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj