



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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August 23, 2019

Josiah Dahlstrom, Administrator
Idaho State Veterans Home - Pocatello
1957 Alvin Ricken Drive
Pocatello, ID 83201-2727

Provider #: 135132

Dear Mr. Dahlstrom:

On **August 9, 2019**, a survey was conducted at Idaho State Veterans Home - Pocatello 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 **September 3, 2019**. Failure to submit an acceptable PoC by **September 3, 2019**, may result in the imposition of penalties by **September 25, 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 **September 13, 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 **November 7, 2019**. A change in the seriousness of the deficiencies on **September 23, 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 **November 9, 2019** includes the following:

Denial of payment for new admissions effective **November 9, 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 **February 9, 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 **November 9, 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 **September 3, 2019**. If your request for informal dispute resolution is received after **September 3, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

bd/lj

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

PRINTED: 09/27/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/09/2019
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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELLO	STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted from August 5, 2019 to August 9, 2019. The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator Jenny Walker, RN Sallie Schwartzkopf, LCSW Theresa Calvert, RN Abbreviations: CNA = Certified Nursing Assistant COPD = Chronic Obstructive Pulmonary Disease DNS = Director of Nursing Services LPN = Licensed Practical Nurse LSW = Licensed Social Worker MDS = Minimum Data Set RN = Registered Nurse	F 000		
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; (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); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		9/13/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 09/03/2019
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	<p>Continued From page 1</p> <p>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 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure the physician was notified when a resident's oxygen</p>	F 580	<p>Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed</p>		

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F 580	<p>Continued From page 2</p> <p>saturation (percentage of oxygen in the blood) was below prescribed parameters. This was true for 1 of 5 residents (Resident #37) reviewed for oxygen therapy, and created the potential for harm should the resident experience adverse consequences from lack of physician notification and intervention. Findings include:</p> <p>The facility's policy for Notification of Changes, undated, documented the physician was notified immediately in the event a resident experienced changes, including but not limited to a significant change in the resident's physical, mental, or psychosocial status, or when there was a need to alter treatment.</p> <p>Resident #37 was readmitted to the facility on 5/9/19, with multiple diagnoses including COPD (a progressive lung disease that results in shortness of breath) and acute respiratory failure with hypoxia (low oxygen level).</p> <p>Resident #37's annual MDS assessment, dated 6/14/19, documented he had shortness of breath with exertion, when sitting at rest, and when lying flat. The MDS documented he received oxygen therapy.</p> <p>Resident #37's physician orders documented an order on 6/5/19 for Oxygen: titrate zero to four liters to maintain oxygen saturation level above 89% as needed. Use oximeter (a device to measure the percentage of oxygen in the blood) during oxygen administration to check oxygen saturation levels.</p> <p>Resident #37's care plan documented the following:</p>	F 580	<p>as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.</p> <p>1.Immediate action(s) taken for the resident(s) found to have been affected include: MD was notified immediately of resident #37 and his oxygen levels falling below the prescribed parameters. The MD and DNS adjusted the prescribed parameters and resident #37 agrees with the new parameters. The resident's guardian is also aware and agrees with the new parameters. Resident #37 has a history of changing his own oxygen flow despite multiple requests not to. Resident 37's care plan has been updated to reflect this behavior.</p> <p>2.Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with orders for oxygen therapy have the potential to be affected.</p> <p>3.Actions taken/systems put into place to reduce the risk of future occurrence include: The facility's policy for Notification of Changes has been reviewed and revised. An in-service education was held for all licensed nursing staff addressing circumstances that require notification of the resident's physician, legal representative or family member. They were also informed of the change in</p>		

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F 580	<p>Continued From page 3</p> <p>* Oxygen at zero to four liters per minute to keep oxygen saturation level above 89%, initiated on 6/7/18 and revised on 1/2/19. * Monitor for any indication of decline in health status. Notify physician of any significant changes, initiated on 6/7/18.</p> <p>Resident #37's Treatment Administration Record (TAR) for August 2019 documented his oxygen saturation level was below 89% as follows:</p> <p>* On day shift 8/2/19 = 88%. * On evening shift 8/4/19 = 87%. * On day shift 8/5/19 = 88%. * On evening shift 8/6/19 = 83%.</p> <p>Resident #37's Weights and Vitals Summary documented his oxygen saturation level was below 89% as follows:</p> <p>* On 7/2/19 at 9:46 PM = 80%. * On 7/3/19 at 9:43 PM = 80%. * On 7/4/19 at 5:38 AM = 88%. * On 7/4/19 at 10:35 PM = 86%. * On 7/5/19 at 1:06 AM = 66% (on room air). * On 7/5/19 at 10:05 PM = 80%. * On 7/6/19 at 1:32 AM = 88%. * On 7/8/19 at 6:07 PM = 86%. * On 7/10/19 at 10:03 PM = 87%. * On 7/15/19 at 1:59 PM = 88%. * On 7/17/19 at 10:51 AM = 88%. * On 7/17/19 at 1:30 PM = 88%. * On 7/18/19 at 2:45 PM = 88%. * On 7/21/19 at 3:17 PM = 88%. * On 7/30/19 at 9:18 PM = 87%. * On 7/31/19 at 9:57 AM = 88%.</p>	F 580	<p>parameters for resident #37. An audit of all residents on oxygen therapy was performed to focus on residents whose oxygen has fallen below their prescribed parameters and the MD was notified of any concerns. Parameters have been adjusted by the MD and the RN charge will contact the MD of concerns related to resident oxygen saturations that fall below the parameters.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DNS, or designee, will conduct a random audit of resident oxygen saturations 5 times a week for two (2) weeks and once a week for four (4) weeks. Findings of these audits will be discussed in the weekly leadership meeting. Audited records will be reviewed at the monthly Quality Assurance meeting until such a time that consistent substantial compliance has been achieved as determined by the committee. Adjustments will be made as necessary.</p>		

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F 580	<p>Continued From page 4</p> <p>There was no documentation in Resident #37's record prior to 8/7/19, the physician was notified when his oxygen saturation level was less than 89%.</p> <p>On 8/7/19 at 10:18 AM, Resident #37 was in his room with oxygen in place at 4 liters per minute by nasal cannula (tubing that administers oxygen through the nose). Resident #37 had an oximeter on his finger, and it read his oxygen saturation level as 84%. Resident #37 said his breathing was "not feeling very good," and he said the hospital previously told him his oxygen saturation level should be 88% to 90%.</p> <p>On 8/7/19 at 10:23 AM, LPN #3 said Resident #37 had hard time maintaining his oxygen saturation level at greater than 89%, and she just administered an inhaler to him. LPN #3 said she did not know why Resident #37 had a hard time maintaining his oxygen saturation level, and it was 86% that morning. LPN #3 said the physician's order was to keep Resident #37's oxygen saturation level above 89%, and he was on four liters of oxygen. LPN #3 said if Resident #37's oxygen saturation level was less than 89%, the nurse should notify the physician and charge nurse, and she had not done that.</p> <p>A Nursing Note, dated 8/7/19 at 10:48 AM, documented there was difficulty keeping Resident #37's oxygen saturation above 86%, and his oxygen saturation dropped into the 70's. When the oxygen tubing was placed in Resident #37's mouth the oxygen saturation increased, but when the tubing was placed into his nose the oxygen saturation dropped back into the low 80's and high 70's. Resident #37 asked to be</p>	F 580			

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F 580	<p>Continued From page 5</p> <p>evaluated in the emergency room, and the charge nurse assessed him. A Nursing Note, dated 8/7/19 at 10:33 AM, documented a physician's order was received to send Resident #37 to the ER for evaluation.</p> <p>There was no documentation in Resident #37's record prior to 8/7/19, the physician was notified when his oxygen saturation level was less than 89%.</p> <p>On 8/7/19 at 11:28 AM, the RN Manager said he was not aware of Resident #37's decreased oxygen saturation levels until LPN #3 told him that morning. The RN Manager said when a resident had a decreased oxygen saturation level, he would expect the nurse to administer nebulizer treatments (medications in an inhaled mist form), and to notify the charge nurse, who would notify the physician. The RN Manager said Resident #37's physician order documented to keep his oxygen saturation level above 90%, and if he could not keep it above that he would notify the physician.</p> <p>On 8/7/19 at 3:52 PM, the DNS said Resident #37 had an oximeter to monitor his oxygen saturation, and he wore it all day. The DNS said if the oxygen saturation level was low, he expected the nurse to have Resident #37 take deep breaths, check the oxygen tank to make sure there was oxygen in the tank, and check the position of the oxygen tubing. The DNS said if Resident #37's oxygen saturation level did not come back up, he would expect the nurse to get in touch with the physician.</p>	F 580			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		9/13/19	

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F 609	Continued From page 6 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 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 bruises of unknown origin in suspicious areas of a resident's body were reported to the Administrator and State Survey Agency within 2 hours of when the bruises were identified by facility staff. This was true for 1 of 1 resident	F 609	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this		

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F 609	<p>Continued From page 7</p> <p>(Resident #31) reviewed for injuries of unknown origin. This failure created the potential harm if the injuries of unknown origin on Resident #31's thigh and breast were a result of abuse. Findings include:</p> <p>The facility's policy titled Freedom from Abuse, Neglect, and Exploitation, last revised 12/2017, documented all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. The policy also documented all violations involving injuries of unknown source were to be reported immediately and an Incident Report completed.</p> <p>Resident #31 was admitted to the facility on 5/31/19, with multiple diagnoses including Parkinson's disease (progressive nervous system disorder that affects movement), COPD (progressive lung diseases characterized by increasing breathlessness), and cancer.</p> <p>Resident #31's admission MDS assessment, dated 6/8/19, documented she was severely cognitively impaired, totally dependent on two</p>	F 609	<p>response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.</p> <p>1.Immediate action(s) taken for the resident(s) found to have been affected include: Immediate education was provided to Charge Nurse #1 and LPN #5 regarding their documentation without notification or an incident report. A skin assessment has been completed and the bruising identified is resolved. Family was notified of the bruising, a report was filed to the BFS Abuse Portal, thus opening an investigation, an incident report was filled out and a statement was gathered from Resident #31. The investigation that was performed consisted of a report to the BFS Abuse Portal, filling out an incident report, gathering statements from any staff and contractors that may have had contact with Resident #31, notifying family, notifying the physician, and reviewing the evidence collected as a team to rule out abuse or neglect. This was all completed within the mandated 5-day time frame and the final report was submitted through the same abuse portal.</p> <p>2.Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected.</p> <p>3.Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education was conducted</p>		

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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
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F 609	<p>Continued From page 8</p> <p>staff members for transfers, and required extensive assistance of two persons for bed mobility.</p> <p>Resident #31's admission skin assessment, dated 5/31/19, documented there was scattered scabbing to the entire body and face with multicolor yellow bruising in various stages of healing. The skin assessment not include documentation of a bruise on Resident #31's left thigh or breast.</p> <p>Resident #31's Progress Note, dated 6/28/19 at 10:35 PM, documented a skin assessment was completed by Charge Nurse #1, and Resident #31 had various areas of bruising that included a bruise on the left thigh. Charge Nurse #1 documented there were no new concerns.</p> <p>On a skin assessment, dated 7/5/19 at 10:17 PM, LPN #5 documented Resident #31 had a bruise on her left breast. LPN #5 documented there were no new concerns.</p> <p>On 8/8/19 at 3:15 PM, Charge Nurse #1 stated he did not remember the skin assessment he completed for Resident #31 on 6/28/19. He stated he did not remember anything about the bruise on her left thigh, such as where the bruise was located on the thigh, the size, and the color. Charge Nurse #1 stated when a new bruise was noted, staff were to write up an Incident Report. Charge Nurse #1 stated he did not follow the procedure.</p> <p>On 8/9/19 at 10:14 AM, LSW #2 stated she did not recall anyone reporting the bruise on the thigh of Resident #31. LSW #2 stated she</p>	F 609	<p>by the DNS for all licensed nurses on 8/14/2019. This included reporting concerns to the home administrator and beginning an incident report for noted incidents and accidents that pertain to the residents and reporting parameters. The facility's policy Freedom from Abuse, Neglect, and Exploitation was reviewed and revised.</p> <p>4.How the corrective action(s) will be monitored to ensure the practice will not recur: The DNS, or designee, will conduct a random audit progress notes weekly for four (4) weeks looking for incidents or accidents that do not have an attached incident report and investigation if required. The Social worker, or designee, will interview at random, 4 residents weekly for four (4) weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate people. Findings of these audits will be discussed in the weekly leadership meeting. Audited records will be reviewed at the monthly Quality Assurance meeting until such a time that consistent substantial compliance has been achieved as determined by the committee. Adjustments will be made as necessary.</p>		

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F 609	Continued From page 9 expected an Incident Report to be filled out, and it should contain a description of the bruise, its location and size, and staff monitoring of it. On 8/8/19 at 2:30 PM, the DNS confirmed there was no Incident Report completed for Resident #31 regarding the bruise of unknown origin on her thigh on 6/28/19 and for the bruise of unknown origin on her breast on 7/5/19. On 8/8/19 at 2:45 PM, the Administrator stated he was not aware of any bruises on Resident #31's thigh because an Incident Report was not completed. The Administrator stated the bruise of unknown origin would trigger more investigating because of its location. On 8/8/19 at 2:55 PM, the Administrator stated, depending on the initial investigation, he would have reported the incident to the State Survey Agency's reporting portal and then completed a five day follow up with the results of the investigation.	F 609			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 610		9/13/19	

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F 610	<p>Continued From page 10</p> <p>accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 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 bruises of unknown origin in suspicious areas of a resident's body were investigated. This was true for 1 of 1 resident (Resident #31) reviewed for injuries of unknown origin. This failure created the potential for Resident #31 to experience undetected abuse. Findings include:</p> <p>The facility's policy titled Freedom from Abuse, Neglect, and Exploitation, undated, documented injuries of unknown origin included injuries that were not observed by any person, or the source of the injury could not be explained. The injuries included severe bruising on the head, neck, or trunk, fingerprint bruises anywhere on the body, lacerations, sprains, or fractures, and were considered a crime. Minor bruising was not considered a crime and did not have to be reported. The policy documented all violations involving injuries of unknown source were reported immediately. The policy documented an incident was an unexpected, unintended event that could cause a resident injury, and an Incident/Accident report was initiated for skin tears and bruises. Any individual aware of an incident/accident that involved a resident should report the incident to the licensed nurse on that unit. The Incident Report was initiated and completed by the attending nurse by the end of the shift. The policy directed staff to initiate immediate interventions, and alert charting would</p>	F 610	<p>Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.</p> <p>1.Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Immediate education was provided to Charge Nurse #1 and LPN #5 regarding their documentation without notification or an incident report. A skin assessment has been completed and the bruising identified is resolved. Family was notified of the bruising, a report was filed to the BFS Abuse Portal, thus opening an investigation, an incident report was filled out and a statement was gathered from Resident #31. A full investigation was completed, to rule out abuse, within 5 business days and filed through the BFS Abuse Portal. The investigation that was performed consisted of a report to the BFS Abuse Portal, filling out an incident report, gathering statements from any staff and contractors that may have had contact with Resident #31, notifying</p>		

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F 610	<p>Continued From page 11</p> <p>be done, as needed. The DNS or designee reported the incident to the clinical team for multidisciplinary evaluation.</p> <p>Resident #31 was admitted to the facility on 5/31/19, with multiple diagnoses including Parkinson's disease (progressive nervous system disorder that affects movement), COPD (progressive lung diseases characterized by increasing breathlessness), and cancer.</p> <p>Resident #31's admission MDS assessment, dated 6/8/19, documented she was severely cognitively impaired, totally dependent on two staff members for transfers, and required extensive assistance of two persons for bed mobility.</p> <p>Resident #31's admission skin assessment, dated 5/31/19, documented there was scattered scabbing to the entire body and face with multicolor yellow bruising in various stages of healing. The skin assessment not include documentation of a bruise on Resident #31's left thigh or breast.</p> <p>Resident #31's skin assessment, dated 6/21/19, did not document any issues with her skin.</p> <p>Resident #31's Progress Note, dated 6/28/19 at 10:35 PM, documented a skin assessment was completed by Charge Nurse #1, and Resident #31 had various areas of bruising that included a bruise on the left thigh. Charge Nurse #1 documented there were no new concerns.</p> <p>On a skin assessment, dated 7/5/19 at 10:17 PM, LPN #5 documented Resident #31 had a bruise</p>	F 610	<p>family, notifying the physician, and reviewing the evidence collected as a team to rule out abuse or neglect. This was all completed within the mandated 5-day time frame and the final report was submitted through the same abuse portal.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: An in-service education was conducted by the DNS for all licensed nurses on 8/14/2019. This included reporting concerns to the home administrator and beginning an incident report for noted incidents and accidents that pertain to the residents and reporting parameters. The facility's policy Freedom from Abuse, Neglect, and Exploitation was reviewed and revised.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DNS, or designee, will conduct a random audit progress notes weekly for four (4) weeks. The Social worker, or designee, will interview at random, 4 residents weekly for four (4) weeks. These residents will be assessed and interviewed to ensure that any injuries are identified, properly investigated and reported to the appropriate people. Findings of these audits will be discussed</p>		

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F 610	<p>Continued From page 12</p> <p>on her left breast, and there was no documentation of a bruise on her left thigh. LPN #5 documented there were no new concerns.</p> <p>On 8/8/19 at 2:20 PM, the Wound Nurse stated an investigation should have been initiated for the bruises that were found on Resident #31's thigh and breast, and it was unknown how the bruises occurred. The Wound Nurse said the bruises should have been documented in the Progress Notes, and an Incident Report should have been initiated. The Wound Nurse stated the charge nurse should have been informed and the facility should have called Resident #31's family. The Wound Nurse stated Resident #31 did not have any falls that could have caused the bruising since she was admitted to the facility.</p> <p>On 8/8/19 at 3:15 PM, Charge Nurse #1 stated he did not remember the skin assessment he completed for Resident #31 on 6/28/19. After reviewing the skin assessment, Charge Nurse #1 stated he did not remember anything about the bruise on Resident #31's left thigh, such as where the bruise was located on the thigh, the size, and the color. Charge Nurse #1 stated in hindsight he should have written up an Incident Report. Charge Nurse #1 stated he had been employed at the facility for less than six months and was still learning the policies and procedures. Charge Nurse #1 stated when a new bruise was noted, staff were to write up an Incident Report, obtain witness statements, measure the bruise and document the location, document any person who had contact with the resident, and notify the family, healthcare team, and the physician. Charge Nurse #1 stated he did not follow the procedure.</p>	F 610	<p>in the weekly leadership meeting. Audited records will be reviewed at the monthly Quality Assurance meeting until such a time that consistent substantial compliance has been achieved as determined by the committee. Adjustments will be made as necessary.</p>		

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

PRINTED: 09/27/2019
FORM APPROVED
OMB NO. 0938-0391

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F 610	<p>Continued From page 13</p> <p>On 8/9/19 at 10:14 AM, LSW #2 stated she did not recall anyone reporting the bruise on the thigh of Resident #31. LSW #2 stated she expected an Incident Report to be filled out, and it should contain a description of the bruise, its location and size, and staff monitoring of it.</p> <p>On 8/8/19 at 2:30 PM, the DNS confirmed there was no investigation or Incident Report completed for Resident #31 regarding the bruise of unknown origin on her thigh on 6/28/19 and for the bruise of unknown origin on her breast on 7/5/19. The DNS stated when the bruise was noted on Resident #31's thigh and breast, an Incident Report should have been initiated and an investigation should have followed. The DNS stated the Interdisciplinary Team reviewed the Incident Reports each day, and there was no evidence an Incident Report was completed for Resident #31.</p> <p>On 8/9/19 at 8:21 AM, the DNS stated an LPN discovered the bruise on Resident #31's breast during a skin assessment on 7/5/19. The DNS stated he talked to the LPN previously, and she thought documenting the bruise was all that was necessary. The DNS stated the LPN was a new nurse, and she was hired at the end of June 2019.</p> <p>On 8/8/19 at 2:45 PM, the Administrator stated he was not aware of any bruises on Resident #31's thigh because an Incident Report was not completed. The Administrator stated the bruise would trigger more investigating because of its location. The Administrator said an Incident Report should have been initiated, the DNS</p>	F 610			

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F 610	Continued From page 14 should have been notified, and an investigation should have been completed.	F 610			
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident	F 622	9/13/19		

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F 622	<p>Continued From page 15</p> <p>exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.</p> <p>§483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i) Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c) (1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii) The documentation required by paragraph (c) (2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>(iii) Information provided to the receiving provider must include a minimum of the following:</p> <p>(A) Contact information of the practitioner responsible for the care of the resident.</p>	F 622			

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F 622	<p>Continued From page 16</p> <p>(B) Resident representative information including contact information</p> <p>(C) Advance Directive information</p> <p>(D) All special instructions or precautions for ongoing care, as appropriate.</p> <p>(E) Comprehensive care plan goals;</p> <p>(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, facility policy review, and resident and staff interview, it was determined the facility failed to ensure the required information was conveyed to the receiving facility or other health care provider when residents were transferred to the hospital and/or discharged home. This was true for 5 of 5 residents (Resident #37, #38, #44, #47, and #61) reviewed for transfer/discharge. This failure created the potential for harm if residents were not treated appropriately or in a timely manner due to a lack of information. Findings include:</p> <p>The facility's policy for Resident Transportation/Transfer, revised June 2006, was reviewed. The policy did not address the need to convey the required information to the receiving facility and document what information was sent.</p> <p>1. Resident #44 was readmitted to the facility on 3/19/19, with multiple diagnoses including a stroke affecting her right side and dementia.</p> <p>A progress note, dated 7/9/19 at 8:43 PM, documented Resident #44's daughter was</p>	F 622	<p>Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Residents #'s 37, 38, 44, and 47 have all returned from their unplanned ER and/or hospital admission therefore communicating all required information to receiving facility is no longer necessary. Follow-up with each resident identified no adverse outcomes of this deficient practice. A follow-up with Resident #61, who was discharged home with Home Health was conducted and no adverse outcomes were identified with this deficient practice.</p>		

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F 622	<p>Continued From page 17</p> <p>notified Resident #44 had a fall resulting in a bump to her left temporal lobe (left side of head).</p> <p>A progress note, dated 7/9/19 at 8:44 PM, documented the physician was notified of Resident #44's fall.</p> <p>A progress note, dated 7/9/19 at 8:55 PM, documented Resident #44's daughter was informed Resident #44 had a second fall of the evening which resulted in a deep skin tear to her left hand, and her daughter agreed to send Resident #44 to the ER for treatment.</p> <p>A progress note, dated 7/9/19 at 9:05 PM, documented direction from the physician to send Resident #44 to the ER for evaluation and treatment of a hand skin tear and multiple falls within the last week.</p> <p>Resident #44's record did not include documentation the required information was provided to the hospital ER to ensure a safe and effective transition of care.</p> <p>A progress note, dated 7/10/19 at 1:10 AM, documented Resident #44 returned to facility at 1:05 AM. There was no evidence the hospital was made aware of the bump to Resident #44's head which she sustained during her first fall the evening of 7/9/19 and whether it was assessed at the hospital.</p> <p>On 8/8/19 at 8:50 AM, the DNS said Resident #44's record did not include documentation the facility conveyed the required information to the hospital ER on 7/9/19.</p>	F 622	<p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents requiring/requesting discharge from the facility could potentially be affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility's policy for Resident Transportation/Transfer has been revised to reflect the need to document the items that are sent to the discharging entity and/or provided to the resident upon discharge, as well as nurse to nurse communication whenever possible. An in-service education was held for all staff assisting in the discharge process to inform them of the importance to send required information and also to document such.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Social Services Department, or designee, will conduct an audit of resident discharges and emergency transfers weekly for two (2) weeks then monthly for four (4) months. Findings of these audits will be discussed in the weekly leadership meeting. Audited records will be reviewed at the monthly Quality Assurance meeting until such a time that consistent substantial compliance has been achieved as determined by the committee. Adjustments will be made as necessary.</p>		

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

PRINTED: 09/27/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135132	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/09/2019
NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
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F 622	<p>Continued From page 18</p> <p>2. Resident #37 was readmitted to the facility on 5/9/19, with multiple diagnoses including COPD (a progressive lung disease that results in shortness of breath) and acute respiratory failure with hypoxia (low oxygen level).</p> <p>On 8/7/19 at 10:18 AM, Resident #37 was in his room with oxygen in place at 4 liters per minute by nasal cannula (tubing that administers oxygen through the nose). Resident #37 had an oximeter on his finger, and it read his oxygen saturation level was 84%. Resident #37 said his breathing was "not feeling very good."</p> <p>A physician's order, dated 8/7/19, documented to send Resident #37 to a hospital emergency room (ER) for evaluation for shortness of breath with hypoxia.</p> <p>A Nursing Note, dated 8/7/19 at 10:33 AM, documented the RN Manager assessed Resident #37 for concerns that he was unable to catch his breath. Resident #37's oxygen saturation level was low, the physician was notified, and an order was received to have him evaluated in the ER.</p> <p>A Nursing Note, dated 8/7/19 at 4:30 PM, documented Resident #37 was admitted to the hospital with diagnoses of pneumonia and hypoxia.</p> <p>There was no documentation that the required information was provided to the receiving hospital when Resident #37 was transferred.</p> <p>On 8/8/19 at 10:05 AM, the RN Manager said when a resident was transferred to the hospital, the charge nurse documented the assessment</p>	F 622			

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F 622	<p>Continued From page 19 and details of the transfer in the Progress Notes.</p> <p>On 8/8/19 at 2:00 PM, the DNS said when a resident was transferred to the hospital, facility staff contacted the family, obtained an order from the physician, copied the resident's face sheet, advanced directive, and Medication Administration Record (MAR), sent the copies with the resident, and completed the transfer form. The DNS said no other documentation was completed upon resident transfers, and he did not think documentation would be found in a Progress Note about what information was sent with Resident #37 to the hospital.</p> <p>3. Resident #47 was readmitted to the facility on 12/4/18, with multiple diagnoses including dementia and iron deficiency anemia.</p> <p>A Nursing Note, dated 8/6/19 at 9:15 AM, documented Resident #47 had a nosebleed upon returning from breakfast and the bleeding continued. He verbalized feeling like he was going to pass out, and was subsequently sent to the ER for treatment.</p> <p>A Notice of Resident Transfer form, dated 8/6/19, documented Resident #47 was being transferred to a hospital ER.</p> <p>On 8/6/19 at 11:19 AM, Charge Nurse #1 stated Resident #47 went to the hospital that morning due to a nosebleed.</p> <p>There was no documentation in Resident #47's record the required information was provided to the receiving hospital when he was transferred to the hospital.</p>	F 622			

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F 622	<p>Continued From page 20</p> <p>On 8/8/19 at 10:05 AM, the RN Manager said when a resident was transferred to the hospital, the charge nurse documented the assessment and details of the transfer in the Progress Notes.</p> <p>There was no documentation in Resident #47's record the required information was provided to the receiving hospital when he was transferred to the hospital.</p> <p>On 8/8/19 at 2:00 PM, the DNS said he did not think documentation would be found in a Progress Note about what information was sent with Resident #47 to the hospital.</p> <p>4. Resident #38 was readmitted to the facility on 6/11/19, with multiple diagnoses including heart disease and congestive heart failure.</p> <p>A progress note, dated 8/6/19 at 12:30 PM, documented verbal communication from the physician to send Resident #38 to the hospital via emergent transport for evaluation and treatment.</p> <p>A progress note, dated 8/6/19 at 1:30 PM, documented Resident #38 was sent to the hospital ER for unresponsiveness, inability to follow commands, weakness, and bradypnea (abnormally slow breathing), after consulting with Resident #38's Durable Power of Attorney.</p> <p>Resident #38's record did not include documentation the required information was provided to the hospital to ensure a safe and effective transition of care.</p>	F 622			

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F 622	<p>Continued From page 21</p> <p>On 8/8/19 at 9:30 AM, the DNS stated Resident #38's record did not include documentation the facility conveyed the required information to the hospital ER on 8/6/19.</p> <p>5. Resident #61 was readmitted to the facility on 4/16/19, with multiple diagnoses including syncope (lightheadedness) and collapse.</p> <p>A Fax Transmittal Sheet, dated 5/8/19, documented information was faxed to a named home health agency. The faxed information included the face sheet, orders, physician note, and physical therapy note. The Fax Transmittal Sheet did not document advance directive information was sent.</p> <p>A physician's order, dated 5/9/19, documented Resident #61 "may discharge to home today 5/9/19 with home health [and] PT (physical therapy)."</p> <p>Resident #61's Physician Discharge Summary note, dated 5/9/19 at 3:50 PM, did not include his advance directive information.</p> <p>A Recapitulation of Resident's Stay, dated 5/9/19, did not document his advance directive information.</p> <p>On 8/9/19 at 10:10 AM, LSW #2 provided Resident #61's Recapitulation of Resident's Stay and Discharge Checklist. LSW #2 said there was no further documentation regarding Resident #61's discharge, and his discharge was abrupt and sudden. On 8/9/19 at 10:27 AM, LSW #2 said the documentation did not indicate his advance directive information was sent to the</p>	F 622			

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F 622	Continued From page 22 home health agency.	F 622			
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 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents' care plans were updated to accurately reflect their code status. This was true for 1 of 15 residents (Resident #37) whose care	F 657	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its	9/13/19	

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F 657	<p>Continued From page 23</p> <p>plans were reviewed. This failure created the potential for life sustaining treatment to be administer or withheld, contrary to residents wishes should they become incapacitated. Findings include:</p> <p>The facility's policy for Resident Care Planning, undated, documented the following:</p> <ul style="list-style-type: none"> * Each resident had a care plan that was "current, individualized, and consistent with the medical regimen." * The interdisciplinary team reviewed and updated the care plan as necessary. * The licensed nurse updated the care plan as new physician orders were received and when new problems were identified. <p>Resident #37 was readmitted to the facility on 5/9/19, with multiple diagnoses including COPD (a progressive lung disease that results in shortness of breath), heart failure, dementia, and obstructive sleep apnea (intermittent cessation of breathing)</p> <p>Resident #37's annual MDS assessment, dated 6/14/19, documented he was moderately cognitively impaired.</p> <p>Resident #37's care plan documented Full Code (resuscitate), initiated on 6/11/18.</p> <p>Resident #37's Physician Orders For Scope of Treatment (POST) documented Do Not Resuscitate, and it was signed by him on 5/10/19.</p> <p>On 8/7/19 at 9:57 AM, LSW #2 said she was</p>	F 657	<p>employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.</p> <p>1.Immediate action(s) taken for the resident(s) found to have been affected include: On 8/07/19, prior to the survey exit, the MDS coordinator and Social Worker updated the care plan for Resident #37 to accurately reflect his code status.</p> <p>2.Identification of other residents having the potential to be affected was accomplished by: All residents of the facility have the potential to be affected by this practice.</p> <p>3.Actions taken/systems put into place to reduce the risk of future occurrence include: On 8/7/19 the facility's MDS coordinator and Social Worker audited all resident care plans to ensure that the most recent code status was reflected in the resident's care plan. The facility social worker met with resident #37 and his guardian to discuss their interests related to the code status to ensure its accuracy. The facilities MDS team and IDT attended an in-service regarding F657, presented by the home administrator the week of 9/2/19.</p> <p>4.How the corrective action(s) will be monitored to ensure the practice will not recur: The facility's clinical team meets daily, Monday-Friday, to review all clinical changes and updates. The MDS</p>		

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F 657	Continued From page 24 involved with advance directive planning. LSW #2 said Resident #37 had a care conference, and his guardian wanted to continue with his wishes regarding his code status. LSW #2 said there was a discrepancy on Resident #37's care plan regarding his code status. On 8/7/19 at 11:25 AM, the RN Manager said there was a discrepancy on Resident #37's care plan regarding his code status, and the MDS Nurse was the one who made sure the care plan matched. On 8/7/19 at 11:39 AM, the MDS Nurse said Social Services was involved with advance directive planning and followed the information on the care plan. The MDS Nurse said Resident #37 may have updated his POST information, and she was not involved with updating the POST information.	F 657	Coordinator and Social Worker attend this meeting to ensure code status changes are reflected in the resident's care plan. Items that are discussed that require care plan revisions are taken care of in this meeting before the clinical team departs. A weekly MDS meeting is held to discuss residents that are due for their quarterly or annual MDS, thus ensuring appropriate review of the resident's care plan with all staff involved from each discipline. The DNS, or designee, will review a random sample of five (5) care plans a week for four (4) to ensure that code status and care plans match. Findings of these audits will be discussed in the weekly leadership meeting. Audited records will be reviewed at the monthly Quality Assurance meeting until such a time that consistent substantial compliance has been achieved as determined by the committee. Adjustments will be made as necessary.		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with	F 661		9/13/19	

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F 661	<p>Continued From page 25</p> <p>the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure the discharge summary included a reconciliation of residents' medications. This was true for 1 of 1 resident (Resident #61) reviewed for discharge from the facility. This failure created the potential for harm and inappropriate care due to incomplete documentation. Findings include:</p> <p>Resident #61 was readmitted to the facility on 4/16/19 with multiple diagnoses, including syncope (lightheadedness) and collapse.</p> <p>Resident #61's physician orders documented "may discharge to home today 5/9/19 with home health [and] PT (physical therapy)," ordered on 5/9/19.</p> <p>Resident #61's Physician Discharge Summary note, dated 5/9/19 at 3:50 PM, did not document</p>	F 661	<p>Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.</p> <p>1. Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>The resident identified as having been discharged without having a medication reconciliation left the facility 5/9/19. Follow up with resident #61, reveals no harm and resident states that if further cares are required for him to be in a skilled nursing facility, he plans to come</p>		

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F 661	Continued From page 26 a reconciliation of his medications. A Recapitulation of Resident's Stay, dated 5/9/19 did not document a reconciliation of Resident #61's medications. Resident #61's Discharge Checklist, undated, documented "has all meds needed." On 8/9/19 at 9:27 AM, the DNS said the facility obtained discharge orders from the resident's medical provider, including medications. The DNS said medications were sent home with the resident when the resident left the facility. On 8/9/19 at 9:29 AM, LSW #2 said when a resident was discharged from the facility, a discharge summary and list of medications were sent to the home health agency. On 8/9/19 at 10:10 AM, LSW #2 provided Resident #61's Recapitulation of Resident's Stay and Discharge Checklist. LSW #2 said there was no further documentation regarding Resident #61's discharge, and his discharge was abrupt and sudden. On 8/9/19 at 10:27 AM, LSW #2 said she did not see a medication reconciliation in Resident #61's record. LSW #2 said Resident #61 stated he had all of his medications at home.	F 661	back to this facility. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents requiring/requesting discharge from the facility could potentially be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility's policy for Resident Transportation/Transfer has been revised to reflect the need to provide a medication reconciliation. A note has been created in the facility's EMR that allows for a simplified process to ensure the resident and/or the caregiver is provided with a medication reconciliation upon discharge. An in-service education was held for all staff assisting in the discharge process to inform them of this new process and how it fits in to the discharge process. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DNS or designee will review all discharges as often as they occur, for four (4) weeks. Findings of these audits will be discussed in the weekly leadership meeting. Audited records will be reviewed at the monthly Quality Assurance meeting until such a time that consistent substantial compliance has been achieved as determined by the committee. Adjustments will be made as necessary.		
F 684	Quality of Care	F 684		9/13/19	

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F 684 SS=D	Continued From page 27 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 policy review, record review, and staff interview, it was determined the facility failed to ensure professional standards of practice were maintained related to neurological assessments being completed following unwitnessed falls. This was true for 1 of 15 residents (Resident #44) reviewed for falls. These failures created the potential for harm if changes in residents' neurological status went undetected and untreated after falls. Findings include. The facility's Neurological Assessments policy and procedure, revised 5/2018, documented: * Residents that have a fall with a suspected head injury such as: Bruise, scrape, lying in suspected position suggestive of hitting head, or any other condition which warrants neurological assessments "will have neurological assessment completed". * Each resident that has a suspected head injury following a suspected fall or any condition that warrants neurological assessments will have a neurological assessment completed immediately	F 684	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1.Immediate action(s) taken for the resident(s) found to have been affected include: Resident #44 has had a recent neuro assessment completed that shows normal findings. 2.Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents requiring neurological assessments have the potential to be affected. 3.Actions taken/systems put into place to reduce the risk of future occurrence		

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F 684	<p>Continued From page 28 following initial nursing assessment after the incident.</p> <p>* Assessment is to be completed on the Neurological Assessment Flow Sheet "by a nurse".</p> <p>* Procedure is as follows: a neurological assessment is to be completed every 15 minutes for 2 hours (8 assessments), then every 30 minutes for 1 hour (2 assessments), then every hour for 4 hours (4 assessments), and then every shift of 8 hours (8 assessments), until approximately 72 hours have elapsed (for a total of 22 assessments) and resident is stable.</p> <p>The facility's Neurological Assessment Flow Sheet included date, time, level of consciousness, pupil response, motor functions, pain response, vital signs, observations of seizures, headaches and vomiting, and nurses' signatures/initials.</p> <p>Resident #44 was readmitted to the facility on 3/19/19, with multiple diagnoses including stroke affecting her right side and dementia.</p> <p>*An Incident Report, dated 6/24/19 at 2:00 AM, documented Resident #44 had an unwitnessed fall and was found in her room lying on her back at bedside, and her head was at the foot of the bed.</p> <p>Resident #44's Neurological Assessment Flow Sheet was started on 6/24/19 at 2:00 AM and was scheduled to end in 72 hours on 6/27/19 at 2:00 AM. Her vital signs and observation assessments were not documented on 6/24/19</p>	F 684	<p>include: An in-service education was conducted by the DNS for all licensed nurses on 8/14/19. This included a discussion regarding completion of incident and accident reports and the purpose of doing Neurological Assessments following a resident fall if one could not rule out whether the resident hit their head. The facility's Neurological Assessments procedure was reviewed and revised.</p> <p>4.How the corrective action(s) will be monitored to ensure the practice will not recur: The DNS, or designee, will conduct an audit of all future incidents and accidents with the IDT, to rule out whether Neuro Checks were needed. The Neuro Checks will be reviewed daily, and the results will be brought to the daily clinical review to ensure they are completed appropriately. Findings of these audits will be discussed in the weekly leadership meeting. Audited records will be reviewed at the monthly Quality Assurance meeting until such a time that consistent substantial compliance has been achieved as determined by the committee. Adjustments will be made as necessary.</p>		

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F 684	<p>Continued From page 29</p> <p>from 3:45 AM to 6:45 AM, (missing 4 assessments); and vital signs and observation assessments were not documented during the 6/26/19 evening shift (2:00 to 10:00 PM, missing 1 assessment). The Neurological Assessment Flow Sheet documented 5 of 22 assessments within the 72-hour period were incomplete.</p> <p>On 8/7/19 at 2:19 PM, the DNS stated the neurological assessments had not been completed for Resident #44's 6/24/19 fall.</p> <p>b. An Incident Report, dated 7/3/19 at 6:02 PM, documented Resident #44 was taken to her room by another resident and appeared to have fallen. The nurse documented when he entered Resident #44's room he found her sitting on the floor in front of her wheelchair.</p> <p>Resident #44's Neurological Assessment Flow Sheet was started on 7/3/19 at 5:55 PM and was scheduled to end in 72 hours on 7/6/19 at 5:55 PM. Her vital signs and observation assessments were not documented on 7/3/19 from 6:10 PM to 6:55 PM (missing 3 assessments), from 7:10 PM to 8:10 PM (missing 3 assessments), and from 9:55 PM to 10:55 PM (missing 1 assessment) and stopped on 7/4/19 during the day shift (6 AM to 2 PM). Assessments were not resumed due to Resident #44 having a fall on 7/4/19 at 7:30 AM. The Neurological Assessment Flow Sheet documented 7 of 15 assessments were incomplete, prior to her next fall.</p> <p>c. An Incident Report, dated 7/4/19 at 7:30 AM, documented Resident #44 was observed on the floor next to her bed on her back with her head by the foot of the bed and her feet facing toward</p>	F 684			

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F 684	<p>Continued From page 30 the head of the bed.</p> <p>Resident #44's Neurological Assessment Flow Sheet was started on 7/4/10 at 7:30 AM and scheduled to end in 72 hours on 7/7/19 at 7:30 AM. None of Resident #44's assessments were documented on 7/4/19 after 7:45 AM until 8:30 AM (missing 2 assessments). No level of consciousness, pupil response, and motor function assessments were not completed on 7/5/19 during the day shift (6 AM to 2 PM, missing 1 assessment). The last assessment was documented on 7/5/19 during the evening shift (2 PM to 10 PM) and not resumed due to Resident #44 having a fall on 7/5/19 at 9:45 PM. The Neurological Assessment Flow Sheet documented 3 of 19 assessments were not completed or were incomplete, prior to her next fall.</p> <p>d. An Incident Report, dated 7/5/19 at 9:45 PM, documented a radio report said Resident #44 was on the floor, the responding nurse observed resident leaning against the bed in a kneeling position.</p> <p>Resident #44's Neurological Assessment Flow Sheet was started on 7/5/19 at 9:40 PM and scheduled to end on 7/8/19 at 9:40 PM. Her pupil and pain response assessments were not documented on 7/5/19 from 10:25 PM to 7/6/19 during the day shift (6 AM to 2 PM, missing 6 assessments); motor function assessments were not completed from 7/5/19 at 10:40 PM to 7/6/19 during day shift (6 AM to 2 PM, missing 12 assessments); and vital signs and observations were not made from 7/5/19 at 1:55 AM to 7/6/19 during the day shift (6 AM to 2 PM, missing 3</p>	F 684			

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F 684	<p>Continued From page 31 assessments). No assessments were made on the 7/7/19 day shift (6 AM to 2 PM, missing 1 assessment). One or more of the assessment areas identified on the Neurological Assessment Flow Sheet had lapses in the documentation from 3 hours to 7 hours. Thirteen of the 22 Neurological Assessment Flow Sheets lacked documentation of 2 to 6 key resident assessment areas.</p> <p>e. An Incident Report, dated 7/9/19 at 8:05 PM, documented Resident #44 was found on the floor, with her legs facing the TV and her head under her bedside table. Resident #44 said her head was hurting and a hematoma (leakage from a larger blood vessel possibly leaving a dark blue or black mark) was found on the left side of her head.</p> <p>Resident #44's Neurological Assessment Flow Sheet was started on 7/9/19 at 8:00 PM and scheduled to end on 7/12/19 at 8:00 PM. One complete neurological assessment was documented on 7/9/19 at 8:15 PM, and at that time Resident #44's pulse was elevated. The vital sign assessments were not continued. All other assessments areas were documented through 8:45 PM on 7/9/19 (total of 4 incomplete assessments) after which Resident #44 had a second fall and was transported to the hospital.</p> <p>f. An Incident Report, dated 7/9/19 at 8:45 PM, documented Resident #44 was found sitting on the floor at bedside leaning against her bed with a full thickness skin tear on her left outer wrist and was sent to the hospital ER for evaluation and treatment. A progress note, dated 7/10/19 at 1:10 AM, documented Resident #44 returned to</p>	F 684			

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F 684	Continued From page 32 facility at 1:05 AM. Upon Resident #44's return from the hospital a new 72-hour Neurological Assessment Flow Sheet was not started. The documentation on the Neurological Assessment Flow Sheet for the prior fall on 7/9/19 at 8:00 PM was resumed. On 7/10/19 at 1:45 AM, it was completed on the 7/12/19 day shift (6 AM to 2 PM) and documented the required assessments for the 7/9/19 at 8:00 PM fall were interrupted; 8 of the 22 assessments were not completed. Neurological Assessments for Resident #44's fall on 7/9/19 at 8:45 PM were not documented for the required 72-hour period. On 8/7/19 at 4:50 PM, the DNS stated the CNAs completed the vital signs portion of the neurological assessments, the Neurological Assessment Flow Sheets were not completed, and a nurse should be completing the whole Neurological Assessment Flow Sheet per the facility's Neurological Assessment policy.	F 684			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of Incident Reports, and staff interviews, it was determined	F 689	Preparation and/or execution of this plan do not constitute admission or agreement	9/13/19	

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F 689	<p>Continued From page 33</p> <p>the facility failed to ensure interventions were developed and implemented, and sufficient supervision was provided, to prevent resident falls. This was true for 1 of 2 residents (Resident #44) reviewed for falls. This failure placed Resident #44 at risk of bone fractures, brain damage, and other life changing injuries when she experienced a total of 7 unwitnessed falls in the facility in 42 days, 6 occurring within 15 days. Findings include:</p> <p>Resident #44 was readmitted to the facility on 3/19/19, with multiple diagnoses including a stroke affecting her right side and dementia.</p> <p>Resident #44's quarterly MDS assessment, dated 6/21/19, documented Resident #44 was severely cognitively impaired, required extensive assistance of two staff members for transfers due, and was always incontinent of bladder and bowel.</p> <p>Resident #44's care plan directed staff to implement the following interventions:</p> <ul style="list-style-type: none"> * Initiated 6/22/17, the bed placed in a lower position when resting to promote safety, and for transfers the bed was placed at correct height to promote proper body ergonomics * Initiated 3/26/19, a resting hand splint for her right arm to be worn at night * Initiated 4/6/19, a self-release belt with alarm was installed on Resident #44's wheelchair to remind her to ask for assistance with transfers due to weakness on right side, impulsivity, and poor safety awareness secondary to dementia 	F 689	<p>by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.</p> <ol style="list-style-type: none"> 1. Immediate action(s) taken for the resident(s) found to have been affected include: Safety and fall risk assessments were completed for Resident #44. Appropriate revisions were made to the care plans to reflect all current safety interventions. The revised assessments and care plans were reviewed with staff involved in the care of Resident #44. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents at risk for falls have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: All Licensed Nursing staff have been inserviced on the facility policy for Accidents and Supervision. A list of interventions that could be used to prevent further falls has been compiled by the IDT to offer further assistance to the nurse that would be completing the incident report. The nursing staff have been encouraged to discuss interventions with all licensed and non-licensed nursing staff to aid in a good resolution to prevent 		

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F 689	<p>Continued From page 34</p> <p>* Initiated 4/24/19, provide Resident #44 with extensive-total assistance of 1 staff for toileting</p> <p>* Initiated 7/2/19, blue leg strap to her right leg when in wheelchair for improved right leg positioning and placed above the knee for maximum external rotational support.</p> <p>Resident #44 had 6 unwitnessed falls within 15 days (6/24/19 to 7/9/19) and a subsequent fall on 8/4/19, 23 days later. The facility failed to provide supervision, and initiate interventions, consistent with Resident #44's physical and cognitive abilities, resulting in multiple falls and injuries. Examples include:</p> <p>* An Incident Report, dated 6/24/19 at 2:00 AM, documented Resident #44 was found in her room on the floor with a urine-soaked brief lying on the bed with urine-soaked linens, the alarm was sounding, and no injuries were observed at that time. New interventions included assessment of passive range of motion (ROM), change of linens, assisting Resident #44 back to bed, arming of alarms, and implementation of neurological checks. The Incident Report included notes from the Interdisciplinary Team (IDT).</p> <p>The IDT notes, dated 6/24/19, documented discussion of the type of Resident #44's incontinent brief and removal of the wheelchair seat belt alarm and replacing it with encouragement to use her call light. The IDT notes, dated 6/26/19, documented discussion with staff who said when Resident #44 was in her room she removed the seat belt alarm and</p>	F 689	<p>further incidents. All resident falls/accidents will be reviewed daily by the nursing management team to ensure appropriate implementation of safety interventions including updating the plan of care.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The nursing management team will review each incident report upon occurrence to ensure appropriate interventions are implemented and an updated plan of care is complete. The DNS, or designee, will complete random weekly chart audits for six (6) consecutive weeks and review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of resident falls/accidents and that care plans have been updated to reflect these interventions. Findings of these audits will be discussed in the weekly leadership meeting. Audited records will be reviewed at the monthly Quality Assurance meeting until such a time that consistent substantial compliance has been achieved as determined by the committee. Adjustments will be made as necessary.</p>		

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F 689	<p>Continued From page 35</p> <p>attempted to self-transfer. It was determined the seat belt should be continued. The IDT notes, dated 6/27/19, three days after the 6/24/19 fall, documented a bowel and bladder monitoring log was to be completed to determine Resident #44's toileting habits and establish times when assistance was needed.</p> <p>Resident #44's Three Day Toileting Pattern Log, completed 6/28/19 thru 6/30/19, documented no pattern; it was inconclusive and no regularly scheduled times for assistance could be identified.</p> <p>A progress note, dated 6/25/19 at 3:00 PM, documented Resident #44 was observed with bruise to her right breast, said she did not know how it happened, and a CNA stated it was present when they dressed her in the morning.</p> <p>On 8/7/19 at 2:19 PM, the DNS said the following interventions were implemented after Resident #44's fall on 6/24/19: discussed and implemented a toileting trial, implemented neurological checks, provided a different more absorbent and comfortable brief, reviewed the use of the seat belt alarm and kept it as an alarm to alert staff when Resident #44 removed the seat belt alarm when in her room.</p> <p>* An Incident Report, dated 7/3/19 at 6:02 PM, documented Resident #44 was assisted to her room by another resident, was found on the floor in front of her wheelchair, and said she did not hit her head. Resident #44 was assisted to a day room area for closer supervision. Interventions included assessment of ROM and implementation of neurological checks per policy.</p>	F 689			

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F 689	<p>Continued From page 36</p> <p>The IDT notes, dated 7/8/19, documented education of the assisting resident that only staff should assist residents to their rooms and into bed. The IDT notes, dated 7/16/19, directed readers to a future fall Incident Report, dated 7/9/19, for information and interventions. Documented on this Incident Report, was RN #6's note that Resident #44 was unaware of her self-transferring deficits. Further interventions to protect Resident #44 from additional falls were not initiated directly following the 7/3/19 fall.</p> <p>On 8/8/19 at 8:50 AM, the DNS said when there was a fall, it was the expectation that the charge nurse put in place fall prevention interventions.</p> <p>* An Incident Report, dated 7/4/19 at 7:30 AM, documented Resident #44 was found in her room on the floor, was assisted into her bed by two persons with a gait belt, no injuries were observed, and neurological checks were implemented. New interventions documented were the education of Resident #44 on the importance of safety and to use her call light for assistance, arming of alarm and confirmation it was in working order. The IDT notes, dated 7/16/19, directed the reader to a future fall Incident Report, dated 7/9/19, for information and interventions.</p> <p>* An Incident Report, dated 7/5/19 at 9:45 PM, documented the staff was alerted by radio that Resident #44 was on the floor in her room. When found Resident #44 was kneeling at the side of her bed. She was then assisted to her wheelchair by two persons with a gait belt, no injuries were observed, and neurological checks were implemented. The intervention documented was</p>	F 689			

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F 689	<p>Continued From page 37</p> <p>the education of Resident #44 on the importance of safety and to use her call light for assistance. The IDT notes, dated 7/16/19, directed readers to a future fall Incident Report, dated 7/9/19, for information and interventions. No new interventions were implemented after the 7/5/19 fall.</p> <p>An Alert Charting Progress Note, dated 7/6/19 at 10:53 AM, documented Resident #44 fell three times, her vital signs and neurological checks were within normal limits, and no new injuries observed at that time.</p> <p>On 8/8/19 at 9:10 AM, the Nurse Manager, the acting DNS at the time of Resident #44's 7/3/19, 7/4/19, and 7/5/19 falls, said they lumped all three falls into one for interventions and referred to a future fall Incident Report, dated 7/9/19, for information and interventions.</p> <p>The facility failed to discuss and consider Resident #44's special needs due to dementia when considering resident education as an intervention, and to discuss and consider other potentially effective interventions, including increased supervision and evaluation for new medical conditions potentially contributing to her falls.</p> <p>* An Incident Report, dated 7/9/19 at 8:05 PM, documented Resident #44 was found in her room on the floor with her head under a bedside table and the alarm sounding. Resident #44 said her head was hurting and a hematoma (leakage from a larger blood vessel possibly leaving a dark blue or black mark) was found on the left side of her head. After Resident #44 was assessed to be</p>	F 689			

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F 689	<p>Continued From page 38</p> <p>moved safely, she was placed back into bed. Interventions included the monitoring of vital signs every 5-10 minutes and implementation of neurological checks.</p> <p>* An Incident Report, dated 7/9/19 at 8:45 PM, documented Resident #44 was found in her room sitting on the floor and the alarm was sounding. Resident #44 was assisted to her bed with a full thickness 9 cm x 0.6 cm (3.5 inches x .25 inches) skin tear injury to her left outer wrist, which was cleansed and dressed. Resident #44 was sent to the hospital ED for evaluation. LPN #1's documented witness statement said on 7/9/19 at 8:05 PM, she looked at Resident #44's head and she had a hematoma forming behind her right ear lobe, and roughly 30 minutes later LPN #1 was called back into Resident #44's room for another fall and skin tear to her left wrist. A progress note, dated 7/9/19 at 9:05 PM, documented direction from the physician to send Resident #44 to the hospital ER for evaluation and treatment of her left hand skin tear and multiple falls within last week.</p> <p>A progress note, dated 7/9/19 at 9:05, documented Resident #44 left the facility with a facility driver to go to the ER. A progress note, dated 7/10/19 at 1:10 AM, documented Resident #44 returned to the facility via family transport, four hours later.</p> <p>Resident #44's Medical Center Discharge Instructions, dated 7/10/19, documented Resident #44 was diagnosed at the hospital with a urinary tract infection (UTI) and was prescribed a 21-day course of antibiotics. On 8/7/19 at 2:19 PM, the DNS said the new intervention after the</p>	F 689			

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F 689	<p>Continued From page 39</p> <p>7/9/19 fall was to replace the pressure-sensor alarm on Resident #44's bed with a motion-sensor alarm placed on the floor pointed towards the bed. The DNS said the protocol for falls was to check vital signs, implement neurological checks if an unwitnessed fall, place bed in lower position, and retrain the resident to push the call light.</p> <p>Resident #44 did not have another fall until 8/4/19.</p> <p>* An Incident Report, dated 8/4/19 at 9:55 PM, documented Resident #44 was observed at the nurses' station sitting on the floor in front of her wheelchair near a recliner. Her safety belt was not fastened and the alarm was turned off and a 2.2 cm x 1.7 cm (.8 inch x .6 inch) skin tear was observed on Resident #44's right shin. Resident #44 said she did not hit her head. Resident #44 was lifted into the recliner and vital signs and neurological checks were implemented. The IDT notes, dated 8/6/19, documented interventions included cleaning and dressing the wound and reminding nursing staff to assure all alarms were on and functional when transferring residents to beds and chairs.</p> <p>The facility failed to provide sufficient supervision to protect Resident #44 from repeated falls, when interventions failed to:</p> <ul style="list-style-type: none"> * Direct staff what to do to keep her from falling * Take into consideration Resident #44's impulsivity and poor safety awareness secondary to dementia, as noted in her care plan * Ensure sufficient supervision while relying on a self-release belt with an alarm to provide that 	F 689			

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F 689	Continued From page 40 supervision * Implement new interventions when those previously in place were ineffective * Consider other treatable medical conditions that potentially contributed to Resident #44's falls * Ensure implementation of interventions in place	F 689			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure the administration of oxygen consistent with the physician's order, and to ensure the tubing for respiratory equipment included the date it was last changed. This was true for 3 of 5 residents (Resident #24, #31, and #37) reviewed who received oxygen. This placed residents at risk of adverse effects from insufficient blood oxygen levels and respiratory infections due to the growth of pathogens (organisms that cause illness) in the tubing of respiratory equipment. Findings include: The facility's policy for Oxygen Therapy - Respiratory Care, revised January 2016, documented oxygen was administered to residents to improve oxygenation. The policy	F 695	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1.Immediate action(s) taken for the resident(s) found to have been affected include: Oxygen was turned on immediately for resident #24 and #31. Resident #37 had their oxygen turned down to 4L per his oxygen order. The oxygen and nebulizer tubing for Resident #37 that was not	9/13/19	

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F 695	<p>Continued From page 41</p> <p>documented oxygen flow rates were set and administered by licensed staff only, and staff could be delegated to apply the cannula and turn on the concentrator. Oxygen administration required a physician's order and the bottle and tubing should be dated and timed.</p> <p>1. Resident #24 was admitted to the facility on 11/1/16, with multiple diagnoses including COPD (a progressive lung disease that results in shortness of breath) and respiratory failure.</p> <p>Review of Resident #24's significant change MDS assessment, dated 5/24/19, documented Resident #24 was severely cognitively impaired and she received oxygen therapy.</p> <p>Resident #24's care plan, with a goal date of 8/28/19, directed staff to titrate her oxygen from zero to five liters per minute to keep her oxygen saturation level greater than 90%. The care plan directed staff to use a nasal cannula (tubing that delivers oxygen through the nose) to administer the oxygen.</p> <p>Resident #24's August 2019 Physician's Orders, documented to titrate her oxygen from zero to five liters per minute to maintain her oxygen saturation level at greater than 90%.</p> <p>On 8/6/19 at 9:38 AM and 10:52 AM, Resident #24 was lying in bed with a nasal cannula in place that was connected to an oxygen concentrator. The the oxygen concentrator was not turned on.</p> <p>On 8/6/19 at 11:08 AM, RN #4 stated Resident #24 used oxygen all the time, and the oxygen</p>	F 695	<p>dated was discarded and new tubing was supplied and dated.</p> <p>2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents with orders for oxygen had the potential to be affected.</p> <p>3. Actions taken/systems put into place to reduce the risk of future occurrence include: Oxygen orders for all residents have been reviewed and oxygen delivery devices were checked to ensure they were set at the appropriate level. An in-service education program was conducted by the DNS with all direct care staff addressing the significance of providing oxygen and dating oxygen supplies for residents with orders for oxygen therapy. The facility's policy for Oxygen Therapy <input type="checkbox"/> Respiratory Care has been reviewed and revised. A checklist has been created to remind all staff going in and out of resident rooms to check on specific items (i.e.: oxygen turned on, call light in place, water within reach, etc.). A visual inspection was done on all residents' oxygen tubing and any oxygen tubing found without a date was discarded and replaced with new, dated, tubing.</p> <p>4. How the corrective action(s) will be monitored to ensure the practice will not recur: The DNS, or designee, will perform random weekly audits for 4 weeks of resident oxygen to ensure oxygen is flowing as ordered and tubing is dated</p>		

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F 695	<p>Continued From page 42</p> <p>was titrated to maintain her oxygen saturation level at greater than 90%. RN #4 stated Resident #24's oxygen saturation level was 93% that morning on three liters of oxygen per minute. RN #4 placed the oximeter (a device that measures the percentage of oxygen saturation) on Resident #24's finger and it showed the oxygen saturation level was 80% with the oxygen concentrator turned off. RN #4 immediately turned the oxygen concentrator on and Resident #24's oxygen saturation level began to improve. RN #4 stated Resident #24 had been hospitalized a couple of times because of respiratory failure. RN #4 stated the CNAs could turn the concentrator on, but they were not allowed to adjust the oxygen flow meter. She stated only the nurses could adjust the oxygen flow meter.</p> <p>2. Resident #31 was admitted to the facility on 5/31/19, with multiple diagnoses including COPD and cancer.</p> <p>Resident #31's admission MDS, dated 6/8/19, documented she was severely cognitively impaired, totally dependent on two staff members for transfers, required extensive assistance of two persons for bed mobility, and received oxygen therapy.</p> <p>Resident #31's care plan, with a goal date of 9/17/19, documented titrate oxygen zero to four liters to keep oxygen saturations greater than 89%, and she used a nasal cannula.</p> <p>Resident #31's August 2019 Physician Orders documented to titrate her oxygen zero to four liters per minute to maintain her oxygen saturation levels to greater than 89%.</p>	F 695	<p>appropriately.</p> <p>Findings of these audits will be discussed in the weekly leadership meeting. Audited records will be reviewed at the monthly Quality Assurance meeting until such a time that consistent substantial compliance has been achieved as determined by the committee. Adjustments will be made as necessary.</p>		

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F 695	<p>Continued From page 43</p> <p>On 8/6/19 at 10:47 AM and 11:20 AM, Resident #31 had a nasal cannula in place. Her oxygen concentrator was not turned on.</p> <p>On 8/6/19 at 11:20 AM, RN #4 stated Resident #31's oxygen concentrator should have been on and it was not. RN #4 stated the CNA did not turn the oxygen concentrator on when Resident #31 was assisted back to bed. RN #4 checked Resident #31's oxygen saturation level and it was 84%. RN #4 immediately turned the oxygen concentrator on, and Resident #31's oxygen saturations began to improve. RN #4 stated Resident #31 was at risk for lethargy and increased confusion since the oxygen concentrator was turned off.</p> <p>On 8/6/19 at 11:23 AM, CNA #2 stated Resident #31 was assisted to bed around 9:30 AM. CNA #2 stated she thought Resident #31's oxygen was already on and she did not turn it on. CNA #2 said CNAs could place the nasal cannula on a resident and could turn the oxygen concentrator on,</p> <p>On 8/9/19 at 8:35 AM, the DNS stated it was not appropriate to leave a resident without oxygen. He stated a resident who did not have oxygen administered could risk increased anxiety, increased confusion, increased falls risk, and possibly respiratory distress.</p> <p>3. Resident #37 was readmitted to the facility on 5/9/19, with multiple diagnoses including COPD and acute respiratory failure with hypoxia (low oxygen level).</p>	F 695			

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F 695	<p>Continued From page 44</p> <p>Resident #37's annual MDS assessment, dated 6/14/19, documented he had shortness of breath with exertion, when sitting, at rest, and when lying flat. The MDS documented he received oxygen therapy.</p> <p>Resident #37's physician orders documented an order on 6/5/19, for his oxygen to be titrated zero to four liters per minute to maintain his oxygen saturation level above 89%.</p> <p>Resident #37's care plan documented his oxygen was to be titrated zero to four liters per minute to maintain his oxygen saturation level above 89%.</p> <p>On 8/6/19 at 9:50 AM, Resident #37 was lying in bed with oxygen flowing at five liters per minute by nasal cannula. There was no date on the oxygen tubing. A nebulizer machine (a device to administer medication via aerosolized inhalation), tubing, and mask were on the bedside table. There was no date on the nebulizer tubing.</p> <p>On 8/7/19 at 10:23 AM, LPN #3 said the physician's order was to keep Resident #37's oxygen saturation above 89%, and he was on four liters of oxygen.</p> <p>On 8/7/19 at 11:28 AM, the RN Manager said it was standard for staff to put a date on the oxygen and nebulizer tubing when it was changed, and maybe it was due to new staff undergoing orientation that it was not dated. The RN Manager said he did not know why the oxygen was set at five liters per minute for Resident #37, he was typically on 4 liters of oxygen, and maybe he manipulated the oxygen setting himself.</p>	F 695			

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F 695	Continued From page 45 On 8/7/19 at 3:52 PM, the DNS said oxygen tubing should be changed by the nurses and it was documented on the Treatment Administration Record (TAR). The DNS said Resident #37 had a history of wearing his oximeter all day, and if his oxygen saturation was not where he thought it should be he adjusted the oxygen flow rate. The DNS said it had been discussed with Resident #37 to leave his oxygen flow rate alone.	F 695			
F 880 SS=D	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and</p>	F 880		9/13/19	

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F 880	<p>Continued From page 46</p> <p>procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review.</p>	F 880			

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F 880	<p>Continued From page 47</p> <p>The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure appropriate infection control measures were maintained. This was true for 2 of 15 residents (Resident #31 and #43) reviewed for infection control. This deficient practice placed residents at risk for infection due to cross contamination. Findings include:</p> <p>The facility's policy for Medication Administration and Medication Order, undated, directed staff to not touch any medications.</p> <p>The facility's policy for Hand Hygiene, revised February 2015, directed staff to perform hand hygiene prior to and following administering medication and other nursing interventions.</p> <p>On 8/7/19 at 9:00 AM, during observation of medication administration, LPN #1 popped a pill out of the medication card, put it into her bare hands, and then placed the medication into a medication cup for Resident #43. LPN #1 continued to pop out 13 medications from their medication cards, put them in her bare hands, and then placed them into the medication cup. LPN #1 went into Resident #43's room and administered the medications. LPN #1 touched the nebulizer mask (a device to administer medication via aerosolized inhalation) and put medication into it, placed the nebulizer mask on Resident #43's face, and removed Resident #43's glasses. LPN #1 left the room and went to the medication cart and pulled the keyboard out.</p>	F 880	<p>Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.</p> <p>1.Immediate action(s) taken for the resident(s) found to have been affected include:</p> <p>Residents #31 and 43 were found to have no adverse outcomes due to the deficient practice and LPN #1 was immediately in-serviced on infection control measures during medication administration and with resident interactions.</p> <p>2.Identification of other residents having the potential to be affected was accomplished by:</p> <p>The facility has determined that all residents have the potential to be affected.</p> <p>3.Actions taken/systems put into place to reduce the risk of future occurrence include:</p> <p>All licensed nurses have been in-serviced on the facility's policy for infection prevention as it pertains to medication administration and resident interactions. Licensed nurse training includes random observation of personnel performing hand</p>		

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F 880	<p>Continued From page 48</p> <p>LPN #1 did not wash or sanitize her hands when she left Resident #43's room. LPN #1 knocked on the door of another residents' room, entered the room, and walked right back out. On 8/7/19 at 9:15 AM, LPN #1 returned to the medication cart and set up medication for Resident #31 without sanitizing her hands. LPN #1 popped out 11 pills from their medication cards, put each medication into her bare hand and then into a medication cup. LPN #1 opened the narcotic drawer with her keys, got medication from it, and signed the narcotic book. LPN #1 took a straw and put it into a cup and proceeded to walk down the hall to the day area where Resident #31 was sitting. LPN #1 touched Resident #31's arm and handed her the cup with the straw in it. LPN #1 returned to the medication cart and started to set up another residents' medication. She stopped and went back into Resident #43's room, repositioned the residents' head and moved her headphones. LPN #1 then sanitized her hands when she came out of Resident #43's room.</p> <p>On 8/7/19 at 9:30 AM, LPN #1 stated she did not sanitize her hands between Resident #31 and Resident #43 because the residents were not in their usual location and it threw her routine off. She stated normally, staff should sanitize their hands between residents and if their hands were heavily soiled they would wash them. LPN #1 stated infection or disease could spread from one resident to another if staff did not sanitize their hands or wash them.</p> <p>On 8/7/19 at 3:06 PM, LPN #1, stated she placed the pills in her hands when she passed medication because the pills sometimes popped out and fell on the floor. She stated the</p>	F 880	<p>hygiene according to facility policy and immediate education related to any deficient practices.</p> <p>4.How the corrective action(s) will be monitored to ensure the practice will not recur: The DNS, or designee, will complete random Validation Checklists for personnel related to hand hygiene and medication administration. To ensure personnel are performing the procedure in accordance with our facility's Practice Guideline, random monitoring will occur each week for 4 weeks. Findings of these audits will be discussed in the weekly leadership meeting. Audited records will be reviewed at the monthly Quality Assurance meeting until such a time that consistent substantial compliance has been achieved as determined by the committee. Adjustments will be made as necessary.</p>		

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NAME OF PROVIDER OR SUPPLIER IDAHO STATE VETERANS HOME - POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1957 ALVIN RICKEN DRIVE POCATELLO, ID 83201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 49</p> <p>medications were secured in her hands.</p> <p>On 8/7/19 at 10:37 AM, LPN #2 said staff were not to touch the pills with their bare hands because it would contaminate the medication, or it could absorb into your own skin. LPN #2 stated if staff touched the pills it was possible to pass pathogens from one resident to another. LPN #2 stated staff should sanitize their hands between residents.</p> <p>On 8/8/19 at 11:12 AM, RN #1 stated staff were not to touch medications and should do hand hygiene before and after each administration. RN #1 stated if medications needed to be touched the staff should wear gloves and perform hand hygiene after administration.</p> <p>On 8/7/19 at 12:05 PM, the DNS stated staff should sanitize their hands between residents to keep from cross contaminating from one resident to another. The DNS said staff should not touch the pills with their hands because whatever was on the staff's hands would contaminate the pills.</p>	F 880			