IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE: (208) 334-6626
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November 1, 2019

J.R. Burt, Administrator
Advanced Health Care of Lewiston
2852 Juniper Drive
Lewiston, ID 83501

Provider #: 135145

Dear Mr. Burt:

On **October 18, 2019**, a survey was conducted at Advanced Health Care of Lewiston by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **November 12, 2019**. Failure to submit an acceptable PoC by **November 12, 2019**, may result in the imposition of penalties by **December 4, 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 <u>in column (X5)</u>.

  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 **November 22, 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 **January 18, 2020**. A change in the seriousness of the deficiencies on **December 2, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **January 18, 2020** includes the following:

Denial of payment for new admissions effective **January 18, 2020**. [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 **April 18, 2020**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 18, 2020** 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

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 **November 12, 2019**. If your request for informal dispute resolution is received after **November 12, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

lt/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135145		10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED HEALTH CARE OF LEWISTON	2852 JUNIPER DRIVE LEWISTON, ID 83501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from October 15, 2019 through October 18, 2019. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Karen George, RN Survey Abbreviations: DON = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record	F 000		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of	F 660		11/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/11/2019

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

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F 660	Continued From page 1 developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized	F 660		

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F 660	Continued From page 2 patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. 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 discharge plans were developed for residents. This was true for 1 of 1 resident (Resident #7) reviewed for discharge planning. This failure created the potential for harm if the resident's various discharge needs were not met. Findings include: The facility's discharge policy, dated 2/21/18, documented the discharge plan of care was developed to assist a resident to adjust to their new living environment by providing continuity of care. This policy was not followed. Resident #7 was admitted to the facility on 6/22/19, for post-operative care following surgical repair of a fracture of the top of her left femur (thigh bone). Additional diagnoses included congestive heart failure and diabetes.	F 660	This plan of Correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor□s conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. Please accept this plan of correction as our credible allegation of compliance F660 Resident Specific: Resident #7 had already discharged from	

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F 660	Continued From page 3 Resident #7's baseline care plan, dated 6/22/19, documented discharge plans were for her to return "home alone." A physician progress note, dated 7/1/19, documented Resident #7 fell in her home in late May, 2019 and was later diagnosed with a left femur fracture. The progress note documented Resident #7 described the reason for the fall as a syncopal episode (fainting or passing out). The progress note further documented over the weekend Resident #7 reported to nursing staff she had chest pain and shortness of breath and was transported to the hospital for evaluation. The progress note stated the hospital evaluation ruled out cardiac (heart) and pulmonary (lung) pathology, but identified she was quite anemic and required a blood transfusion. A progress note, dated 7/20/19 at 10:29 PM, documented Resident #7 complained she could not catch her breath and had chest and low back pain. Medications administered were not effective. The note documented emergency services were called and Resident #7 was transported to the hospital via ambulance. A progress note, dated 7/21/19 at 1:33 AM, documented Resident #7 was admitted to the hospital with a diagnosis of CHF exacerbation. A progress noted, dated 7/22/19 at 2:45 PM, documented Resident #7 returned to the facility. A physician order, dated 7/23/19, documented Resident #7 was discharged to her home with services from a home health agency on 7/23/19.	F 660	the facility Other residents: See systemic changes Systemic Changes: Admissions and discharge nurses have been in-serviced on the discharge policy and process to include discharge care plan and discharge planning with resident involvement. Monitors: DON or designee will review 3 discharges weekly times 4 and monthly time 3 to ensure that the resident is involved in the discharge plan, a discharge care plan is done and that a discharge note is written. DON or designee will report findings at the QAPI meeting and will make changes to the above plan of correction as needed. Date of Compliance 11/18/2019	

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F 660	Continued From page 4 Resident #7's record did not include documentation a discharge plan was completed. There was not a plan addressing Resident #7's episodes of shortness of breath when she was alone in her home. On 10/18/19 at 8:37 AM and 9:08 AM, the DON said Resident #7 was discharged from the facility with home health. The DON said there was not a discharge plan in her record.	F 660		
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 the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (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	F 661		11/18/19

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F 661	Continued From page 5 that have been made for the resident's follow up care and any post-discharge medical and non-medical services. 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 were involved in the post-discharge plan of care. This was true for 1 of 1 resident (Resident #7) reviewed for discharge planning. This failure created the potential for residents to be discharged without plans in place to effectively meet their post-discharge needs. Findings include: The facility's discharge policy, dated 2/21/18, documented a post-discharge plan of care would be developed with the participation of the resident and their family and would be provided a copy. This policy was not followed. Resident #7 was admitted to the facility on 6/22/19, for post-operative care following surgical repair of a fracture of the top of her left femur (thigh bone). Additional diagnoses included congestive heart failure and diabetes. Resident #7's baseline care plan, dated 6/22/19, documented discharge plans were for her to return "home alone." A physician progress note, dated 7/1/19, documented Resident #7 fell in her home in late May, 2019 and was later diagnosed with a left femur fracture. The progress note documented Resident #7 described the reason for the fall as a	F 661	F661 Resident Specific: Resident #7 had already discharged from the facility Other residents: See systemic changes Systemic Changes: Admissions and discharge nurses have been in-serviced on the discharge policy and process to include discharge care plan and discharge planning with resident involvement. Monitors: DON or designee will review 3 discharges weekly times 4 and monthly times 3 to ensure that the resident is involved in the discharge plan, a discharge care plan is done and that a discharge note is written. DON or designee will report findings at the QAPI meeting and will make changes to the above plan of correction as needed. Date of Compliance	

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F 661	Continued From page 6 syncopal episode (fainting or passing out). The progress note further documented over the weekend Resident #7 reported to nursing staff she had chest pain and shortness of breath and was transported to the hospital for evaluation. The progress note stated the hospital evaluation ruled out cardiac (heart) and pulmonary (lung) pathology, but identified she was quite anemic and required a blood transfusion. A progress note, dated 7/20/19 at 10:29 PM, documented Resident #7 complained she could not catch her breath and had chest and low back pain. Medications administered were not effective. The note documented emergency services were called and Resident #7 was transported to the hospital via ambulance. A progress note, dated 7/21/19 at 1:33 AM, documented Resident #7 was admitted to the hospital with a diagnosis of CHF exacerbation. A progress noted, dated 7/22/19 at 2:45 PM, documented Resident #7 returned to the facility. A physician order, dated 7/23/19, documented Resident #7 was discharged to her home with services from a home health agency on 7/23/19. Resident #7's record did not include documentation she was involved in the post-discharge plan of care, to ensure her needs were met after returning home. On 10/18/19 at 8:37 AM and 9:08 AM, the DON said Resident #7 was discharged from the facility with home health. The DON said Resident #7's record did not include documentation of her involvement in the discharge planning process.	F 661	11/18/2019	

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F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, Activity Calendar review, and resident and staff interview, it was determined the facility failed to ensure there was an ongoing activity program to meet the individual and social needs for 1 of 1 resident (Resident #162) reviewed for activities and had the potential to affect all other 25 residents in the facility. This failure created the potential for residents to experience boredom and lacked meaningful engagement throughout their stay. Findings include: The facility's Activity policy, dated 1/3/18, documented the facility provided an ongoing program of resident activities to meet the interests and physical, mental and psychosocial well-being of each resident and scheduled activities were posted. This policy was not followed. The facility's October 2019 Activity Calendar documented the following activities and times:	F 679	F679 Resident Specific: Resident #162□s activities program has been re-evaluated to ensure it meets individual need. Other Residents: Please see systemic changes Systemic Changes: The activities director and activities assistant have been in-serviced on the importance of having an activities program that meets the individual need of all residents and the activities will be posted in such a manner that the residents will know what activity is available and where the activity will be done.	11/18/19

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F 679	Continued From page 8 * Mondays - Wii Game of Choice at 10:00 AM and Bingo at 2:15 PM * Tuesdays - Cornhole (Game) at 10:00 AM and Root Beer Floats at 2:15 PM * Wednesday - Trivia at 10:00 AM and Bingo at 2:15 PM * Thursday - Wii Games at 10:00 AM and Nail Care at 2:15 PM, except 10/31/19 10:00 AM Costume Contest and 5:00 PM Trick or Treat * Friday - Outdoor Games or Board Games at 10:00 AM, Ice Cream Social at 2:15: PM, and Walks at 2:30 PM * Saturday and Sunday - Movies at 2:15 PM Resident #162 was admitted to the facility on 10/11/19, with multiple diagnoses including a stroke and dementia. Resident #162's admission activity assessment, dated 10/14/19, documented she liked cards, games, walking outside, music, and watching TV. The assessment documented she had no interest in watching movies. Resident #162's Activity Participation record from 10/11/19 to 10/16/19, documented she attended one ice cream social, one root beer float activity, attended bingo once, and refused movies twice. On 10/15/19 at 3:54 PM, Resident #162 was sitting on a couch in the lobby, near the fireplace and not engaged in an activity. A minute later, she stood up and walked down the hallway toward her room. At 4:40 PM, Resident #162 was back on the couch in the lobby and not engaged in an activity. She said, "There really isn't anything to do. It's boring here." She said she	F 679	Monitors: Administrator or designee will monitor the activities department to ensure all patients are notified of the upcoming activities, where the activities will be held and that they meet individual needs, weekly times 4 and monthly times 3. Administrator or designee will report findings at the QAPI meeting and will make changes to the above plan of correction as needed. Date of Compliance 11/18/2019	

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F 679	Continued From page 9 was not aware of what activities there were for her to do and said she liked to play games. On 10/15/19 at 4:48 PM, near Resident #162's room there was an electronic display board with the activity calendar in the hallway. The activity calendar display showed there was going to be cornhole at 10:00 AM and root beer floats at 2:15 PM. The display also showed the activities for the following day were trivia at 10:00 AM and bingo at 2:30 PM. The display did not tell residents where the activities were to take place. On 10/16/19 from 9:40 AM to 10:10 AM, during observations it was noted the activity display board showed trivia as an activity at 10:00 AM. There were no staff members observed offering residents to attend the trivia activity, including Resident #162. At 10:03 AM, there was no trivia game observed occurring in the facility as an activity in the lobby, the dining room, or the therapy room. On 10/16/19 at 10:10 AM, Resident #162 was in the recliner in her room with the TV off. She said she liked games and would be interested in a trivia game. She said no one had offered her to attend a trivia activity that day. She said there was a woman who sat with her on the couch in the lobby with her that morning for a few minutes and she said she liked that. Resident #162 said she was not sure what activities were available and no one had offered her a schedule of activities. On 10/16/19 at 2:34 PM, the activity display board showed bingo as an activity at 2:30 PM. There were no staff members observed offering	F 679		

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F 679	Continued From page 10 residents to attend the bingo activity. There was no bingo activity observed occurring in the facility as an activity in the lobby, the dining room, or the therapy room. Resident #162 was observed spending time in her room or on the couch in the lobby. She was not observed engaging in activities she enjoyed according to her activity assessment. Examples include: * On 10/16/19 from 8:15 AM to 8:30 AM, Resident #162 finished eating breakfast in the dining room and a staff member walked with her from the dining room, into the lobby area and the staff member assisted Resident #162 onto the couch. A minute later the Director of Rehabilitation (DOR) sat next to her and began talking with her. At 8:30 AM, the DOR told Resident #162 that she had to go and left the resident on the couch. * On 10/16/19 from 8:32 AM to 8:34 AM, Resident #162 got up from the couch and walked down to her room. At 8:34 AM, Resident #162 came out of her room with her TV remote in her hand and asked the DON to help her turn on the TV. * On 10/16/19 from 9:03 AM to 9:35 AM, Resident #162 was in the therapy room participating in therapy. At 9:35 AM, a therapist walked with Resident #162 back to her room. * On 10/16/19 from 9:40 AM to 10:10 AM, Resident #162 was in the recliner in her room with the TV on. At 9:54 AM, her eyes were closed, and the TV was still on.	F 679		

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F 679	Continued From page 11 * On 10/16/19 at 10:36 AM and 11:04 AM, Resident #162 was on the couch in the lobby and was observed leafing through a magazine or sitting and not engaging in an activity. * On 10/16/19 at 11:26 AM, Resident #162 was on the couch in the lobby and not engaged in an activity. CNA #1 (Certified Nursing Assistant) informed her lunch was in a half hour. CNA #1 said, "The fireplace feels pretty good, huh?" CNA #1 then walked away from Resident #162. * On 10/16/19 at 2:39 PM, Resident #162 had completed her therapy and OT #1 walked out of the therapy room with her. OT #1 asked Resident #162 if she had any plans for the rest of the day and Resident #162 responded she was not sure. OT #1 did not suggest bingo which was scheduled as an activity for 2:30 PM that day. They walked back to her room and OT #1 situated her in the recliner. On 10/16/19 at 2:44 PM and 4:36 PM, OT #1 said Resident #162 had some memory issues and needed some direction. OT #1 said Resident #162 usually spent time on the couch in the lobby or in her room. OT #1 said she was unaware that bingo was on the calendar for 2:30 PM that day and said she normally found out about the activities from the scrolling board or from the Activity Assistant (AA). On 10/16/19 at 2:58 PM, OT #2 was in the therapy room and said bingo was held in the therapy room and ice cream socials were held in the lobby. OT #2 said there were no activities and no scheduled activities in the therapy room that	F 679		

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F 679	Continued From page 12 day. On 10/16/19 at 3:57 PM, CNA #2 said Resident #162 was restless sometimes and staff would take her down to the lobby couch and turn the fireplace on. CNA #2 said staff read the activity display board to find out what activities were scheduled and asked residents if they wanted to attend the activities. On 10/16/19 at 4:12 PM, the AA said he conducted the majority of the activities on the weekdays, unless he had to drive one of the facility's transportation vans, like he did that morning. He said he was one of the back-up van drivers and therapy staff conducted the activities when he was pulled from activities to drive. He said he was unaware the trivia activity did not occur as scheduled that morning and said he conducted the bingo activity later than the scheduled posted time and Resident #162 attended. He said bingo was held in the therapy room and root beer floats and ice cream socials started in the lobby and then he went room to room offering the floats and ice cream. The AA said if an activity was changed or postponed, he placed that information on a cork board with an easel in the lobby outside of the therapy room. He said he had not put up the cork board and had not posted any changes for that day. He said since the facility was a short-stay rehabilitation facility there was a lack of interest and participation in activities by most of the residents. The AA said residents were verbally informed upon admission where the activities were held. He said residents were not given activity calendars because they were posted on the electronic display boards. He said there were no	F 679		

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F 679	Continued From page 13 activities scheduled in the evenings. On 10/17/19 at 8:25 AM, the Activity Director (AD) said she was off work the previous day and was not aware the trivia activity did not occur or that bingo was delayed. The AD said she expected staff to conduct scheduled activities as planned and within a reasonable time frame. She said if there was a change in an activity, she expected staff to post that information on the cork board and to make an announcement on the overhead speaker system. She said Resident #162 wandered a lot and said there was not a specific plan to address her activity needs. The AD said staff had been walking and talking with Resident #162, but staff had not documented those interactions in her activity participation record. The AD said Resident #162's representative had informed her that Resident #162 "was not much of a TV watcher." She said there were no activities scheduled in the evenings. She said evenings were a time for residents to do individual activities like using the games that were in the library.	F 679		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		11/18/19

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F 761	Continued From page 14 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure medications were properly labeled and stored for 1 of 5 residents (Resident #161) observed for medication administration. This deficient practice placed residents at risk for receiving the wrong medication and experiencing an adverse event. Findings include: On 10/17/19 at 7:33 AM, during a medication administration observation, LPN #1 pulled medications that were held in three small paper cups out of the top drawer of the medication cart and administered the medication to Resident #161. LPN #1 said he tried to administer the medications earlier, but Resident #161 was not ready. The paper cups were not labeled with Resident #161's name, the date, or the time. On 10/17/19 at 8:20 AM, LPN #1 said he could not recall how he was trained regarding labeling of medications when they were returned to the	F 761	F761 Resident Specific: See systemic changes Other residents: See systemic changes Systemic Changes: LPN #1 has been 1-1 in-serviced on the 6 medication administration rights and the importance of labeling the cups if the resident isn□t immediately available. All licensed staff have been in-serviced on the 6 medication administration rights. Monitors: DON or designee will monitor 3 med	

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F 761	Continued From page 15 medication cart. On 10/17/19 at 8:49 AM and on 10/18/19 at 8:12 AM, the DON said nursing staff were trained on medication administration during orientation and when an issue arose. She said the paper cups containing medication were to be labeled if they were put back into the medication cart for any reason, and were only held for a short period of time. She said the facility did not have a policy that specifically addressed returning a paper cup full of pills to a medication cart. She said the medication administration policy instructed the nurse to offer the medication three times and then dispose of the medication. The DON said the policy did not address labeling the cup. The DON said she expected the cup to be labeled before it was returned to the medication cart for storage.	F 761	passes a week to ensure the nurses are following the 6 Medication Administration Rights weekly times 4 and monthly times 3. DON or designee will report findings at the QAPI meeting and will make changes to the above plan of correction as needed. Date of Compliance 11/18/2019	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and	F 880		11/18/19

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F 880	Continued From page 16 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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 17 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection prevention practices were implemented and followed during medication administration and blood glucose testing. This was true for 3 of 5 residents (#1, #156, and #161) whose medication administrations were observed. This deficient practice placed residents and staff at risk for infection due to potential cross contamination and exposure to needle sticks or blood. Findings include: The facility's undated Glucometer Disinfection policy and procedure, documented, after completing patient's blood testing and prior to leaving the patient's room, thoroughly clean and disinfect the machine by wiping all surfaces with an approved disinfecting wipe (Bleach wipe). This policy was not followed. According to the Centers for Disease Control and Prevention (CDC) website, accessed 10/31/19, if blood glucose meters are shared the device should be cleaned and disinfected after every	F 880	F880 Resident Specific: See systemic changes Other residents: See systemic changes Systemic Changes: LPN #1 has been 1-1 in-serviced on the glucometer disinfection policy and infection control policy. All licensed staff have been in-serviced on the glucometer disinfection policy and infection control policy. Monitors: DON or designee will monitor blood sugars on 3 residents to ensure proper handling of medical equipment, weekly times 4 and monthly times 3. DON or	

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F 880	Continued From page 18 use, per the manufacturer's instructions, to prevent carry-over of blood and infectious agents. The CDC website also stated "Do not carry supplies and medications in pockets." On 10/17/19 at 7:15 AM, during an observation of Resident #156's blood glucose monitoring, LPN #1 placed the glucose test strips, the lancet, and the glucose meter into the pocket of his scrub top. To perform the glucose monitoring assessment, he pulled the items from his pocket and after completion of the assessment he put the bottle of glucose test strips, the lancet, and the glucose meter back into the same pocket prior to cleaning the items. LPN #1 returned to the medication cart and pulled the items out of his pocket, disposed of the lancet, and wiped the testing strips bottle and glucose meter with an approved cleanser wipe. On 10/17/19 at 7:37 AM, during an observation of Resident #161's blood glucose monitoring, LPN #1 placed the glucose test strips, the lancet, and the glucose meter into the pocket of his scrub top. To perform the glucose monitoring assessment, he pulled the items from his pocket and handed them to Resident #161 to perform the test herself. After completion of the assessment, LPN #1 put the bottle of glucose test strips, the lancet, and the glucose meter back into his scrub top pocket, prior to cleaning the items. LPN #1 returned to the medication cart and pulled the items out of his pocket, disposed of the lancet, and wiped the test strips bottle and glucose meter and allowed it to dry per protocol. LPN #1 then prepared 2 insulin pens to be used to administer 42 units of Lantus U-100 (2 pens were necessary as the original pen did not	F 880	designee will report findings at the QAPI meeting and will make changes to the above plan of correction as needed. Date of Compliance 11/18/2019	

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F 880	Continued From page 19 contain enough product to reach the needed 42 Units). He then prepared a syringe of 3 Units of Humalog (insulin). LPN #1 then placed the 2 pens and the syringe into his scrub top pocket. After reaching Resident #161's room at 7:51 AM, LPN #1 pulled the 2 insulin pens and the insulin syringe out of his pocket and used them to administer the ordered insulin to Resident #161. After the administration of the insulin, LPN #1 placed the 2 insulin pens and the syringe into his scrub top pocket and returned to the medication cart. At the cart LPN #1 disposed of the syringe, the sharps from the pens, and the exhausted insulin pen, and placed the remaining pen in a plastic bag and then in the drawer of the medication cart. On 10/17/19 at 8:10 AM, during an observation of Resident #1's medication administration, LPN #1 placed a Vigflex container (a type of intravenous medication delivery system), which held an antibiotic solution into his scrub top pocket. Upon reaching Resident #1's room he then pulled the system from his pocket and administered the medication. On 10/17/19 at 8:20 AM, LPN #1 said that everywhere he had worked they just put things in their pockets. When asked how he had been trained at the current facility, LPN #1 did not respond. On 10/17/19 at 8:40 AM, the DON said training for infection control was conducted during employee orientation and said audits were conducted on an annual basis. She said if an issue with infection control was identified then training would be conducted at that time. The	F 880		

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F 880	Continued From page 20 DON said the testing and antibiotic delivery system should not have been placed in the pockets of the scrub top. On 10/17/19 at 9:10 AM, the Clinical Care Coordinator said the glucose meters should be cleaned immediately after checking a blood sugar and before leaving a room.	F 880		