



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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December 8, 2019

Corrected December 9, 2019

Stephanie Bonanzino, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Bonanzino:

On **November 8, 2019**, a survey was conducted at Life Care Center of Post Falls 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 a widespread deficiency that constitutes immediate jeopardy to resident health or safety, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

On **November 11, 2019**, the facility submitted a credible allegation that the immediate jeopardy for :

- **F600 -- S/S: J -- 483.12(a)(1) -- Free From Abuse And Neglect**
- **F725 -- S/S: L -- 483.35(a)(1)(2) -- Sufficient Nursing Staff**
- **F689 -- S/S: J -- 483.25(d)(1)(2) -- Free Of Accident Hazards/supervision/devices**
- **F686 -- S/S: J -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer**

was corrected. An onsite revisit conducted from November 13 through November 14, 2019 confirmed that the Plan of Correction was implemented. It was determined that the immediate jeopardy to the residents had been removed as of November 12, 2019. However, the deficiencies as identified on the revised Form CMS-2567 remain and require a Plan of Correction.

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The most serious deficiency now constitutes actual harm that is not immediate jeopardy and that is widespread in scope, as evidenced by the Form 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.) **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 **December 18, 2019**. Failure to submit an acceptable PoC by **December 18, 2019**, may result in the imposition of additional civil monetary penalties by January 8, 2020.

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.
- 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.

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- 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*.

Based on the immediate jeopardy cited during this survey:

- **F600 -- S/S: J -- 483.12(a)(1) -- Free From Abuse And Neglect**
- **F725 -- S/S: L -- 483.35(a)(1)(2) -- Sufficient Nursing Staff**
- **F689 -- S/S: J -- 483.25(d)(1)(2) -- Free Of Accident Hazards/supervision/devices**
- **F686 -- S/S: J -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer**

this agency is required to notify Centers for Medicare & Medicaid Services (CMS) Regional Office of the results of this survey. We are recommending to the CMS Regional Office that the following remedy(ies) be imposed:

Civil money penalty, **per day**, effective **October 30, 2019**.
(THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED IN THE STATE OPERATIONS MANUAL §7510) (42 CFR §488.430)

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 8, 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 and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Your facility's noncompliance with the following:

- **F600 -- S/S: J -- 483.12(a)(1) -- Free From Abuse And Neglect**
- **F689 -- S/S: J 483.25(d)(1)(2) -- Free Of Accident Hazards/supervision/devices**
- **F686 -- S/S: J -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer**
- **F684 -- S/S: G -- 483.25 -- Quality Of Care;**
- **F759 -- S/S: F -- 483.45(f)(1) -- Free Of Medication Error Rts 5 Prcnt Or More**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR

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§488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents # **#6, #14, #18, #19, #32, #38, #65, #131, #380, #430, and #431** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information in a timely matter will result in termination of participation or imposition of additional remedies.

If you believe the deficiencies have been corrected, you may contact Laura Thompson, RN, or Belinda Day, RN, Supervisors LTC, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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

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This request must be received by **December 18, 2019**. If your request for informal dispute resolution is received after **December 18, 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 Laura Thompson, RN, or Belinda Day, RN, at (208) 334-6626, option 2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson".

Laura Thompson, RN, Supervisor
Bureau of Facility Standards

lt/lj

c: Chairman, Board of Examiners - Nursing Home Administrators

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

PRINTED: 12/31/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854		
(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	<p>INITIAL COMMENTS</p> <p>A federal recertification and complaint survey was completed at the facility from October 27, 2019 through November 8, 2019.</p> <p>Immediate jeopardy to residents' health and safety was cited at F600, F686, F689, and F725. The immediate jeopardy was not removed prior to the exit conference.</p> <p>The surveyors conducting the survey were:</p> <p>Cecilia Stockdill, RN, Team Coordinator Jenny Walker , RN Sallie Schwartzkopf, LCSW Michael Brunson, RN Linda Zuschlag, RN Carmen Blake, RN Sharon Whitehead, RN Janet Kubisiak, RN</p> <p>Abbreviations include:</p> <p>A.D. = Activity Director ADL = Activities of Daily Living ARD = Assessment Reference Date ASHD = Arteriosclerotic Heart Disease BOM = Business Office Manager cm = Centimeter CNA = Certified Nursing Assistant COPD =Chronic Obstructive Pulmonary Disease DON = Director of Nursing E.D. = Executive Director EMS = Emergency Medical Services ER = Emergency Room EMT = Emergency Medical Technician g = grams</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

12/12/2019

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 000	Continued From page 1 I&A = Incident and Accident IV = Intravenous LN = Licensed Nurse LPN = Licensed Practical Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set mcg = microgram mg = milligram ml = milliliter mmHg = millimeters of Mercury P.A. = Physician Assistant RCM = Resident Care Manager RN = Registered Nurse TAR = Treatment Administration Record x = times 24/7 = Twenty-four hours per day, seven days a week	F 000			
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		1/2/20	

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F 561	<p>Continued From page 2</p> <p>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>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 residents received incontinence briefs that were an appropriate size and per resident choice. This was true for 1 of 7 residents (Resident #28) reviewed for choices. This failure created the potential for psychological harm when resident preferences were not honored. Findings include:</p> <p>The facility's policy for Activities of Daily Living, reviewed 4/22/19, documented the following: "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 resident's choices..."</p> <p>Resident #28 was admitted to the facility on 11/20/18, with diagnoses including non-pressure ulcer, weakness, and cellulitis (a potentially serious bacterial skin infection).</p> <p>Resident #28's annual MDS assessment, dated 8/23/19, documented she was cognitively intact,</p>	F 561	<p>Individual Residents: Resident #28 has properly sized briefs available for use. Care plan reviewed and updated as needed.</p> <p>Other Resident in Similar Situations: Brief stock and ordering was reviewed to ensure adequate availability and product. No negative findings noted.</p> <p>Measures to Prevent Reoccurrence: Central Supply Director was educated on ordering and ensuring that there are enough bariatric brief supplies to meet the needs of residents. CNAs were educated on ensuring residents had briefs available and not taping briefs together.</p> <p>On-going Monitoring: Central Supply Director will audit stock and availability of bariatric briefs weekly x4 and then monthly x2 to ensure on going compliance. Negative findings will be reviewed through QAPI to identify trends and additional training</p>		

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F 561	<p>Continued From page 3</p> <p>required 2 persons for toileting, required extensive assistance of one person for dressing, and required one person physical assistance for personal hygiene.</p> <p>On 10/28/19 at 1:20 PM, Resident #28 stated that care was not provided as specified in her care plan. Resident #28 said the facility did not have the correct size briefs on a Thursday, she reminded staff on Friday, and ran out of briefs on Saturday. Resident #28 said months ago she told her husband that the facility was not going to order her size of incontinence supplies and they wanted her to use a smaller size. Resident #28 said she was told on the following Monday morning the order for her incontinence supplies had not arrived, and the facility did not have her size. Resident #28 said the facility had to borrow incontinence supplies from a sister facility, and her supplies arrived on the following Tuesday. Resident #28 said she could not take Lasix (a diuretic) as needed for fluid retention in her legs when she did not have the correct size incontinent brief, it was difficult to manage changing the incontinence brief, and she did not want to be left sitting in wet conditions. Resident #28 said staff stuck together 2 smaller incontinence pads for her use 2 weeks ago, and it "did not work."</p> <p>On 10/28/19 at 12:18 PM, Resident #28 said she would not take her Lasix when she did not have properly sized incontinence briefs.</p> <p>On 10/31/19 at 2:40 PM, RCM #2 stated he was aware Resident #28 required bariatric (for those who have obesity) incontinence briefs. RCM #2 said he was unaware there were times when the</p>	F 561	<p>opportunities.</p> <p>Individual to ensure compliance: The Executive Director will ensure ongoing compliance.</p>		

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F 561	Continued From page 4 facility did not have the correct size incontinence brief for Resident #28, and he was unaware 2 briefs were taped together for her. RCM #2 said he was unaware Resident #28 refused to take Lasix if she did not have the correct size incontinence brief. Also present, the Central Supply Director said Resident #28 should be able to wear a size 3 incontinence brief, and she would not take Lasix if she did not have a size 4 incontinence brief, and "a week or so ago" the facility ran out of size 4 incontinence briefs. On 11/6/19 at 1:38 PM, the DON said she was not aware Resident #28 was placed in 2 incontinence briefs that were taped together, the facility did not have the correct size incontinence briefs for her, and she did not take her Lasix on the days when her incontinence briefs were not the correct size.	F 561			
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a	F 565		1/2/20	

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F 565	<p>Continued From page 5</p> <p>resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.</p> <p>(A) The facility must be able to demonstrate their response and rationale for such response.</p> <p>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.</p> <p>§483.10(f)(6) The resident has a right to participate in family groups.</p> <p>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on Resident Council Group interview, policy review, and staff interview, it was determined the facility failed to address Resident Council concerns regarding lengthy call light response times. This was true for 5 of 14 (#7, #17, #32, #61, and #333) residents in the Resident Council Group interview and those residents in the facility whose views and concerns were represented by the Resident Council. The deficient practice had the potential to cause psychosocial harm for residents frustrated by the perception their concerns were not valued by the facility and the potential for physical harm due to the facility's failure to address the lack of timely staff response to call lights. Findings include:</p> <p>The facility's Grievance Procedures and Concern</p>	F 565	<p>Individual Residents: Residents 7, 17, 32 and 61 were interviewed regarding call light response time and to identify unmet needs. Concern cards generated as needed and addressed with follow up. ED met with Resident Council to discuss concerns, process and expected follow up and facility changes.</p> <p>Resident #333 no longer resides in the facility.</p> <p>Other Resident in Similar Situations: Residents and/or responsible parties were interviewed to identify individual concerns related to call light response time and grievance process. Concern</p>		

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F 565	<p>Continued From page 6 and Comment Program, effective date 5/6/19, documented the policies and procedures, including:</p> <ul style="list-style-type: none"> * Residents and their families had the right to file a complaint without fear of reprisal. * Residents' rights should have been protected when voicing complaints to maximize the quality of life for each individual and to promote customer satisfaction with facility care and services. * The Social Services staff and/or the E.D. was responsible for the following: <ul style="list-style-type: none"> - Maintaining a recordkeeping system of all complaints reported via Concern & Comment Program or any other means of reporting that included the steps taken to investigate the grievance and a statement as to whether the grievance was confirmed or not confirmed. * Administrative staff were responsible for the following: <ul style="list-style-type: none"> - The appointed manager would contact the concerned party within 24 hours, to share the status of the investigation and resolution. * E.D. and/or Designee were responsible for the following: <ul style="list-style-type: none"> - Ensuring that all grievances and Concern & Comment Reports were reviewed and addressed in a timely and appropriate manner and that concerned individuals felt that some type of resolution had been communicated, achieved and maintained. - Collaborating with the interdisciplinary team to identify and address repeated concerns from 	F 565	<p>cards were generated and addressed/followed up. Ongoing interviews and manager rounds in place.</p> <p>Measures to Prevent Reoccurrence: Facility staff have been educated by ED or designee on call light response time and grievance procedure to include expected follow up and monitoring.</p> <p>On-going Monitoring: ED will attend council meetings at invitation to ensure that council is satisfied and feels grievances are being addressed. Call light audits will be conducted weekly x12 weeks and trends will be reviewed through monthly QAPI x3 to identify needed education, training and facility changes.</p> <p>Individual to ensure compliance: The Executive Director will ensure ongoing compliance.</p>		

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F 565	<p>Continued From page 7 residents and families.</p> <p>The completed Concern & Comment Forms, known as "the blue cards", were organized by month in two binders for the year 2019. Each pre-printed blue 5x8 inch card was organized with the front side for the complainants' information/comments and the back side for facility response. The front side included space to write the name of the person reporting, date, resident's name, description of comment or concern, if able to report it to a staff member, and if the staff member was able to resolve it at the time it was shared. It stated, "A facility manager will contact you as soon as possible to discuss the concern, and any subsequent investigation and measures to resolve the concern". The back side of the card with the facility response included space to write the name of the person designated to investigate and follow-up with the concern, the date/time the concerned party was initially contacted, investigation findings, actions taken to resolve/respond to the concern, the date/time the findings/action plan was shared with the concerned party, and the concerned party's response to the action outcome, and space for the E.D.'s signature and date.</p> <p>The backside of the card did not include the steps taken by the facility to investigate the grievance, nor a statement as to whether the grievance was confirmed or not confirmed.</p> <p>Five facility blue cards, dated 2/14/19 (2 on this date), 6/19/19, 7/17/19 and 8/14/19, documented the Resident Council filed grievances regarding call light wait times on each date.</p>	F 565			

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F 565	<p>Continued From page 8</p> <p>- The blue card, dated 2/14/19, documented "per Resident Council", Resident #7 was told staff was sent home early due to low census - she is upset because she feels it causes her a longer wait time in getting her call light answered. The facility documented on the back the investigation findings were: staffing was adjusted to resident acuity and census. Facility continued to monitor staffing levels and call light audits. Actions taken to resolve/respond to the concern was: continue to monitor through QAPI. The date the findings/action plan were shared with the concerned party was 2/26/19, 12 days after complaint was filed, and the concerned party's reaction was checked as "cautious but optimistic." The direct response from the concerned party was not documented. The facility failed to take steps to investigate and develop solutions for the Resident Council's concern for reduced staff and provide a timely response to the Council and Resident #7, so they felt that some type of resolution had been communicated and achieved.</p> <p>- The blue card, dated 2/14/19, written "per Resident Council", documented Resident #32 agreed that call lights were not being answered in a very timely manner. The facility documented investigation findings on the back side as: continue to work with QAPI plan and conduct call light audits and daily Angel Rounds (manager makes rounds to talk with residents), and the concerned party's reaction was checked as "Cautious but optimistic", no quote was provided. The facility failed to develop solutions for the Resident Council's concern for long call light responses and provide a timely response to the Council and Resident #32, so they felt that some</p>	F 565			

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F 565	<p>Continued From page 9</p> <p>type of resolution had been communicated and achieved.</p> <p>- The blue card, dated 6/19/19, documented the grievance was filed on behalf of the Resident Council, and described the concern as "residents feel call lights are getting to be slower lately", and they reported the concern to a staff member. The facility documented the person designated to investigate/follow-up with the concern was the MDS Coordinator, and investigation findings were: "Have received multiple C/O [complaints] call light wait times; will address in QAPI 7/9/19". Actions taken were documented as: "Audit completed, we are addressing the call light response time, Angel Rounds [implemented]." Date findings/action plan shared with the concerned party was documented as: next Resident Council meeting. The document was signed by E.D. #1 on 7/16/19. The facility failed to review and implement solutions for the Resident Council's concern for slower call light responses in a timely manner, so the Council felt that some type of resolution had been achieved and maintained.</p> <p>- The blue card, dated 7/17/19, documented the grievance was filed on behalf of the Resident Council, and described the concern as: "[Resident Council] would like us to do our audits at off times, like during meals and after meals when residents want to lay down, to show us just how long they really have to wait for help." It was documented the complaint was reported to a staff member. The facility documented the person designated to investigate/follow-up with the concern was the MDS Coordinator, and investigation findings were: "Talked with</p>	F 565			

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F 565	<p>Continued From page 10</p> <p>department heads about doing call light audit with PM Manager." Actions Taken: "See above." Date findings/action plan was shared with concerned party documented as the next Resident Council meeting. No concerned party's response was documented. The document was signed by E.D. #1 on 9/11/19. The facility failed provide a solution to the slow call light concern and provide follow up communication with the Resident Council.</p> <p>- The blue card, dated 8/14/19, documented the grievance was filed on behalf of the Resident Council, provided resident name as "100 and 200 Hall", and described the concern as: "call lights are still slow to answer", and that the concern was reported to a staff member. The facility documented the person designated to investigate/follow-up with the concern was the MDS Coordinator. The blue card did not document a date/time of initial contact with the concerned party (Resident Council President) and the investigation findings were: "Work in progress, this needs to be all team members, See QAPI." Actions taken were documented as: "Off hour call light audits continuing with PM Managers." The date the action was shared with the concerned parties and their response was not documented. The document was signed by E.D. #1 without a date. The facility failed to address the Resident Council's grievance, provide a solution to the slow call light concern, and provide follow up communication with the Resident Council.</p> <p>On 11/7/19 at 9:58 AM, E.D. #2 (who assumed the Executive Director position on 11/1/19), said the A.D., or her designee, attended the Resident</p>	F 565			

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F 565	Continued From page 11 Council meetings, and reported concerns on a blue card, which went to the E.D. The E.D. reviewed the concerns/blue cards every day and distributed them to the appropriate department managers. The appropriate department manager addressed and returned the blue card to the E.D. and they were then returned to the Resident Council. E.D. #2 said she anticipated all grievances to be resolved in 10 days, be reviewed with the Resident Council President, and at the next meeting with the Resident Council. On 11/7/19 at 2:13 PM, the Resident Council President, Resident #7, said the A.D. took notes, the Activities Assistant may have taken notes if the A.D. was gone. Resident #7 said the A.D. went to the department managers associated with the issues, and the A.D. provided a response at the next Resident Council meeting. She said she was never involved in the investigative process after grievances were heard at the meeting and she heard back at the following Resident Council meeting. The call light grievances from 2/14/19 to 8/14/19 were not resolved. The facility failed to address the call light wait time concerns in a timely manner and ensure the Resident Council President, and the Resident Council as a whole, were provided an acceptable resolution.	F 565			
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		1/2/20	

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

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F 578	<p>Continued From page 13</p> <p>resident and staff interview, it was determined the facility failed to ensure residents' records included clear and accurate information related to Advance Directives. This was true for 3 of 10 residents (#16, #54, and #75) whose Advance Directives were reviewed. This failure created the potential for harm if a resident's medical treatment wishes were not followed due to lack of accurate information in residents' records. Findings include:</p> <p>The State Operations Manual, Appendix PP, defines an "Advance Directive" as "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." "Physician Orders for Life-Sustaining Treatment (or POST) paradigm form" is a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POST paradigm form is not an advance directive."</p> <p>The facility's Advance Directive policy, dated 8/21/19, documented procedures including the following:</p> <ul style="list-style-type: none"> - The Admissions Director or designee interviewed the resident and/or family upon admission to determine the need and knowledge relative to Advance Directives. If the resident had an Advance Directive, the social worker 	F 578	<p>Residents #16 and 54 had their advanced directives and medical records reviewed. Education provided on current choices and care plans reviewed and updated as needed.</p> <p>Resident #75 no longer resides in the facility.</p> <p>Other Resident in Similar Situations: Current resident records were audited to identify if advanced directives were in place and if so, care plans and orders matched. Residents without directives were interviewed and educated on formulating. Care conferences were held with residents and directives were reviewed at this time.</p> <p>Measures to Prevent Reoccurrence: LNs and SS were educated by Executive Director or Director of Nursing on Advanced Directives, care conferences and the review of directives at this time.</p> <p>On-going Monitoring: Advanced Directives will be audited at the time of admission and with quarterly care conferences to ensure that resident choices are documented and care planned. Negative findings of audits will be reviewed in QAPI x3 months for identification of education.</p> <p>Individual to ensure compliance: Executive Director will ensure ongoing compliance.</p>		

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F 578	<p>Continued From page 14</p> <p>requested a copy of the directive so that it may become part of the medical record. Documentation of such directives were placed in the Social Services progress notes. The resident's attending physician was made aware, and the appropriate orders were incorporated into the resident's care plan.</p> <p>- Each time the resident was admitted to the facility, quarterly, after a significant change, and as needed, Social Services reviewed the Advance Directive information for accuracy with the resident or legal representative and documented the findings in the progress notes.</p> <p>On 11/4/19 at 10:50 AM, the Admissions Director said that upon admission, she provided each resident a folder with multiple documents which they signed electronically. Advance Directives were addressed in Attachment E of the Resident Admission Agreement Acknowledgement. The resident was asked if they had an Advanced Directive, and if so the Admissions Director collected it. If the resident did not have an Advance Directive, she provided a Living Will and Durable Power of Attorney for Health Care packet and offered assistance from Social Services to complete it during their first appointment with the Social Services Director.</p> <p>a. Resident #75 was readmitted to the facility on 10/5/19, with multiple diagnoses including Parkinson's disease (a progressive disease of the nervous system that affects movement), seizures, type 2 diabetes mellitus, and dependence on dialysis.</p> <p>Resident #75's Living Will and Durable Power of</p>	F 578			

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F 578	<p>Continued From page 15</p> <p>Attorney for Health Care, dated 4/25/16, documented her code status was "No Code", meaning do not resuscitate (DNR) .</p> <p>Resident #75's care plan documented her wishes for resuscitation were DNR with limited interventions, initiated on 5/6/19.</p> <p>Resident #75's record documented she was transferred to the hospital on 9/29/19, and returned to the facility on 10/5/19.</p> <p>Resident #75's Physician Orders for Scope of Treatment (POST) documented her wishes for resuscitation were Full Code, meaning initiate all lifesaving measures, and it was signed by her on 10/5/19. Resident #75's physician order, dated 10/24/19, also documented Full Code.</p> <p>There was no documentation in Resident #75's record the Advance Directive information included in her Living Will and Durable Power of Attorney for Health Care, was reviewed and her code status was updated after she returned to the facility on 10/5/19.</p> <p>On 11/4/19 at 4:15 PM, the Admission Director said she asked residents upon admission if they had an Advance Directive, and she asked them to provide a copy of their Advance Directive if they had one. The Admission Director said if the resident did not have an Advance Directive, she asked if they wanted to complete one and then gave the form to the Social Services staff to help the resident complete it. The Admission Director said Resident #75 did not want to receive information about Advance Directives when she returned to the facility on 10/5/19, and it was</p>	F 578			

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F 578	<p>Continued From page 16</p> <p>documented on the admissions paperwork that she declined an Advanced Directive at that time.</p> <p>On 11/4/19 at 4:26 PM, RCM #1 reviewed Resident #75's record and stated the care plan documented No Code, and her POST documented she was a Full Code. RCM #1 said it looked like Social Services updated Resident #75's code status, and she did not know when it was changed.</p> <p>On 11/5/19 at 9:15 AM, Resident #75 said she wanted her code status to be Full Code, and the facility talked to her about that "not too long ago."</p> <p>On 11/5/19 at 10:34 AM, the DON said she did not know why there was a discrepancy between Resident #75's Advanced Directive, POST and care plan. The DON said the RCMs were responsible for residents' Advance Directives and care plan information.</p> <p>b. Resident #16 was admitted to the facility initially on 7/27/17 and readmitted on 9/21/19, with multiple diagnoses including sepsis (a life-threatening complication of an infection), generalized muscle weakness, heart failure (the heart cannot pump enough blood to meet the body's needs), and chronic atrial fibrillation (long lasting irregular heart beat).</p> <p>Resident #16's Resident Admission Agreement Acknowledgement, signed 7/27/17 (greater than two years prior), documented she had executed an Advance Directive.</p> <p>Resident #16's Social Services Progress Notes, dated 2/18/19 and 2/25/19, did not document a</p>	F 578			

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F 578	<p>Continued From page 17 discussion regarding an Advance Directive. The progress note did document the family was in attendance.</p> <p>Resident #16's Care Plan Conference Records, dated 2/14/19 and 8/8/19, did not document a discussion regarding an Advance Directive. The Care Plan Conference Records did document the family was in attendance.</p> <p>On 11/4/19 at 3:32 PM, the Admissions Director said Resident #16's family had not brought in the Advance Directive. The Admissions Director said at the time of admission, if the family said the resident had an Advance Directive she marked "yes" on the Resident Admission Agreement Acknowledgement document. If the family was not sure she marked "no". She said if the family came into the facility, she had a follow up conversation to remind the family to bring it in. She said she did not document those conversations.</p> <p>On 11/6/19 at 2:13 PM, the Social Services Director said the Advance Directive was not discussed at every care conference due to the understanding that the Admissions Director would notify Social Services if they did not receive the Advance Directive.</p> <p>The facility did not periodically review Advance Directives as part of the comprehensive care planning process and did not follow up with Resident #16's family to collect the available Advance Directive.</p> <p>c. Resident #54 was admitted to the facility on 9/16/18, with multiple diagnoses including</p>	F 578			

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F 578	Continued From page 18 dementia and muscle weakness. Resident #54's Annual MDS Assessment, dated 9/25/19, documented she had short and long-term memory problems, was without recall, and was severely cognitively impaired. On 10/28/19 at 3:27 PM, Resident #54's record did not include a copy of an Advance Directive. Resident #54's Social Services Progress Notes, dated 11/27/18, 1/3/19, 1/10/19, and 2/6/19, did not document a discussion regarding an Advance Directive. The progress notes did document the family was in attendance. Resident #54's Care Plan Conference records, dated 9/20/18, 1/3/19, and 3/11/19, did not document a discussion regarding an Advance Directive. The progress note did document the family was in attendance. Resident #54's Resident Admission Agreement Acknowledgement, dated 9/16/18 (one year prior), documented Resident #54 had an Advance Directive. On 11/4/19 at 3:32 PM, the Admissions Director said Resident #54's family did not deliver the Advance Directive to the facility.	F 578			
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-	F 580		1/2/20	

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F 580	<p>Continued From page 19</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various</p>	F 580			

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F 580	<p>Continued From page 20</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and resident and staff interview, it was determined the facility failed to ensure a resident's physician was notified of significant changes in the resident's clinical condition in a timely manner. This was true for 2 of 3 (#61 and #180) residents reviewed for appropriate notification. This had the potential for harm when the facility failed to immediately notify Resident #61's physician of not receiving IV antibiotics and failed to immediately notify Resident #180's physician of his death. Findings include:</p> <p>The facility's policy for Changes in Resident's Condition or Status, reviewed 4/15/19, stated "This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status. In the case of death of a resident, the resident's physician will be notified immediately by facility staff..."</p> <p>This policy was not followed.</p> <p>1. Resident #61 was admitted to the facility on 8/1/19 with diagnoses that included type 2 diabetes mellitus with a foot ulcer, lymphedema (edema in lower and upper extremities, due to removal or damage to lymph nodes), hypertension and a right foot infection.</p> <p>Resident #61's hospital discharge instructions</p>	F 580	<p>Individual Residents: Resident #61's MD is aware of current condition. Resident #180 no longer resides in the facility.</p> <p>Other Resident in Similar Situations: A review of the last 14 days of physician orders, changes in condition, incident reports and grievances was conducted to ensure that proper notifications were completed. Notifications were made at time of discovery.</p> <p>Measures to Prevent Reoccurrence: LNs were educated on the policy of notifying physician and responsible party/resident on changes in condition at time of occurrence.</p> <p>On-going Monitoring: Audits will be conducted on physician orders, incident reports, grievances and 24 hour reports to verify appropriate notifications are completed. Audits will be conducted weekly x12 and negative findings will be reviewed through the monthly QAPI meeting x3 months.</p> <p>Individual to ensure compliance: Director of Nursing will ensure ongoing compliance.</p>		

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F 580	<p>Continued From page 21 dated 8/1/19 at 9:30 AM, documented a discharge prescription of Ampicillin Sodium/Sulbactam 3 G, every 6 hours times 38 doses, for right foot infection, last dose on 8/8/19 at 6:00 PM.</p> <p>The 8/8/19 and 9/28/19 quarterly MDS assessment documented Resident #61 was receiving IV medications while a resident at the facility.</p> <p>Resident #61's care plan directed staff to administer antibiotic medications as ordered by the physician.</p> <p>Resident #61's nurse progress note, dated 8/1/19 at 5:51 PM, documented the IV antibiotic was not available and the physician was made aware and the pharmacy was notified. The note documented the medication would be delivered in the evening.</p> <p>Resident #61's August 2019 MAR documented, Ampicillin Sulbactam (antibiotic) 3 G IV (intravenously) every 6 hours until 8/8/19. The MAR documented the antibiotic was not administered from 8/1/19 to 8/6/19.</p> <p>A Fax Request/Notification form, dated 8/1/19 at 6:40 PM, documented Resident #61 was admitted with an order for IV antibiotics. The form stated the pharmacy was notified but would not be able to deliver the antibiotic. The P.A. reviewed the form and signed and dated it on 8/5/19, 5 days later.</p> <p>Residents #61's nurse progress notes, dated 8/2/19 through 8/4/19, did not include further documentation of notification to the physician</p>	F 580			

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

PRINTED: 12/31/2019
FORM APPROVED
OMB NO. 0938-0391

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F 580	<p>Continued From page 22 regarding the unavailability of the IV antibiotic.</p> <p>On 10/28/19 at 10:30 AM, Resident #61 said the facility told her the antibiotic was not available from the pharmacy and did not call the physician to get another antibiotic.</p> <p>On 11/1/19 at 12:05 PM, the Medical Director stated the facility did not notify him that the pharmacy was unable to provide the Ampicillin Sulbactam IV antibiotic for Resident #61 until 4 days later. The Medical Director stated there was a shortage of Ampicillin Sulbactam IV antibiotics and the pharmacy was unable to fill the order for Resident #61. The Medical Director stated he, or one of his colleagues, was on-call 24/7 and the pharmacy was also on-call 24/7 to fill orders for a different antibiotic. The Medical Director stated there should not have been a delay in treatment for Resident #61's infection to her right foot.</p> <p>On 11/5/19 at 11:05 AM, the P.A. said she had not received a call about the IV antibiotic not being available for Resident #61.</p> <p>A Fax Request/Notification form, dated 8/4/19 at 6:30 PM, documented the Ampicillin Sulbactam IV antibiotic was not received from pharmacy and requested the physician change the order since the antibiotic was not available. The form documented Resident #61 had been without the antibiotic since admission on 8/1/19. A reply request box was checked on the form. The P.A. reviewed the form and signed and dated the form on 8/5/19.</p> <p>A physician's written order, dated 8/5/19, documented Vancomycin (antibiotic) 1 GM IV</p>	F 580			

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F 580	<p>Continued From page 23 every 12 hours with stop date 8/12/19, and Rocephin (antibiotic) 2 GM IV every 24 hours with stop date 8/12/19.</p> <p>A physician progress note, dated 8/5/19 at 10:15 AM, documented Resident #61 had not received ordered antibiotics since admission on 8/1/19.</p> <p>On 11/6/19 at 11:41 PM, the DON stated the nurses should have notified the physician by phone on 8/1/19 that the pharmacy could not provide the Ampicillin Sulbactam IV antibiotic, instead of by sending a fax notification form.</p> <p>2. Resident #180 was admitted to the facility on 9/13/19, with multiple diagnoses including heart failure, respiratory failure with hypoxia (low oxygen level), chronic kidney disease, atrial fibrillation (irregular heart rhythm), and Parkinson's disease (a progressive nervous system disorder that affects movement).</p> <p>On 11/1/19 at 8:40 AM, RCM #1 said Resident #180 was actively dying and he was receiving hospice services.</p> <p>On 11/1/19 at 9:10 AM, Resident #180 was in bed with his eyes closed, was breathing heavily, and did not respond to verbal stimuli. Resident #180's family member said he received a call from the facility at approximately 9:30 PM or 10:00 PM the previous night he "took a turn for the worse."</p> <p>Resident #180's hospice notes, dated 11/1/19, documented he was admitted to hospice services on 11/1/19 and passed away approximately 4 hours after being admitted. There was no</p>	F 580			

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F 580	Continued From page 24 documentation in Resident #180's record the facility notified his primary physician of his death. On 11/2/19 at 7:19 PM, LPN #9 said Resident #180 passed away at approximately 4:00 PM the previous day. On 11/4/19 at 9:46 AM, the DON said Resident #180 had passed away, and she became aware of it on 11/1/19. On 11/5/19 at 2:13 PM, the P.A. said she was not notified when Resident #180 died, the facility staff did not call her or the on-call physician, and she found out about his death that day (11/5/19). On 11/5/19 at 2:30 PM, RCM #1 said the nurse did not notify the physician when Resident #180 died. On 11/6/19 at 1:31 PM, the hospice nurse said after Resident #180 died, she notified RCM #1 and RCM #3, the CNAs who were caring for him, and the hospice Medical Director. On 11/6/19 at 3:45 PM, the facility's Medical Director said he was not sure when he was made aware Resident #180 died.	F 580			
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585		1/2/20	

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F 585	<p>Continued From page 25</p> <p>furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.</p> <p>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:</p> <p>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;</p>	F 585			

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F 585	Continued From page 26 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement	F 585			

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F 585	<p>Continued From page 27</p> <p>Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident and staff interview, policy review, record review, and review of grievances, it was determined the facility failed to ensure residents were able to voice grievances without fear of reprisal and grievances were responded to, investigated, and prompt corrective action was taken to resolve the grievances. This was true for 5 of 14 residents (#7, #17, #32, #61, and #333) reviewed for grievances. This failure created the potential for harm if residents' grievances were not acted upon and residents did not receive appropriate care or were at risk for abuse or neglect. Findings include:</p> <p>The facility's Grievance Procedures and Concern and Comment Program, effective date 5/6/19, documented the policies and procedures, including:</p> <ul style="list-style-type: none"> * Residents and their families had the right to file a complaint without fear of reprisal. * Residents' rights should have been protected when voicing complaints to maximize the quality of life for each individual and to promote customer satisfaction with facility care and services. * The Social Services staff and/or the E.D. was 	F 585	<p>Individual Residents: Residents #7, 17, 32 and 61 were interviewed for additional concerns and no new concerns were noted.</p> <p>Residents #333 no longer resides.</p> <p>Other Resident in Similar Situations: Residents and/or responsible parties were interviewed to identify concerns with care and services. Grievances were generated as indicated and addressed per policy. Executive Director attended resident council meeting to address outstanding concerns, educate on grievance process and identify new concerns.</p> <p>Measures to Prevent Reoccurrence: Facility staff were educated on the grievance process to ensure understanding of the resident's right to file grievances and responsibility of resolution.</p> <p>On-going Monitoring: The Executive Director will review grievances daily (M-F) through morning meeting to ensure that they are</p>		

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F 585	<p>Continued From page 28</p> <p>responsible for the following:</p> <ul style="list-style-type: none"> - Maintaining a recordkeeping system of all complaints reported via Concern & Comment Program or any other means of reporting that included the steps taken to investigate the grievance and a statement as to whether the grievance was confirmed or not confirmed. <p>* Administrative staff were responsible for the following:</p> <ul style="list-style-type: none"> - The appointed manager would contact the concerned party within 24 hours, to share the status of the investigation and resolution. <p>* E.D. and/or Designee were responsible for the following:</p> <ul style="list-style-type: none"> - Ensuring that all grievances and Concern & Comment Reports were reviewed and addressed in a timely and appropriate manner and that concerned individuals felt that some type of resolution had been communicated, achieved and maintained. - Collaborating with the interdisciplinary team to identify and address repeated concerns from residents and families. <p>This policy was not followed.</p> <p>The completed Concern & Comment Forms, known as "the blue cards", were organized by month in two binders for the year 2019. Each pre-printed blue 5 x 8 inch card was organized with the front side for the complainants' information/comments and the back side for facility response. The front side included space to write the name of the person reporting, date, resident's name, description of comment or concern, if able to report it to a staff member, and</p>	F 585	<p>addressed and resolved timely.</p> <p>Grievances will be reviewed through Council for those initiated in this meeting to ensure resolution. Grievances will be trended through monthly QAPI for identification of education and facility system changes.</p> <p>Individual to ensure compliance: The Executive Director will ensure compliance.</p>		

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F 585	<p>Continued From page 29</p> <p>if the staff member was able to resolve it at the time it was shared. It stated, "A facility manager will contact you as soon as possible to discuss the concern, and any subsequent investigation and measures to resolve the concern". The back side of the card with the facility response included space to write the name of the person designated to investigate and follow-up with the concern, the date/time the concerned party was initially contacted, investigation findings, actions taken to resolve/respond to the concern, the date/time the findings/action plan was shared with the concerned party, and the concerned party's response to the action outcome, and space for the E.D.'s signature and date.</p> <p>The backside of the card did not include the steps taken by the facility to investigate the grievance, nor a statement as to whether the grievance was confirmed or not confirmed.</p> <p>a. On 10/29/19 at 10:16 AM, the Resident Council meeting attendees had these comments regarding grievances: Resident #7 said "It is difficult to fill out blue cards. Some residents can fill them out, some can't fill them out." Resident #17 said "CNAs are hop-scotched from hall to hall. How can you trust someone you're not familiar with?" Resident #32 said "They do not respond to the blue cards." Resident #61 said she "gave [blue cards] to the CFO on 10/2/19. I had not heard back. There is no response if the administration doesn't respond." Resident #333 said "I was never made aware of where to file my concerns/complaints."</p> <p>b. Resident #61 was admitted on 11/12/18, with multiple diagnoses including diabetes mellitus</p>	F 585			

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F 585	<p>Continued From page 30 and arthritis.</p> <p>Resident #61's quarterly MDS assessment, dated 9/28/19, documented she was cognitively intact.</p> <p>On 10/29/19 at 10:33 AM, Resident #61 said on 10/2/19 "the staff took 2 hours to answer her call light "from 6:45 PM to 8:40 PM", she called the facility and "the phone rang 25 times with no answer" and she hung up. Resident #61 became teary eyed and upset and said that she "loves it here, but not right now - it keeps getting worse and I am tired of hearing it will get better when in fact it gets worse every day." She said the worst time was the evening shift 2:00 -10:00 PM, especially after dinner, "it's a ghost town out in the hallway, you can't find anyone to help you."</p> <p>Two Comment and Concern blue cards, dated 10/2/19, were completed by Resident #61 regarding lack of staff assistance. On one she wrote: "I have never been treated so poorly. The last two nights I had my call light on for more than two hours without any assistance. I went out to the [200 hall] nurse's station and no one could be found. Is anyone even working here anymore? I even called the facility and the phone rang 25 times and no answer." She wrote on the blue card that she reported the concerns to two nurses on the 200 Hall. There was no facility response included on the card copy.</p> <p>On Resident #61's second blue card, dated 10/2/19, she wrote: "We are constantly denied a shower. It has been a week this time and has been as many as 12-14 days. Hygiene is just as important to my healthcare. I am disappointed in the overall care I have gotten during my stay this</p>	F 585			

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F 585	<p>Continued From page 31</p> <p>time. I have always requested Post Falls Life Care." She wrote she reported the concern to two nurses on the 200 Hall. There was no facility response included on the card copy.</p> <p>On 11/7/19 at 1:38 PM, regarding the grievance procedure, Resident #61 said people were now reluctant to complete a blue card - residents were turning in blue cards but when nothing happened, no action was taken, they quit filing them. Resident #61 said she filed two grievances on 10/2/19 regarding her inability to get a response when she sought assistance and lengthy delays between showers. Resident #61 said she completed two blue cards, received no answers, and no explanation was provided to her. Resident #61 said E.D. #1 "fired staff who expressed concerns, he just wanted it to be happy."</p> <p>c. Resident #32 was admitted on 1/9/18, with multiple diagnoses including diabetes mellitus, heart failure and peripheral vascular disease (restricted blood flow to the extremities).</p> <p>Resident #32's quarterly MDS assessment, dated 9/4/19, documented she was cognitively intact.</p> <p>A Comment and Concern blue card, dated 10/23/19, documented by the Admissions Director said Resident #32 was "furious over the quality/quantity of dinner" (seafood platter). She said it had a few small pieces of seafood, the salad was a tiny serving, and everything was hard and crunchy. She said she was "angry that the quality is so bad, no one seems to care in the kitchen". She feels she "has not been listened to" and wants a meeting with the Kitchen Manager</p>	F 585			

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F 585	<p>Continued From page 32</p> <p>and the E.D. The Admissions Director documented that she calmed Resident #32, listened, and told her she would turn the blue card over to E.D. #1. On the back side of the blue card, dated 10/25/19, was documented that E.D. #1 "spoke with the resident about the issues and would be informing dietary of the issues", and "a plan of correction would be implemented to fix some issues." Investigation findings were documented as: "Resident was upset with a few issues." The blue card was signed by E.D. #1, and did not include the steps taken by the facility to investigate the grievance, a statement as to whether the grievance was confirmed or not confirmed, or what the plan of correction was.</p> <p>On 11/6/19 at 11:59 AM, Resident #32 said administration did not pay attention to grievances, grievances were brought to their attention and "nothing seemed to happen, nothing had changed". Resident #32 said she had been in the facility three years and when she first came things were "so much better." She said comfort with complaining depended on who you were talking to. She said she did not complain because the facility should know [what is happening and what do do]. Resident #32 said residents were reluctant to open up because "they have seen a history of no response", and "some people have nowhere else to go and fear the facility will close down."</p> <p>d. Resident #7 was admitted on 4/28/19, with multiple diagnoses including diabetes mellitus.</p> <p>Resident #7's quarterly MDS assessment, dated 7/19/19, documented she was cognitively intact.</p>	F 585			

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F 585	<p>Continued From page 33</p> <p>A Comment & Concern blue card, dated 8/24/19, documented by LPN #4 on behalf of Resident #7, said "I think it is totally ridiculous" that my scheduled Friday shower - "she [shower aide] couldn't do it because she was pulled to the floor". The card documented Resident #7 said the shower aide told her she would do the shower on Saturday and she was pulled to the floor again so she did not receive a shower on Saturday. The card documented "Why don't they have enough staff? I shouldn't have to miss my shower. What about agency working? Never see them on days, only evenings." On the backside, it was documented that an RN was designated to investigate and follow up with the concern, the RN initially contacted Resident #7 on 8/26/19, and documented she interviewed the shower CNA. The card further documented Resident #7 was offered a shower on Friday, but she declined, and the shower aide was not pulled to the floor on Friday. There was no documentation CNA Schedules were reviewed or Shower Tasks were reviewed for timeliness.</p> <p>On 11/7/19 at 2:13 PM, Resident #7 said filling out the card was difficult, residents needed to go to someone for help [no anonymity], they tell us about the blue cards, but most residents do not follow up, or cannot write. She said she had someone complete a blue card for her, but they did not provide her a copy of it. Residents did not remember the grievance by the time they got the response. Resident #7 said she had never received a copy of the grievance procedure. She said it had been a long time since she had filed a grievance or completed a blue card because "it didn't seem to work". Resident #7 said being afraid to complete a blue card depended on what</p>	F 585			

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F 585	<p>Continued From page 34</p> <p>she had a grievance about. If she was unhappy and raised her voice to a CNA, and complained about what made her raise her voice, the administration would get the CNA's version. She said she was concerned about the CNA's reaction.</p> <p>On 11/5/19 at 11:17 AM, the P.A. said in January the E.D. separated from the facility and things got worse. The P.A. said the new E.D. (E.D. #1) requested only positive attitudes from staff and would fire those who complained.</p> <p>On 11/7/19 at 9:58 AM, E.D. #2 (who assumed the Executive Director position on 11/1/19), said the E.D. reviewed the concerns/blue cards every day and distributed them to the appropriate department managers. The appropriate department manager addressed and returned the blue card to the E.D. E.D. #2 said she anticipated all grievances to be resolved in 10 days.</p> <p>e. Located in the front pocket of the Concern & Comment Binder were 14 photo copies of blue cards, front side only, with October 2019 dates. No associated original blue cards, or copies of the back-sides, were found in the binder or binder pocket.</p> <p>On 11/5/19 at 4:15 PM, the Regional Vice President (VP), VP #2 said she was not aware of where the original blue cards were or whose copies were in the front pocket of the Concerns/Comments binder.</p> <p>The facility failed to ensure residents' rights were protected when voicing complaints to maximize</p>	F 585			

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F 585	Continued From page 35 the quality of life for each resident, and that concerned individuals felt that some type of resolution had been communicated, achieved and maintained, and that repeated concerns were addressed.	F 585			
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's Abuse Policy, review of facility grievances, family and resident interview, and staff interview, it was determined the facility failed to ensure residents were free from staff intimidation when reporting verbal abuse for 8 of 97 residents (#4, #7, #32, #35, #61, #62, #333 and #480) reviewed for abuse and neglect. This failure resulted in immediate jeopardy related to the psychosocial harm of residents due to fear and intimidation of retaliation by the facility in reporting abuse and neglect by staff. Findings include:	F 600	The facility submitted an IJ removal plan and the immediacy was lifted as of 11/12/19. The following actions are submitted for continued compliance. Individual Residents: Residents #4, 7, 32, 35, 61, 62 were interviewed to ensure that they had no new concerns related to care and services. Incident reports and grievances were completed in accordance with policy and regulation for any concerns identified.	1/2/20	

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F 600	<p>Continued From page 36</p> <p>The facility's policy Protection of Residents: Reducing the Threat of Abuse and Neglect, revised 1/21/19, included the definition of mental abuse which stated "Mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. May occur through either verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation." The policy stated the facility must provide residents and representatives with information on how and to whom they may report concerns, incidents, and grievances without the fear of retribution. The facility policy also stated residents have the right to live at ease in a safe environment without the fear of retaliation when allegations are reported.</p> <p>This policy was not followed.</p> <p>a. Resident #4 was admitted to the facility on 10/3/18, with diagnoses which included expressive aphasia (an impairment of language due to brain injury with partial loss of the ability to produce language), stroke, hemiplegia (paralysis on one side of the body), anxiety, and depression.</p> <p>On 10/27/19 at 11:55 AM, Resident #4 was interviewed. Resident #4 was alert and oriented to person and place. When asked if she had any concerns with the staff or care provided, Resident #4 exclaimed "Yes." When asked if anything negative had occurred with her care or if anyone had ever been abusive to her, Resident #4 stated no and cried with tears rolling down her cheeks. She was unable to vocalize what if any negative outcomes had occurred.</p>	F 600	<p>Residents #333 and 480 no longer reside in facility.</p> <p>Other Resident in Similar Situations: Residents and/or responsible parties were interviewed related to concerns with abuse/neglect and general care issues. Interviews were conducted weekly x4 to ensure that there were no ongoing issues related to these areas. Incident reports were completed and reported per regulation.</p> <p>Measures to Prevent Reoccurrence: Facility staff were educated by ED, DON, DVP, RDCS or designee and completed competencies on abuse and neglect regulations. Immediate Removal plan was initiated and completed with immediacy lifted as of 11/12/19.</p> <p>On-going Monitoring: The Executive Director will monitor incident reports and grievances daily (M-F) to ensure compliance with regulations. Staff will be educated monthly x3 months on abuse/neglect regulations and facility policies. Manager rounds will be conducted weekly x4 and monthly x2 throughout the facility to ensure resident concerns are identified and addressed as required. Trends and findings with these programs will be reviewed monthly through QAPI x3.</p> <p>Individual to ensure compliance: Executive Director will ensure on going compliance.</p>		

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F 600	<p>Continued From page 37</p> <p>b. On 10/27/19 at 2:16 PM, Resident #7 stated staff made her feel degraded and had "made me cry" in the last month, the last time was about two weeks ago. She said staff talked down to her and acted like she was "out of bounds" with them. Resident #7 was asked if she could recall any particular staff member or names and Resident #7 stated "It's all the CNAs, on every shift." Resident #7 was asked if she had reported these incidents to the E.D. and she stated no, she wanted to remain anonymous because she was afraid of retaliation from staff after the survey team left. Resident #7 requested the team lead and this surveyor's business card, "just in case." When asked why, Resident #7 added "just in case the staff does something to me after you leave."</p> <p>c. On 10/27/19 at 3:00 PM, Resident #480 reported CNA #13 yelled at him to "hurry up, we have 16 people and there is only two of us." Resident #480 stated he felt the staff member was getting angry with him. Due to this interaction Resident #480 said he avoided going to the dining room when CNA #13 was there and went to another dining/public area. Resident #480 stated he also kept his door closed, so he knew whenever someone entered his room. When asked if he had reported the incidents, Resident #480 stated that he thought he had but was unsure.</p> <p>The facility's grievance and incident logs from March 2019 through October 2019 did not include a grievance or incident filed for Resident #480.</p>	F 600			

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F 600	<p>Continued From page 38</p> <p>On 10/29/19 at 8:45 AM, with permission from Resident #7, E.D. #1 and the Director of Clinical Services were informed of the allegation of verbal abuse by staff towards Resident #7.</p> <p>d. On 10/28/19 at 12:00 PM, a family member reported overhearing an unnamed staff member tell Resident #35 "If you don't eat, you are not going to dialysis." Per the family member they wished to remain anonymous because they were afraid of what would happen if someone found out they said anything and that their family member would not receive care if the staff knew they reported it. The incident was reported to E.D. #1 and the Director of Clinical Services to investigate.</p> <p>A Resident Council meeting was conducted on 10/29/19 at 10:16 AM, with a sample of the facility residents. The residents were asked collectively if the staff treated them with respect and dignity. Residents #4, #32, #61, and #62 responded "no" and stated they were made to feel like an imposition, being "shuffled around like we are furniture." When the residents were asked if they had reported this to the facility, they stated they were very apprehensive about reporting staff incidents. The residents in attendance stated they did not feel anyone would do anything, and they did not trust and/or were afraid of the agency staff because they did not know them. Residents #4, #32, #61, and #62 added the staff were demeaning and disrespectful towards residents.</p> <p>On 10/30/19 at 12:30 PM, Resident #333 stated she was afraid to say anything to the staff, because she did not trust them. Resident #333</p>	F 600			

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F 600	Continued From page 39 stated a CNA threatened to turn her water off, so she could not shower without facility knowledge which made her "feel like a child." Resident #333 stated a CNA failed to follow through when she made a request, and she was told "you can just leave" in a "nasty" tone by the CNA. When asked who the staff member was, Resident #333 refused to say any more about the incident. On 11/7/19 at 9:30 AM, during a telephone interview, CNA #13 was asked if she remembered yelling at Resident #480 and telling him to hurry up, that she had 16 people and there was only two of us. CNA #13 responded she did not recall the incident. CNA #13 added she had a loud voice, but that she would not even speak to residents that way. On 11/8/19 at 9:00 AM, the DON was questioned about the outcome of the investigations for Resident #7, Resident #35, and Resident #480. The DON stated for Resident #35 LPN #7 was placed on leave until the investigation was completed and LPN #7 was provided with customer service, abuse, and neglect training. Related to Resident #480, CNA #13 was suspended and received customer service, abuse, and neglect training. Related to Resident #7, the remaining staff was provided with customer service, abuse, and neglect training. E.D. #1 was informed on 10/31/19 at 4:00 PM, there was an Immediate Jeopardy related to resident abuse. The Immediate Jeopardy was not removed at the time of survey exit on 11/8/19.	F 600			
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)	F 622		1/2/20	

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F 622	Continued From page 40 §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 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	F 622			

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F 622	Continued From page 41 facility. The facility must document the danger that failure to transfer or discharge would pose. §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. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c) (1)(i) of this section. (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). (ii) The documentation required by paragraph (c) (2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate.	F 622			

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F 622	<p>Continued From page 42</p> <p>(E) Comprehensive care plan goals; (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: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure the required documentation was completed and the appropriate information was communicated to the receiving facility when a resident was transferred to the hospital. This was true for 1 of 3 residents (Resident #75) reviewed for transfer to the hospital and had the potential to cause harm if the resident was not treated appropriately or in a timely manner due to a lack of information. Findings include:</p> <p>The facility's policy for Transfers and Discharges, dated 5/6/19, stated "...the facility 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." The policy stated the documentation included the basis for the transfer, the specific resident needs that could not be met, the facility's attempts to meet the resident's needs, and the services available at the receiving facility to meet the resident's needs.</p> <p>The policy also stated information provided to the receiving provider included contact information of the provider responsible for care of the resident, resident representative contact information,</p>	F 622	<p>Individual Residents: Resident #75 no longer resides in the facility.</p> <p>Other Resident in Similar Situations: A review of residents transferred to the hospital in the last 14 days was completed to ensure compliance with notifications.</p> <p>Measures to Prevent Reoccurrence: LNs were educated by the Director of Nursing on the required completion of discharge/transfer paperwork and proper and timely notifications.</p> <p>On-going Monitoring: Discharge/transfer documentation and proper notifications will be audited weekly x12 for compliance with required documentation. Negative findings of these audits will be reviewed through QAPI monthly x3 for further education needs.</p> <p>Individual to ensure compliance: The Director of Nursing will ensure ongoing compliance.</p>		

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F 622	<p>Continued From page 43</p> <p>advance directive information, special instructions or precautions for ongoing care, comprehensive care plan goals, and all other necessary information "to ensure a safe and effective transition of care."</p> <p>Resident #75 was readmitted to the facility on 10/5/19, with multiple diagnoses including Parkinson's disease, seizures, Type 2 diabetes mellitus, and dependence on dialysis.</p> <p>Resident #75's Discharge MDS assessment, dated 9/29/19, documented she was discharged to an acute hospital on that date.</p> <p>A physician's order, dated 9/29/19, documented an order to transport Resident #75 to the hospital via non-emergent ambulance transport.</p> <p>A Progress Note, dated 9/29/19 at 6:01 PM, documented Resident #75's daughter notified the facility that Resident #75 was admitted to the hospital due to "spasms of pain and becoming limp and unresponsive."</p> <p>On 11/5/19 at 9:18 AM, Resident #75 said she went to hospital in September 2019, for low blood sugar, and she did not recall any paperwork being offered to her or being sent with her.</p> <p>On 11/5/19 at 2:30 PM, RCM #1 said the nurse did not document anything else regarding Resident #75's transfer to the hospital on 9/29/19.</p> <p>On 11/5/19 at 3:15 PM, RCM #1 provided a handwritten note that documented on 9/29/19 at 1:00 PM, a nurse called Resident #75's daughter</p>	F 622			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854		
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F 622	Continued From page 44 and called an ambulance for Resident #75, and there was no documentation in the record of that. On 11/5/19 at 4:01 PM, the DON said there was a form staff were supposed to complete regarding transferring residents to the hospital and the appropriate notifications. On 11/7/19 at 2:20 PM, the DON said she did not find any documentation of the required transfer information in Resident #75's record.	F 622			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		1/2/20	

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F 623	<p>Continued From page 45</p> <p>before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:</p> <p>(i) The reason for transfer or discharge;</p> <p>(ii) The effective date of transfer or discharge;</p> <p>(iii) The location to which the resident is transferred or discharged;</p> <p>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with</p>	F 623			

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F 623	<p>Continued From page 46</p> <p>developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure written notification of transfer was provided to residents and their representative. This was true for 1 of 3 residents (Resident #75) reviewed for transfer to the hospital and had the potential to cause harm if</p>	F 623	<p>Individual Residents: Resident #75 no longer resides in the facility.</p> <p>Other Resident in Similar Situations: A review of residents transferred to the hospital in the last 14 days was</p>		

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F 623	<p>Continued From page 47</p> <p>the resident was not made aware of or able to exercise her rights related to transfers. Findings include:</p> <p>The facility's policy for Transfers and Discharges, dated 5/6/19, stated "Before transferring or discharging a resident the facility must...Notify the resident and the resident's representative(s) of the transfer or discharge and the reason for the move in writing and in a language and manner they understand..." The policy stated the written notice must contain the reason for the transfer/discharge, the date of the transfer/discharge, the location of where the resident was being transferred, a statement of the resident's right to appeal the transfer/discharge, and contact information for the State Long-Term Care Ombudsman.</p> <p>Resident #75 was readmitted to the facility on 10/5/19, with multiple diagnoses including Parkinson's disease, seizures, Type 2 diabetes mellitus, and dependence on dialysis.</p> <p>Resident #75's Discharge MDS assessment, dated 9/29/19, documented she was discharged to an acute hospital on that date.</p> <p>A physician's order, dated 9/29/19, documented an order to transport Resident #75 to the hospital via non-emergent ambulance transport.</p> <p>A Progress Note, dated 9/29/19 at 6:01 PM, documented Resident #75's daughter notified the facility of Resident #75 being admitted to the hospital due to "spasms of pain and becoming limp and unresponsive."</p>	F 623	<p>completed to ensure compliance with notifications.</p> <p>Measures to Prevent Reoccurrence: LNs were educated by the Director of Nursing on the required completion of discharge/transfer paperwork and proper and timely notifications.</p> <p>On-going Monitoring: Discharge/transfer documentation and proper notifications will be audited weekly x12 for compliance with required documentation. Negative findings of these audits will be reviewed through QAPI monthly x3 for further education needs.</p> <p>Individual to ensure compliance: The Director of Nursing will ensure ongoing compliance.</p>		

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F 623	Continued From page 48 On 11/5/19 at 9:18 AM, Resident #75 said she went to hospital in September 2019, for low blood sugar, and she did not recall any paperwork being offered to her or being sent with her. On 11/5/19 at 2:30 PM, RCM #1 said the nurse did not document anything else regarding Resident #75's transfer to the hospital. On 11/5/19 at 4:01 PM, the DON said there was a form staff were to complete regarding transferring residents to the hospital and the appropriate notifications. On 11/7/19 at 2:20 PM, the DON said she did not find documentation of the notice of transfer in Resident #75's record.	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625		1/2/20	

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F 625	<p>Continued From page 49</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure a bed-hold notice was provided to residents when they were transferred to the hospital. This was true for 1 of 3 residents (Resident #75) reviewed for transfer/discharge. This deficient practice created the potential for harm if the resident was not informed of her right to return to her former bed/room at the facility within a specified time. Findings include:</p> <p>The facility's policy for Bedhold/Reservation of Room, dated 5/2/19, stated the bed-hold policy should be given to the resident upon admission or "...upon transfer of a resident to the hospital (if in an emergency within 24 hours)..." The policy stated the facility provided written information to residents or their representative regarding the facility's policy on bed-hold time periods and the resident's return to the facility, to ensure the resident were aware of the bed-hold and reserve payment policy before and upon transfer to the hospital.</p> <p>The policy also stated before residents were transferred to the hospital, the facility provided</p>	F 625	<p>Individual Residents: Resident #75 no longer resides in the facility.</p> <p>Other Resident in Similar Situations: A review of residents transferred to the hospital in the last 14 days was completed to ensure compliance with bed hold notification and offerings.</p> <p>Measures to Prevent Reoccurrence: LNs were educated by the Director of Nursing on the requirement of offering bed holds at the time of transfer and or as soon as reasonably possible.</p> <p>On-going Monitoring: Bed hold documentation and offerings will be audited weekly x12 for compliance with required documentation. Negative findings of these audits will be reviewed through QAPI monthly x3 for further education needs.</p> <p>Individual to ensure compliance: The Director of Nursing will ensure</p>		

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F 625	<p>Continued From page 50</p> <p>written information to the resident or their representative that specified: the duration of the bed-hold policy during which the resident was allowed to return to the nursing facility, the reserve bed payment policy (if any), and the facility's policy regarding bed-hold periods.</p> <p>Resident #75 was readmitted to the facility on 10/5/19, with multiple diagnoses including Parkinson's disease, seizures, Type 2 diabetes mellitus, and dependence on dialysis.</p> <p>Resident #75's Discharge MDS assessment, dated 9/29/19, documented she was discharged to an acute hospital on that date.</p> <p>A physician's order, dated 9/29/19, documented an order to transport Resident #75 to the hospital via non-emergent ambulance transport.</p> <p>A Progress Note, dated 9/29/19 at 6:01 PM, documented Resident #75's daughter notified the facility of Resident #75 being admitted to the hospital due to "spasms of pain and becoming limp and unresponsive."</p> <p>On 11/5/19 at 9:18 AM, Resident #75 said she went to hospital in September 2019, for low blood sugar, and she did not recall any paperwork being offered to her or being sent with her.</p> <p>On 11/5/19 at 2:30 PM, RCM #1 said the nurse did not document anything else regarding Resident #75's transfer to the hospital.</p> <p>On 11/5/19 at 3:40 PM, the Business Office Manager said Social Services was responsible for the bed hold notice.</p>	F 625	ongoing compliance.		

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

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F 625	Continued From page 51 On 11/5/19 at 3:43 PM, the Social Services Director said the nurse who transferred the resident should provide the bed hold notice, and he did not have anything to do with that. On 11/5/19 at 3:59 PM, RCM #1 said she was not aware a bed hold notice was to go with residents when they were transferred to the hospital. On 11/5/19 at 4:01 PM, the DON said there was a form staff were supposed to complete regarding transferring residents to the hospital and the appropriate notifications. On 11/7/19 at 2:20 PM, the DON said she did not find any documentation of the bed-hold information in Resident #75's record.	F 625			
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		1/2/20	

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F 656	<p>Continued From page 52</p> <p>provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>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 develop and implement comprehensive resident-centered care plans. This was true for 4 of 32 residents (#54, #134, #430, and #431) whose care plans were reviewed. The residents' care plans did not include pressure ulcer treatment, cardiac issues, use of oxygen, and bowel/bladder incontinence care. This failure created the potential for harm if residents received inappropriate or inadequate care with a subsequent decline in health.</p> <p>Findings include:</p>	F 656	<p>Individual Residents:</p> <p>Resident #54 had her care plan reviewed and updated to reflect care with bowel and bladder tasks.</p> <p>Residents #134, 430 and 431 no longer reside in the facility.</p> <p>Other Residents in similar situations:</p> <p>Residents have the potential to be affected by this practice and will have care plans reviewed and updated with their next scheduled MDS assessment and/or with changes in condition,</p>		

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F 656	<p>Continued From page 53</p> <p>The facility's policy for Care Planning and Interventions, dated 7/23/09, documented the following:</p> <ul style="list-style-type: none"> * A comprehensive person-centered care plan was developed by an interdisciplinary team for each resident, and was updated as needed, but not less than quarterly. * The care plan addressed the following: <ul style="list-style-type: none"> - The resident's objectives and options - Measures to prevent avoidable declines in functioning - Resident-specific interventions - Current professional standards - Treatment goals with measurable outcomes - Time intervals - Parameters for monitoring <p>This policy was not followed.</p> <p>1. Resident #134 was readmitted to the facility on 9/4/19, with multiple diagnoses including atrial fibrillation (irregular heartbeat), renal failure, and respiratory failure.</p> <p>Resident #134's hospital discharge orders, dated 9/4/19, documented therapy orders for pressure ulcer precautions.</p> <p>An Admission/Readmission Collection Tool, dated 9/5/19, documented Resident #134 had a 3 cm pressure ulcer covered with an Allevyn (absorbent foam) dressing on his coccyx (tailbone).</p>	F 656	<p>incidents and as needed.</p> <p>Measures to prevent reoccurrence: LNs, including MDS nurses, were educated by the Director of Nursing on maintaining and updating care plans to reflect the residents current care needs with changes in condition.</p> <p>Ongoing Monitoring: Care plans will be reviewed in conjunction with the resident's MDS schedule and weekly x12 weeks to verify changes in condition/events are reflected in the care plan. Negative findings of these audits will be reviewed through QAPI x3 months.</p> <p>Individual to ensure compliance: MDS Coordinator will ensure ongoing compliance.</p>		

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F 656	<p>Continued From page 54</p> <p>Resident #134's skin integrity care plan, dated 9/7/19, documented he was at risk for skin breakdown. The care plan interventions were for staff to complete weekly skin checks, clean and dry skin after each incontinent episode, and apply a pressure reducing mattress. The care plan did not include Resident #134's pressure ulcer to his coccyx and related interventions.</p> <p>The admission MDS assessment, dated 9/11/19, documented Resident #134 was moderately cognitively impaired and required extensive assistance from staff members for bed mobility, transfers, and dressing. The assessment documented he had one Stage II pressure ulcer, which is a partial-thickness skin loss with exposed dermis (thick layer of living tissue below the top of the skin that contains blood vessels, nerve endings, sweat glands, hair follicles, and other structures) present on admission.</p> <p>On 11/7/19 at 5:27 PM, RCM #2 stated Resident #134's care plan should include interventions for the pressure ulcer to his coccyx.</p> <p>2. Resident #431's Admission Record documented she was admitted to the facility on 2/8/19. Her diagnoses included arteriosclerotic heart disease (ASHD - a thickening and hardening of the walls of the coronary arteries) with angina (heart muscle pain).</p> <p>Resident #431's medical record documented on the morning of 4/21/19, she exhibited signs and symptoms of cardiac and circulatory distress and was later reported not breathing by family members at 3:00 PM. CPR efforts were initiated, but Resident #431's was unable to be revived.</p>	F 656			

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F 656	<p>Continued From page 55</p> <p>Resident #431's undated comprehensive care plan did not include information and interventions related to her diagnosis of ASHD with angina, emergency lifesaving assessments and interventions for acute cardiac events, and parameters for notifying the physician in the event of chest pain or other symptoms of an acute cardiac event.</p> <p>During an interview on 11/8/19 at 9:35 AM, the DON stated Resident #431's cardiac condition and emergency measures should have been included on the care plan along with the appropriate interventions.</p> <p>3. Resident #54 was admitted to the facility on 9/16/18, with multiple diagnoses including dementia and muscle weakness.</p> <p>Resident #54's annual MDS assessment, dated 9/25/19, documented the following:</p> <ul style="list-style-type: none"> * She was severely cognitively impaired. * She was totally dependent on the physical assistance of 2 persons for transfers and toileting, and she required extensive assistance of one person for personal hygiene. * She was frequently incontinent of urine. * She was always incontinent of bowel. <p>Resident #54's care plan directed staff to assist her with Activities of Daily Living as needed. The care plan did not document Resident #54 was incontinent or address her needs for bowel and bladder care.</p> <p>On 10/28/19 at 3:35 PM, Resident #54 was</p>	F 656			

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F 656	<p>Continued From page 56</p> <p>awake and sitting in her lounge chair in her room. An odor of feces was noted in her room.</p> <p>On 11/7/19 at 5:38 PM, the DON said she expected a care plan intervention for every 2 hour checks for residents who were incontinent. On 11/7/19 at 6:28 PM, the DON said Resident #54's care plan did not address her bowel and bladder needs.</p> <p>4. Resident #430's Admission Record documented he was admitted to the facility on 7/25/19. His diagnoses included below knee amputation of right leg, chronic obstructive pulmonary disease (COPD - a progressive lung disease characterized by increasing breathlessness), ASHD, and heart failure.</p> <p>Resident #430's Order Summary Reports for July and August 2019 included an order for oxygen (O2) at four liters/minute continuously via nasal cannula every shift for COPD with an order date of 7/25/19.</p> <p>Resident #430's admission MDS assessment, dated 8/1/19, stated he had moderately impaired cognitive skills and required extensive assistance of 2 or more staff for bed mobility and transfers. The MDS assessment stated he received oxygen prior to admission and while a resident of the facility.</p> <p>Resident #430's undated comprehensive care plan did not include information and interventions related to his diagnosis of COPD and orders for oxygen at four liters per minute continuously via nasal cannula every shift.</p>	F 656			

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F 656	Continued From page 57 During an interview on 11/8/19 at 9:35 AM, the DON stated Resident #430's need for continuous oxygen should have been included on the care plan along with the appropriate interventions.	F 656			
F 657 SS=E	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 observation, record review, policy review, and interviews with staff and a resident's	F 657	Individual Residents: Residents #13, 54 and 131 had their care	1/2/20	

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F 657	<p>Continued From page 58</p> <p>family member, it was determined the facility failed to ensure residents' care plans were revised to accurately reflect the status of pressure ulcers and included related interventions, and the use of mobility aides, and that quarterly care conferences were held. These deficient practices directly impacted 3 of 32 residents (#13, #54, and #131) whose care plans were reviewed, These failures created the potential for harm if residents and/or their representatives were not included and updated regarding the plan of care, and if appropriate care and/or services were not provided due to incorrect information on the care plan. Findings include:</p> <p>The facility's policy for Care Planning and Interventions, dated 7/23/09, documented the following:</p> <ul style="list-style-type: none"> * The interdisciplinary team met at a scheduled time and developed the individualized care plan. * The care plan was updated as needed, at least least quarterly, and as conditions changed, when goals were met, and when interventions were determined to be ineffective or needed to be revised. <p>1. Resident #13 was admitted to the facility on 7/30/19, with multiple diagnoses, which included dementia and age-related physical debility.</p> <p>The quarterly MDS assessment, dated 10/14/19, documented Resident #13 was severely cognitively impaired and required extensive assistance of two staff members for bed mobility and dressing.</p>	F 657	<p>plans reviewed related to pressure ulcers and assistive devices and pressure ulcer prevention techniques. Care Conference completion was reviewed and audited to ensure that they had their care plans reviewed with resident/resp. party.</p> <p>Other Residents in similar situations: Residents with pressure ulcers, assistive devices and PICC lines had their care plans reviewed and updated with interventions and status of these areas. Current residents were audited to determine if care conferences had been held within the last 90 days to include care plan reviews. Residents identified had care conference offered/scheduled to complete care plan reviews.</p> <p>Measures to prevent reoccurrence: LNs including MDS and Social Services were educated on care plan revisions and holding quarterly care conferences and care plan review meetings with resident/resp. parties by the Director of Nursing and Executive Director.</p> <p>Ongoing Monitoring: Care plans will be reviewed in conjunction with the residents MDS schedule and with changes in pressure ulcer status, assistive devices and PICC lines. An Additional 2 residents/week x12 weeks will have care plans reviewed and updated as needed. Additionally, care conferences will be audited monthly x3 months. Findings of these audits will be reviewed through monthly QAPI x3</p>		

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F 657	<p>Continued From page 59</p> <p>On 10/27/19 at 3:22 PM, Resident #13 was observed lying in bed on an air mattress with her left heel resting on the air mattress. Resident #13's left heel was open with serous drainage (clear, thin, and watery) on the mattress. RN #1 stated Resident #13 was to have a heel foam pad for protection. RN #1 stated Resident #13 should have wound care orders for her left heel.</p> <p>On 10/28/19 at 2:01 PM, Resident #13's left heel had no dressing in place and the wound was open with drainage.</p> <p>Resident #13's actual skin breakdown care plan, dated 7/31/19, documented her left heel pressure ulcer was healed.</p> <p>Resident #13's care plan did not include her current open left heel pressure ulcer.</p> <p>On 10/30/19 at 12:20 PM, RCM #2 stated he was unaware of Resident #13's pressure ulcer to her left heel. RCM #2 stated Resident #13's care plan should include all pressure ulcer interventions.</p> <p>2. Resident #131 was admitted to the facility on 8/20/19 with multiple diagnoses, including an unstageable necrotic (dead tissue) pressure ulcer to his sacrum (triangular bone at the base of the spine).</p> <p>The admission MDS assessment, dated 8/27/19, documented Resident #131 was moderately cognitively impaired and at risk for developing a pressure ulcer and had an unhealed pressure ulcer.</p>	F 657	<p>months for trends and additional education.</p> <p>Individual to ensure compliance: The Director of Nursing will ensure ongoing compliance.</p>		

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F 657	<p>Continued From page 60</p> <p>a. Resident #131's care plan, dated 8/22/19, documented bilateral bed mobility aides (bed rails) to increase independence with bed mobility, and a bed trapeze to increase independence with bed mobility.</p> <p>On 10/27/19 at 4:15 PM, Resident #131 was assisted to bed from his wheelchair and there was no trapeze or bed mobility aides to help with bed mobility.</p> <p>On 10/31/19 at 9:53 AM, RCM #2 stated Resident #131 did not have a trapeze or bed mobility aides. RCM #2 stated Resident #131's care plan would be revised based on the next quarterly assessment, which would be in November 2019.</p> <p>b. Resident #131's care plan, dated 8/23/19, documented PICC (Peripherally Inserted Central Catheter) line dressing changes per physician's orders/protocol, and PICC line flushes were to be completed prior to and following blood draws, and IV medication.</p> <p>The care plan, dated 8/23/19, documented Resident #131 was on IV therapy related to wounds and sepsis, to observe the intravenous dressing to his left arm every shift, change the dressing, and record observations of the wound site every week.</p> <p>Resident #131's August 2019 TAR, documented an order, dated 08/23/19 at 1:56 PM, to change left upper extremity PICC line dressing, measure his upper arm circumference, and if there was concern for line movement or infection, to hold the antibiotic and notify the provider. The order</p>	F 657			

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F 657	<p>Continued From page 61 discontinue date was 10/13/19.</p> <p>A progress note, dated 10/6/19, documented Resident #131's PICC line was removed in error. The PICC line was not replaced.</p> <p>On 10/27/19 at 4:15 PM, Resident #131 was observed in his room. RN #1, present at the time, stated he had not had a PICC line for a while.</p> <p>On 10/30/19 at 10:08 AM, RCM #2 stated Resident #131's record had an order to discontinue his PICC line on 10/13/19. RCM #2 was unable to explain why the discontinued PICC line order was written on 10/13/19, when Resident #131's record documented the PICC line was removed on 10/6/19. RCM #2 stated the nurses who documented on 10/7/19 to 10/10/19 that Resident #131 had a PICC line did not assess him to know he had not had one since 10/6/19.</p> <p>On 10/31/19 at 10:20 AM, the DON stated Resident # 131's care plan should have been revised to discontinue the trapeze, bed rails, and PICC line according to physicians order.</p> <p>3. Resident #54 was admitted to the facility on 9/16/18, with multiple diagnoses including dementia and muscle weakness.</p> <p>Resident #54's annual MDS assessment, dated 9/25/19, documented she was severely cognitively impaired.</p> <p>It was documented the care plan and medications were reviewed with Resident #54's Power of Attorney/son on 2/6/19.</p>	F 657			

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F 657	Continued From page 62 Resident #54's Care Plan Conference Record, dated 3/11/19, documented Social Worker #2 spoke to Resident #54's Power of Attorney/son on 3/27/19. There were no new care needs or concerns. There was no documentation in Resident #54's record that a Care Conference was held after 3/11/19. On 10/28/19 at 3:40 PM, Resident #54's son said he could not recall the last quarterly care plan meeting, except a 10 minute conversation in the hallway with a gentleman. On 11/6/19 at 11:51 AM, the Director of Social Services said care conferences were held quarterly and annually, if family members attended it was documented in the resident's record, and if only the resident attended then no Care Plan Conference Record was written.	F 657			
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident, family member, and staff interview, it was determined the facility failed to ensure residents were provided with bathing consistent with their needs. This was true for 7 of 10 (#13, #20, #24, #46, #61 #131 and #180) residents sampled for bathing. This failure	F 677	Individual Residents: Residents #13, 20, 24, 46, 61 and 131 were interviewed to identify bathing preferences and had care plans updated to reflect. Resident #180 no longer resides in the facility.	1/2/20	

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F 677	<p>Continued From page 63</p> <p>created the potential for residents to experience embarrassment, isolation, decreased sense of self-worth, skin impairment, and/or otherwise compromise their physical and psychosocial well-being. Findings include:</p> <p>The facility's policy for Activities of Daily Living (ADL), reviewed 4/22/19, documented the following:</p> <ul style="list-style-type: none"> * Residents received assistance as needed to complete ADL. * The facility must provide care and services for ADL, including bathing, dressing, and grooming. * Residents who were unable to perform ADL received the necessary services to maintain good grooming and personal hygiene. <p>This policy was not followed.</p> <p>1. Resident #180 was admitted to the facility on 9/13/19, with multiple diagnoses including heart failure, respiratory failure with hypoxia (low oxygen level), chronic kidney disease, atrial fibrillation (irregular heart beat), and Parkinson's disease (a progressive nervous system disorder that affects movement).</p> <p>Resident #180's admission MDS assessment, dated 9/20/19, documented he was cognitively intact, he required extensive assistance of one person for personal hygiene, and bathing did not occur during the assessment period.</p> <p>Resident #180's care plan documented he required extensive assistance from staff with bathing/showering 2 to 3 times per week, initiated on 9/25/19.</p>	F 677	<p>Other Residents in similar situations: Residents who were interviewable were interviewed to ensure that bathing preferences were identified and scheduled according to preference. Non-interviewable residents had resp. party contacted when possible to ensure needs are met. Care plans were updated to reflect these choices.</p> <p>Measures to prevent reoccurrence: The Executive Director increased shower staff available along with extended times to ensure resident preferences could be met. A new shower schedule was completed in accordance with resident preferences. Clinical staff were educated on resident rights and bathing preferences by the Director of Nursing.</p> <p>Ongoing Monitoring: Shower completion will be audited weekly x4 and then monthly x2 to ensure that showers are being completed per resident preference. Negative findings of these audits will be reviewed through monthly QAPI x3 months.</p> <p>Individual to ensure compliance: Director of nursing will ensure ongoing compliance.</p>		

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F 677	<p>Continued From page 64</p> <p>Resident #180's ADL Reports for September and October 2019 documented he refused bathing on 9/15/19, 9/24/19, 9/25/19, and 10/30/19. He was not available on 10/16/19.</p> <p>There was no documentation of bathing being offered or performed from 9/16/19 through 9/24/19, 8 days. There was no documentation Resident #180 was offered or received a bath or shower from 9/26/19 through 10/29/19, 34 days.</p> <p>On 10/27/19 at 3:26 PM, Resident #180 was lying in bed. He appeared unshaven and disheveled. Resident #180's family member said he was not getting shaved and he did not appear clean.</p> <p>On 11/1/19 at 11:10 AM, the Regional Consultant Nurse said Resident #180 went 2 weeks without a documented shower, and she would see if there was additional documentation of showers elsewhere.</p> <p>On 11/4/19 at 9:49 AM, the DON said she expected each resident to be offered a shower twice a week.</p> <p>2. Resident #20 was admitted to the facility on 5/4/18, with multiple diagnoses including diabetes mellitus, cerebral palsy (impaired muscle coordination), generalized muscle weakness, polyneuropathy (degeneration of nerves in extremities), and morbid obesity.</p> <p>A quarterly MDS assessment, dated 8/12/19, documented Resident #20 was cognitively intact, and required extensive physical assistance of 2</p>	F 677			

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

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F 677	<p>Continued From page 65</p> <p>persons with transfers, dressing, toilet use, and physical assistance of 1 person with personal hygiene. Resident #20 had total dependence and required physical assistance of 1 person with bathing.</p> <p>Resident #20's Care Plan documented she was to receive a shower or bath twice a week per the shower schedule, date initiated 11/6/18.</p> <p>On 10/28/19 at 10:03 AM, Resident #20 was observed with greasy and uncombed hair. Resident #20 said she got a shower once a week, and had no options to ask for more, or when they were scheduled.</p> <p>On 10/30/19 at 3:31 PM, Resident #20 was observed with clean hair this day. Resident #20 said she got showers every Wednesday, and got a shower that day (10/30/19), but had not had one on Saturdays as scheduled. She said she refused a shower last Wednesday.</p> <p>On 10/31/19 at 3:05 PM, RCM #1 said Shower Aide #2 was in charge of showers on the 100 Hall and she would know more about them than herself.</p> <p>On 10/31/19 at 3:06 PM, Shower Aide #2 said when she started working in the facility 2 months ago she interviewed each resident on the unit to learn when residents preferred showers and created/documented a schedule. Shower Aide #2 said she worked in the facility Monday through Friday from 5:00 AM to 3:00 PM. She said she showered 15 people a day maximum, it varied due to resident bathing type preferences, and CNAs helped with transfers. Shower Aide #2 said</p>	F 677			

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F 677	<p>Continued From page 66</p> <p>twice weekly showers were planned for residents, Wednesdays were scheduled as open days to shower residents who had missed a shower, and if a resident refused she informed the RN. Shower Aide #2 said Resident #20 got a shower once a week and PRN (as needed), she got a shower on Wednesdays, and if she refused it was documented. The DON joined the discussion and said Shower Aide #2's internal notes were reflected in the electronic record Task Notes. Regarding provision of twice weekly showers the DON asked Shower Aide #2 if she documented when residents refused, and Shower Aide #2 said no, she did not. Shower Aide #2 said Resident #20 "sometimes refused a shower, but the refusals were not documented." Shower Aide #2 said "I am only one person, I tried to get to them". Shower Aide #2 said she worked 10-11 hours a day and did not have time to provide showers twice a week, she offered showers once a week, and sometimes offered afternoon showers but the residents did not want that, they wanted a shower before breakfast.</p> <p>The bathing Task Sheets documented Resident #20 had a shower on 9/27/19 at 10:00 AM, refused a shower on 9/30/19 at 11:30 AM, had a shower on 10/1/19 at 6:00 AM, on 10/11/19 at 1:59 PM, and on 10/16/19 at 2:30 PM.</p> <p>The Task Sheets documented Resident #20 went 9 days without a shower (10/2/19 - 10/10/19) and 13 days without a shower (10/17/19 - 10/29/19). The Task Sheets documented no PRN shower was provided to Resident #20 between her 10/16/19 and 10/30/19 showers. Resident #20 did not receive showers as documented on her care plan.</p>	F 677			

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F 677	<p>Continued From page 67</p> <p>On 10/31/19 at 3:25 PM, RCM #1 said the October shower task documented Resident #20 had not had showers twice a week per the care plan.</p> <p>3. Resident #61 was admitted to the facility on 8/1/19, with multiple diagnoses, including type 2 diabetes mellitus with a foot ulcer, lymphedema (edema in lower and upper extremities, due to removal or damage to lymph nodes), hypertension, and chronic pain.</p> <p>An admission MDS assessment, dated 8/8/19, documented Resident #61 was cognitively intact and she required extensive assistance for transferring from one person and set up only for bathing.</p> <p>Resident #61's care plan documented she required extensive assistance from one staff with showering twice weekly, and as necessary.</p> <p>Resident #61's September 2019 ADLs Report documented she did not receive a bath from 9/21/19 through 9/26/19, 6 days.</p> <p>On, 10/2/19 Resident #61 completed a Comment and Concern card: "We are constantly denied a shower. It has been a week this time and has been as many as 12-14 days. Hygiene is just as important to my healthcare..."</p> <p>On 10/28/19 at 10:32 AM, Resident #61 stated she was not consistently receiving showers twice a week as scheduled.</p> <p>On 11/6/19 at 4:37 PM, RCM #2 stated that</p>	F 677			

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F 677	<p>Continued From page 68</p> <p>according to the documentation Resident #61 did not receive showers twice a week as scheduled.</p> <p>4. Resident #24 was admitted to the facility on 7/9/13 with multiple diagnoses including dementia, generalized muscle weakness, and neuropathy (damage to the nerves outside of the brain and spinal cord which often causes weakness, numbness and pain).</p> <p>A quarterly MDS assessment, dated 8/17/19, documented Resident #24 was severely cognitively impaired, and required extensive physical assistance from 1 person with transfers, personal hygiene, and bathing.</p> <p>Resident #24's care plan documented she required extensive assistance of 1 staff with showering twice weekly and PRN. Resident #24 resided on 100 Hall, and Shower Aide #2 was her shower aide.</p> <p>The bathing Task Sheets documented Resident #24 was to receive a bath or shower twice weekly. The Task Sheets documented Resident #24 refused a shower on 10/23/19 at 11:45 AM, received a shower on 10/24/19 at 12:30 PM and on 10/30/19 at 10:59 AM, refused a shower on 11/6/19 at 12:31 PM, and received a shower on 11/7/19 at 10:59 AM.</p> <p>Resident #24 was not offered a shower and did not receive a shower from:</p> <ul style="list-style-type: none"> * 10/1/19 through 10/23/19, 22 days, * 10/31/19 to 11/6/19, 7 days <p>Resident #24 did not receive showers per her</p>	F 677			

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F 677	<p>Continued From page 69 care plan.</p> <p>On 11/7/19, E.D. #2 said Resident #24 did not get 2 showers a week per her care plan.</p> <p>5. Resident #13 was admitted to the facility on 7/30/19, with multiple diagnoses, which included dementia and age-related physical debility.</p> <p>Resident #13's admission MDS assessment, dated 8/6/19, documented her cognition was intact and she required extensive assistance from one person for bathing.</p> <p>A significant change in status MDS assessment, dated 10/14/19, documented Resident #13 was severely cognitively impaired and required extensive assistance from two-persons while bathing.</p> <p>Resident #13's care plan, dated 8/12/19, documented extensive assistance of one staff for showering, twice a week and as necessary.</p> <p>Resident #13's August 2019 ADL Report documented she did not receive a bath from 8/1/19 through 8/8/19, 8 days.</p> <p>Resident #13's September 2019 ADL Report documented she did not receive a bath from 9/6/19 through 9/17/19, 12 days.</p> <p>Resident #13's October 2019 ADL Report documented she did not receive a bath from 10/5/19 through 10/24/19, 20 days.</p> <p>On 11/5/19 at 4:30 PM, the DON stated Resident #13 should have a bed bath 2 times a week since</p>	F 677			

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F 677	<p>Continued From page 70 she did not want to get out of bed.</p> <p>6. Resident #131 was admitted to the facility on 8/20/19, with multiple diagnoses including an unstageable necrotic (dead tissue) pressure ulcer to his sacrum (a triangular bone in the lower back situated between the two hipbones of the pelvis).</p> <p>An MDS assessment, dated 9/3/19, documented Resident #131 was moderately cognitively impaired and required extensive assistance from two people for bathing.</p> <p>Resident #131's care plan documented he required assistance from one person with showering twice weekly, and as necessary.</p> <p>Resident #131's August 2019 ADLs Report documented he did not receive a bath from 8/23/19 through 8/27/19, 5 days.</p> <p>Resident #131's September 2019 ADLs Report documented he did not receive a bath from 9/5/19 through 9/16/19, 12 days, and did not receive a bath from 9/18/19 through 9/29/19, 12 days.</p> <p>Resident #131's October 2019 ADLs Report documented his bathing schedule. Resident #131 did not receive bathing from 10/1/19 through 10/14/19, 14 days and from 10/16/19 through 10/27/19, 12 days.</p> <p>On 11/4/19 at 1:29 PM, Shower Aide #1 stated 4-5 month ago she started as the shower aide for Monday through Friday schedule. The weekend showers were to be completed by someone else, she said that did not happen. Six weeks prior to</p>	F 677			

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F 677	<p>Continued From page 71</p> <p>10/31/19 she was on light duty, working as a hospitality aide. The facility did not schedule a shower aide for the week, but residents were scheduled 7 days a week to receive 2 showers per week unless the care plan documented specific times. If a resident missed a shower, the charge nurse was to be notified and the resident was added to the next day's list, which was kept in the shower room. If a shower was not completed, she would not document it, leaving the entry blank. Shower Aide #1 reviewed the showering task and stated Resident #131 did not receive showers 2 times a week as scheduled.</p> <p>7. Resident #46 was admitted to the facility on 1/2/19, with multiple diagnoses including essential hypertension, dementia, and overactive bladder.</p> <p>An MDS assessment, dated 9/20/19, documented Resident #46 was cognitively intact and was totally dependent on one-person assistance for personal hygiene, including bathing.</p> <p>The care plan area addressing Resident #46's ADL care, revised 1/24/19, documented Resident #46 was to receive showers twice a week.</p> <p>Resident #46's September and October 2019 ADL Report documented she did not receive a bath from 9/4/19 through 9/10/19, 7 days. She also did not receive a bath from 9/25/19 through 10/7/19, 13 days.</p> <p>On 10/30/19 at 3:50 PM, E.D. #1 said the facility was facing a "staffing crunch." E.D. #1 said at times a shower aide was pulled from giving</p>	F 677			

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F 677	Continued From page 72 showers to work on the floor, but now they were "catching up on showers."	F 677			
F 679 SS=D	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, staff interview, and record review, it was determined the facility failed to ensure there was an ongoing activity program to meet individual resident needs. This was true for 1 of 32 residents (#54) whose care plans were reviewed and created the potential for residents to become bored or depressed when not provided with meaningfully engagement throughout the day. Findings include: Resident #54 was admitted to the facility on 9/16/18, with multiple diagnoses including dementia and muscle weakness. Resident #54's annual MDS assessment, dated 9/25/19, documented she had short and long term memory problems, was without recall, and was severely cognitively impaired. Resident #54's care plan, initiated 10/11/18,	F 679		1/2/20	
			Individual Residents: Resident/responsible party #54 was interviewed to determine personal activity preferences and care plan was updated to reflect these choices. Other Residents in similar situations: Residents who have limited activity participation were interviewed to ensure that their individual programming meets their personal preferences and choices. Measures to prevent reoccurrence: Activity Department staff were educated by the Executive Director on meeting the individual needs of residents to include one on one programing and documentation. Ongoing Monitoring:		

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F 679	<p>Continued From page 73</p> <p>documented her representative participated in the MDS assessment and agreed to help with the annual interview, and stated the following:</p> <p>Focus: * She has no interest in group activity and her son is in daily.</p> <p>Goals: *She will be receptive to 1 to 1 visits twice a week through review. *She will do her own self directed activities daily for 90 days.</p> <p>Interventions: * She is friendly and approachable, and vocally uncommunicative. * She does not wish to participate in religious services at this time. * She liked to watch TV and visit with her son. * She prefers activities in her room. * Staff will continue to visit with Resident #54 twice a week. Target date 1/31/20.</p> <p>There was no evidence the facility provided twice weekly 1 to 1 visits for Resident #54 as follows:</p> <p>On 10/28/19 at 1:59 PM, Resident #54 was observed sleeping in her lounge chair.</p> <p>On 10/28/19 at 3:35 PM, Resident #54 was observed awake in her lounge chair, and a note was present on her table that her son would bring dinner for her.</p> <p>On 10/30/19 at 3:23 PM, Resident #54 was observed sitting in her lounge chair in her room watching TV.</p>	F 679	<p>The one to one activity program documentation and completion will be audited weekly x4 and monthly x2 to ensure completion of programing per resident preference. Negative findings of these audits will be reviewed through the monthly QAPI meeting x3 months.</p> <p>Individual to ensure compliance: Activity Director will ensure ongoing compliance.</p>		

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F 679	Continued From page 74 On 11/7/19 at 8:30 AM, Resident #54 was observed in her lounge chair in her room. On 11/7/19 at 9:34 AM, the Activities Assistant said staff provided 1 on 1 activities for residents who were unable to leave their room, and documented in hard copy all activity visits. During the interview with the Activities Assistant, the October hard copy documentation was observed with 2 visits documented for the month of October. The Activities Assistant said 1 to 1 visits were documented twice in October 2019 for Resident #54. The Activities Assistant said Resident #54 did not receive 1 to 1 activity twice a week in October.	F 679			
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and review of the facility's policies, it was determined the facility failed to ensure residents were provided care and services in a manner which enhanced and promoted each resident's highest practicable physical, mental, and psychosocial health and well-being for 6 of 32 residents (Residents #18,	F 684	Individual Residents: Resident #18 had medications and current condition reviewed for negative findings related to failed medication administration practice and none were noted. Resident #61 had blood sugars reviewed for last 7 days to ensure no negative	1/2/20	

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F 684	<p>Continued From page 75 #61, #65, #131 #430, and #431) reviewed for quality of care. Specifically:</p> <ul style="list-style-type: none"> * Resident #431, with a known history of cardiovascular disease, was harmed when the facility failed to ensure her care plan included interventions related to her cardiac instability and conduct a thorough physical assessment during cardiovascular events. Resident #431 subsequently underwent unsuccessful CPR. * Resident #430 was harmed when the facility failed to ensure the administration of oxygen as ordered, and he subsequently underwent unsuccessful CPR. * Resident #61 was at risk of harm when the facility failed ensure insulin was administered as ordered, wound treatments were performed as ordered, and accurate wound assessments were completed. * Resident #131 was at risk of harm when the facility failed to perform wound dressing changes as ordered, and erroneously discontinued his a peripherally inserted central catheter (PICC) intravenous access device. * Resident #65 was at risk of harm when wound dressing changes were not completed as ordered and per accepted standards of practice. * Resident #18 was at risk of harm when the facility failed to administer medications per accepted standards of practice for Resident #18. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident #431 was admitted to the facility on 2/8/19, with multiple diagnoses including ASHD (arteriosclerotic heart disease - a thickening and hardening of the walls of the coronary arteries), with angina (cardiac pain), presence of a cardiac 	F 684	<p>outcomes related to insulin administration and none were noted. Wounds were assessed and treatments completed without negative findings. Resident #65 had wound care completed per orders and current assessment was communicated to physician. Resident #131 had wound care and assessment completed per orders and status updated to physician. MD was aware of PICC line discontinuation and no new orders at this time. Residents #430 and 431 no longer reside in the facility.</p> <p>Other Residents in similar situations: Current residents are at risk due to this unmet requirement. Licensed nurses have been educated and have had competencies completed regarding wound care and medication administration and residents with oxygen orders were audited to ensure that delivery was in conjunction with physician order.</p> <p>Measures to prevent reoccurrence: LNs were educated by Director of Nursing or designee on medication administration, wound care/treatments, following physician orders, oxygen administration and the revision of care plans.</p> <p>Ongoing Monitoring: Medication administration and treatment audits will be completed with LNs upon hire and annually and with 5 additional nurses per week x4 weeks and then</p>		

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F 684	<p>Continued From page 76</p> <p>pacemaker, presence of other cardiac implants and grafts, and hypertension.</p> <p>The admission MDS assessment, dated 2/15/19, documented Resident #431 was cognitively intact and required extensive assistance of 1 to 2 or more staff members for her ADLs except for eating. She received oxygen prior to admission and while a resident of the facility.</p> <p>Resident #431's undated comprehensive care plan failed to include information and interventions related to her diagnosis of cardiovascular disease including ASHD with angina, cardiac implants and grafts, and hypertension. The care plan did not include emergency assessments and interventions for acute cardiac events, or the parameters for notifying the physician in the event of acute chest pain or other symptoms of an acute cardiac event.</p> <p>Resident #431's Progress Notes from 4/21/19 through 4/23/19 documented the following:</p> <ul style="list-style-type: none"> - On 4/21/19 at 2:28 PM, RCM #2 documented, the administration of, "Nitroglycerin Tablet Sublingual [a medication that dilates the arteries of the heart to improve blood flow and oxygen to the heart muscle] 0.4 mg...1 tablet sublingually [under the tongue] every 5 minutes as needed for Chest Pain x 3 doses. If no relief, call MD." - On 4/21/19 at 3:55 PM, RCM #2 documented Resident #431 coded (term used when a person's the heart and/or breathing stops) at approximately 3:00 PM and CPR was initiated. The note also documented no shock (electrical 	F 684	<p>5/month x2 months to ensure compliance. Wound observations, assessment and measurements will be completed by the wound care team weekly. Oxygen delivery will be audited monthly x3 months for compliance with following physician orders and care plans will be reviewed in conjunction with the residents MDS schedule. Negative findings of these audits will be reviewed through QAPI x3 months.</p> <p>Individual to ensure compliance: Director of nursing will ensure ongoing compliance.</p>		

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F 684	<p>Continued From page 77</p> <p>impulse method to restart the heart) was advised during entire episode, and EMS was called at approximately 3:02 PM. RCM #2 also documented she notified the DON and E.D. #1 and left them messages. The Nurse Manager was notified at 3:45 PM.</p> <p>- On 4/21/19 at 5:38 PM, RCM #2 documented the administration of, "Nitroglycerin Tablet Sublingual 0.4 mg...1 tablet sublingually every 5 minutes as needed for Chest Pain x 3 doses. If no relief, call MD. PRN [as needed]. The medication was documented as: Effective."</p> <p>- On 4/21/19 at 6:20 PM, LPN #9 documented, "At approximately 3 pm resident's family came to the nurses [sic] station and stated that she had stopped breathing. We had been putting a packet together to send her to the ER, so this writer and CNA...went down to the room and started CPR. On our way down, I directed a CNA to call 911 and a second to obtain the crash cart [a supply cart with emergency and lifesaving medications and supplies]. CPR was started...AED [automated external defibrillator - a device that delivers an electric shock through the chest to the heart] was placed, and no shock was advised during the session. CPR was not stopped until Ambulance staff and EMT's took over. EMT's preformed [sic] CPR for another 30 minutes or so. Resident was intubated [breathing tube placed] and...IV was started. [Two] bags of fluid and 5 rounds of epinephrine [a cardiac medication] were administered. See next note for continued information."</p> <p>- On 4/22/19 at 4:01 AM, LPN #9 documented, "At [4:05 PM], by family and EMT/ER MD, it was</p>	F 684			

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F 684	Continued From page 78 decided that further CPR would not bring about a positive result. CPR was stopped. . ." - On 4/23/19 at 12:59 PM, RCM #2 documented a late entry note for 4/21/19, which stated, "Around 0930 [9:30 AM] this LN [Licensed Nurse] was alerted by CNA that resident [was] turning grey, upon entering room resident was not turning grey encouraged to breath [sic] through nose instead of mouth, auscultated lungs found clear bilateral throughout. Continued to monitor throughout day. [At] Approx. [2:15 PM] [the resident's] husband approached this LN about resident having mid lower sternum [chest area] upper mid abd [abdominal] pain, administered nitro [nitroglycerin] at [2:28 PM - 13 minutes after the notification of the resident's complaint of chest pain], [at] [2:35 PM] reevaluated resident asked resident directly if still in pain, denies pain at that time. [At] Approx. [2:50 PM] husband requested for resident be transported to [the] ER, inquired on what he saw different, stated resident just is not being herself. Around [2:55 PM] started paperwork for transfer to ER. Around [3:00 PM] family approached and stated resident not breathing. [LPN #9] stated she would take a look, seconds later heard her state to bring [the] Crash Cart. This LN instructed [CNA #15] to call 911 and this LN took crash cart to resident room where CPR was already initiated. This LN and [LPN #9] started to use Ambu-bag [a device used to assist breathing] since unable to tilt head d/t [due to] spinal fusion and that jaw was extremely still that required more force for a jaw thrust. AED was attached and resident analyzed to find no shock advised, CPR continued...until EMS arrived who took over."	F 684			

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F 684	<p>Continued From page 79</p> <p>The facility's policy titled, Changes in Resident's Condition or Status, with a review date of 4/15/19, stated, "This facility will notify the resident, his/her primary care provider, and resident/resident representative of changes in the resident's condition or status...In a long-term care setting, it's important to identify and address any change in a resident's status from baseline...Upon recognition of a potentially life-threatening condition or significant change in status, you must communicate with other health care providers to meet the resident's needs...Chronic diseases and conditions can lead to potentially life-threatening conditions. It's your responsibility to be informed of the resident's status and to monitor for changes...At a minimum, you should assess the resident by:</p> <ul style="list-style-type: none"> · reviewing the medical record · asking how the resident feels and what symptoms are present · obtaining vital signs · observing the resident's overall condition, including function and cognition · exploring complaints. . . <p>[You are] responsible for communicating a resident's change in status, including the assessment findings, to the practitioner. Most cases of cardiopulmonary arrest are preceded by clinical signs of deterioration that the practitioner could recognize and treat quickly."</p> <p>During an interview on 11/7/19 at 2:50 PM, RCM #2 stated he was told by the CNA that Resident #431 was "turning grey." RCM #2 stated, "I asked the CNA to obtain the resident's vital signs and I checked her pulse ox [oxygen level] and it was</p>	F 684			

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F 684	<p>Continued From page 80</p> <p>normal. I checked her lung sounds and asked if she was having pain, and she stated no pain. She did not have a grey cast to her skin." RCM #2 stated he did not notify the physician of the event but continued to monitor the resident. RCM #2 stated he did not know the results of Resident #431's vital signs taken by the CNA. RCM #2 stated that he performed additional assessments of Resident #431 that morning but did not document the assessments. He stated Resident #431 had no nausea or vomiting and was not sweating. RCM #2 stated, "At 2:15 PM, the resident's husband came to the desk and said the resident was complaining of 'sternal pain.' I went down to the room and asked her about the pain, and she said she didn't have any pain. At 2:50 PM, the family wanted her sent to the ER, so I started getting the paperwork ready. [LPN #9] then checked on the resident and she was unresponsive. A code was called, but she couldn't be revived. I was in the process of notifying the doctor to send her out to the ER for evaluation. She had an extensive cardiac history."</p> <p>During an interview on 11/8/19 at 9:35 AM, the DON stated that Resident #431's cardiac condition should have been included in her care plan, and that she would have expected the nurse to conduct a comprehensive physical assessment when the resident reported symptoms. The DON also stated if an assessment was positive for acute symptoms, the nurse should notify the physician for treatment orders.</p> <p>2. Resident #430 was admitted to the facility on 7/25/19, with multiple diagnoses including below</p>	F 684			

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F 684	<p>Continued From page 81</p> <p>the knee amputation of the right leg, COPD, ASHD, heart failure, and a history of acute and persistent respiratory failure.</p> <p>Resident #430's Physician Order Summary Reports for July and August 2019 documented an order for oxygen (O2) at four liters per minute [L/min] continuously via nasal cannula every shift for COPD with an order date of 7/25/19.</p> <p>The admission MDS assessment, dated 8/1/19, documented Resident #430 was moderately cognitively impaired and required extensive assistance of 2 or more staff members for bed mobility and transfers, and received oxygen prior to admission and while a resident at the facility.</p> <p>Resident #430's undated comprehensive care plan, failed to include information and interventions related to his diagnosis of COPD and orders for oxygen at four liters per minute continuously via nasal cannula every shift.</p> <p>An SNF Initial Physician Evaluation completed by the P.A. on 8/7/19 at 1:15 PM, stated Resident #430 denied, "...cp [chest pain], sob [shortness of breath], [or] n/v [nausea/vomiting]...." The P.A. also documented Resident #430's lung assessment as, "...no dyspnea [difficulty breathing]...good air movement...decreased breath sounds" and his cardiovascular assessment as, "RRR [regular rate and rhythm]...pulses...normal throughout." The P.A. documented Resident #430 had oxygen on at 2 liters per minute." Resident #430's physician order dated 7/25/19, documented O2 at 4 liters per minute.</p>	F 684			

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F 684	<p>Continued From page 82</p> <p>A Mayo Clinic website article, dated 12/1/18, accessed on 12/3/19, documented: "Normal pulse oximeter readings usually range from 95 to 100 percent. Values under 90 percent are considered low."</p> <p>Resident #430's Progress Notes for 8/1/19 through 8/13/19, documented on 8/1/19 at 10:36 PM, Resident #430 stated he fell and had a "heart attack." Resident #430's oxygen tubing was off to the side of the bed. His oxygen saturation level registered 78%. After five minutes on oxygen, "[Resident #430] denied chest pain and waived away questions so that he could return to sleep. Resident with a pattern of tossing off his nasal cannula and was checked on frequently for the remainder of the evening."</p> <p>Resident #430's Progress Notes documented he had 2 more falls, 1 on 7/29/19 (documented as a Late Entry note) with no injuries, and the other on 8/6/19 at 12:13 PM, after which, he experienced severe back pain. The nurse documented Resident #430's oxygen saturation level was 75% with a respiratory rate of 24 breaths per minute. The oxygen flow rate was not documented. However, Resident #430's oxygen was, "increased to 4L/min" and his oxygen saturation level increased to 95%.</p> <p>A Cleveland Clinic website article, last reviewed on 1/23/19, accessed on 12/3/19, documented: "The normal respiration rate for an adult at rest is 12 to 20 breaths per minute."</p> <p>None of the Progress Notes reviewed, other than on 8/1/19 at 10:36 PM, documented evidence Resident #430 tossed off his oxygen tubing. The</p>	F 684			

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F 684	<p>Continued From page 83</p> <p>Progress Notes continued until 8/12/19 at 4:17 PM, when the RN documented the administration of an intravenous antibiotic. The next Progress Note, dated 8/13/19 at 1:55 PM, stated Resident #430 had "passed away." The medical record failed to reflect the events leading up to the staffs' discovery of Resident #430 on the floor in his room without a pulse, and with no oxygen worn.</p> <p>A Facility Reported Incident concerning Resident #430, dated 8/13/19, stated Resident #430 ". . . was found on the floor, face down with no vital signs. CPR was initiated but resident was not [able to be] resuscitated." The report stated night shift CNA #9 reported that while performing the last rounds of her shift, she checked on Resident #430 at 5:05 AM and found him on the floor next to the bed with no pulse. CNA #9 summoned and received assistance from staff that included fellow night shift CNA #10 and the oncoming day shift nurse RN #4. Staff performed CPR while a call to 911 was placed with EMS responding. Resident #430 was pronounced dead at 5:40 AM.</p> <p>During an interview with CNA #9 on 10/30/19 at 2:30 AM, the CNA stated Resident #430 was his "usual self" during the night shift (8/12/19 to 8/13/19). CNA #9 stated she checked on him at 4:30 AM, and he wanted his remote control, his covers adjusted, and the door closed to his room. CNA #9 stated "around 5:05 AM," during her final rounds for that night, she found Resident #430 face down on the floor beside his bed. The CNA stated she shook Resident #430's shoulder and called his name with no response. She then checked for a pulse and found none. CNA #9 stated she went to the nurses' station for the</p>	F 684			

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F 684	<p>Continued From page 84</p> <p>charge nurse, LPN #8, and to get CNA #10. They went to Resident #430's room, but LPN #8 did not stay and start CPR. LPN #8 went back to the nurses' station to call the "Code" overhead but did not know how to use the overhead paging system. Another nurse from a different hallway came to Resident #430's room and started CPR with CNA #10. CNA #9 stated she went after the crash cart. When EMS arrived, they took over the code, but were not able to bring back Resident #430. After completion of the code and Resident #430 was pronounced deceased, she and CNA #10 did the post-mortem (after death) care for Resident #430. It was during this time that CNA #10 noted and told her that Resident #430's oxygen flowmeter was turned off at the wall. CNA #9 stated she did not check Resident #430's oxygen saturation level during her shift. CNA #9 stated the facility later provided oxygen administration training to her and other staff.</p> <p>During an interview on 11/4/19 at 1:15 PM, RN #4 stated when she entered Resident #430's room during CPR, she saw the resident's oxygen tubing was, "...coiled around the oxygen flow meter on the wall and the O2 flow meter was turned off." RN #4 stated the agency nurse responsible for Resident #430's care the previous night, LPN #8, did not address the code situation and death of Resident #430 during the shift-to-shift report that morning. RN #4 stated the facility had not provided CPR or "code" training since the departure of the previous E.D. in January 2019. RN #4 added that the facility did not provide agency staff orientation training specific to the building and residents. RN #4 stated "There is a book at each nurses' station that includes information on the agency staffs'</p>	F 684			

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F 684	<p>Continued From page 85 responsibilities, but that's all."</p> <p>During an interview on 11/8/19 at 10:30 AM, CNA #10 stated she worked her night shift on the hall with CNA #9, the same hall with Resident #430's room. CNA #10 stated that CNA #9 came up to her and told her that Resident #430 was on the floor in his room face down and he had no pulse. CNA #10 stated when she entered Resident #430's room, he did not have his oxygen tubing on. She and a nurse started CPR. EMS took over the code when they arrived but were unable to revive Resident #430. After the code and Resident #430 was pronounced dead, she and CNA #9 performed the resident's post-mortem care. CNA #10 stated this was when she noticed that Resident #430's oxygen flow meter on the wall was turned off. CNA #10 stated that no one in the room during or after the code touched the flow meter to turn off the oxygen, "It was already off."</p> <p>During an interview on 11/8/19 at 9:35 AM, the DON stated that Resident #430's oxygen use should have been on his care plan with interventions clearly stated.</p> <p>3. According to Potter-Perry, Stockert-Hall "Fundamentals of Nursing," Eighth Edition (2013): "Administering medications to patients requires knowledge and a set of skills that are unique to a nurse. You must first assess that the medication ordered is the correct medication. Do not assume that all medications that are in the patient's 'drawer' or pillbox are to be given to him or her."</p> <p>Resident #18's Admission Record documented</p>	F 684			

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F 684	<p>Continued From page 86</p> <p>she was admitted on 5/29/14. Her diagnoses included sepsis (a potentially life-threatening condition caused by the body's response to an infection), gastro-esophageal reflux, anxiety disorder, psoriasis (an immune-mediated disease that causes raised, red, scaly patches to appear on the skin), neuromuscular dysfunction of bladder (a problem in which a person lacks bladder control) , chronic pain, adult failure to thrive, diabetes, hemiplegia and hemiparesis (hemiplegia is paralysis of one side of the body; hemiparesis is a slight paralysis or weakness on one side of the body) , depression and hypertension.</p> <p>On 11/1/19, at 10:15 AM, RN #3 was observed outside of Resident #18's room in the hallway at the medication cart. RN #3 opened the top drawer of the medication cart and there was a plastic medicine cup with eight medications. At the time of the observation, RN #3 showed she had dispensed the eight medications, and then realized Resident #18 was in the bathroom. RN #3 placed the medications in the medication cart. She stated the medications were for Resident #18. RN #3 identified the medications as: Lasix 20mg, Aspirin 81mg, Lisinopril, Divalproex ER 500mg, Metformin 1000mg, Meloxicam 7.5mg, Lyrica 25mg, multivitamin and D-Menose Powder in water.</p> <p>RN #1 approached the medicine cart and stated she would administer the medications since RN #3 was visibly upset. RN #3 left the area and RN #1 began dispensing the remainder of Resident #18's medication into the plastic medication cup with the eight medications that she had not dispensed. She began preparing additional</p>	F 684			

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F 684	<p>Continued From page 87</p> <p>medications into the same medication cup RN #3 had been using. RN #1 added Omega 3 1 gram 2 tabs, Omeprazole 20 mg, Phenytoin 100 mg 3 caps, potassium chloride 20meq, Nystatin, vitamin B 5000, Venlafaxine Hydrochloride ER 150 mg and UTI Stat 30 ml was added to the D-Menose that RN #3 stated she had mixed in water.</p> <p>During an interview with RN #1 on 11/1/19 at 11:03 AM, she verified she gave medications to Resident #18 that were dispensed by RN #3.</p> <p>A policy was requested, and on 11/8/19 at 10:00 AM, the DON said there was no medication policy specific to this deficient practice.</p> <p>4. Resident #61 was readmitted to the facility on 8/1/19, with multiple diagnoses including aftercare of an infected surgical incision to her right foot, diabetes, and lymphedema (the chronic build-up of lymph fluid in tissues causing swelling).</p> <p>Resident #61's records from the hospital, dated 7/22/19, documented Resident #61 underwent a partial fifth MTP (toe joint) resection (surgically removing part or all of a tissue, structure, or organ) and a cuboid resection (outer side of the foot) with closure to her right foot. Resident #61's right foot wound drainage was positive for corynebacterium striatum and enterococcus faecium (bacterial infections) and she continued on IV antibiotics for a wound infection.</p> <p>A quarterly MDS assessment, dated 9/28/19, documented Resident #61 was cognitively intact. The MDS assessment documented she required</p>	F 684			

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F 684	<p>Continued From page 88</p> <p>extensive assistance of 2 staff members with bed mobility and transfers. The MDS assessment documented Resident #61 had a surgical wound.</p> <p>Resident #61's care plan, dated 8/2/19, documented she was non-weight bearing to her right foot related to a diabetic foot ulcer post debridement (removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue) and resection of the cuboid bone and fifth metatarsal (long bones that link your ankle to your toes). The care plan documented staff were to complete weekly skin checks and provide treatment as ordered.</p> <p>a. Resident #61's admission orders, dated 8/1/19, documented Ampicillin-Sulbactam Sodium Solution Reconstituted (antibiotics) 3 grams via IV (intravenously) every 6 hours until 8/8/19.</p> <p>The August 2019 MAR documented the times for the IV antibiotics were scheduled for 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Resident #61 was to receive the first dose of the Ampicillin IV at 6:00 PM. The August MAR documented Resident #61 did not receive doses from 8/1/19 at 6:00 PM to 8/6/19 at 12:00 PM.</p> <p>The admission progress note, dated 8/1/19, documented LPN #2 verified the physician orders were received for the pharmacy to fill the medications. The progress note documented the pharmacy would fill the medication order and deliver the medication to the facility that tonight. The admission progress note also documented the physician was notified the medications were going to be started later on 8/1/19.</p>	F 684			

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F 684	Continued From page 89 A Fax Order Request/Notification Form, dated 8/1/19 at 6:40 PM, documented Resident #61 was admitted on 8/1/19 at 4:00 PM and the pharmacy would not be able to deliver her medications until later that night. The request form was signed by the physician on 8/5/19. A physician's progress note, dated 8/5/19, documented Resident #61 "expressed significant concern and displeasure that she has not had any IV abx (antibiotics) for 4 days." The progress note documented Resident #61 had not received IV antibiotics since her admission on 8/1/19 and the Infectious Disease physician recommended IV Vancomycin and Rocephin in place of the IV Ampicillin-Sulbactam antibiotics. A physician's order, dated 8/5/19, documented to discontinue the Ampicillin and start Vancomycin 1 gram IV every 12 hours with a stop date of 8/12/19 and Rocephin 2 grams IV once a day with a stop date of 8/12/19. The nurse's progress notes from 8/2/19 through 8/4/19 did not include documentation the physician was notified or the pharmacy was notified that Resident #61 did not receive the IV antibiotic medication for 20 doses of the medication for her right foot surgical incision infection. A physician's progress note written by the infectious disease physician, dated 8/13/19, documented Resident #61 did not receive the IV antibiotic for 72 hours due to a shortage of the Ampicillin-Sulbactam. Resident #61 did not receive the IV Ampicillin-Sulbactam from 8/1/19	F 684			

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F 684	<p>Continued From page 90 to 8/5/19.</p> <p>On 10/28/19 at 10:30 AM, Resident #61 stated when she was readmitted to the facility on 8/1/19, the facility was delayed in treating her infection to her right foot with IV antibiotics.</p> <p>On 11/1/19 at 12:05 PM, the Medical Director stated he was not notified the pharmacy was unable to provide the IV Ampicillin-Sulbactam due to a shortage of the antibiotics for Resident #61 until 4 days later. The Medical Director stated he was on-call 24/7 or one of his colleagues and the pharmacy was on-call 24/7 to notify them of the shortage of the Ampicillin-Sulbactam. The Medical Director stated the antibiotic could have been changed to a different one. The Medical Director stated there should not have been a delay in treatment for Resident #61's infection to her right foot.</p> <p>On 11/6/19 at 11:31 AM, LPN #1 provided an inventory list of medications stocked in the emergency kit in the facility. The inventory list, dated 8/27/19, documented Ampicillin-Sulbactam 3 grams vial 1 each was one of the normally stocked medications. The inventory list documented the emergency kit did not have the Ampicillin-Sulbactam available at that time.</p> <p>On 11/6/19 at 11:41 AM, the DON stated the pharmacy delivered medications to the facility Monday through Friday at 5:00 PM and 12:30 AM, Saturdays at 5:00 PM, and no delivery on Sundays. The DON stated if there was a new medication ordered on the weekends the facility used a back up pharmacy that was local. The DON stated the pharmacy consultant came to the</p>	F 684			

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F 684	Continued From page 91 facility once a month to restock the emergency kit. The DON was unable to provide an inventory list of medications prior to 8/27/19. The DON stated the nurses should have notified the physician by phone on 8/1/19 and not by writing a fax notification form that the physician responded on 8/5/19 to change the IV antibiotics for Resident #61. The DON stated the pharmacy should have notified the facility right away when there was a shortage of the IV antibiotics and the pharmacy was unable to fill the prescription order. b. The facility's Wound/Skin Management policy and procedure, dated 2/6/19, documented, "Upon admission, a full-body skin assessment is conducted. If there is an abnormal skin condition, a Licensed Nurse must visualize and document, describing the skin conditions and update the Care Plan/Kardex." The physician and resident representative would be notified and treatment was obtained "immediately following identification of a wound." The policy documented the facility would complete weekly skin assessments and document on the "Weekly Skin Integrity Data Collection", the facility established a wound care team comprised of the Director of Nursing/designated RN, dietary representative, a therapy representative, and additional team members could be added as needed. The policy stated "It is encouraged that the RN on the wound team have advanced training in wound assessment and care, such as wound care competency, Wound Care Nurse training through [the facility's name] or actual certifications in wound care." The policy documented the wound team completed weekly wound rounds and if the wound had not changed for two weeks or had	F 684			

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F 684	<p>Continued From page 92</p> <p>deteriorated since the last assessment, the physician was notified for potential treatment changes. The facility failed to follow its policy.</p> <p>The facility used an Admission Skin Assessment form. The form included a section for "Skin Condition," which included check boxes staff were to mark if the resident had skin integrity problems, such as surgical incisions, or open areas/wounds. The form also included a diagram of a body. Licensed staff were to mark the area of the body which corresponded to the area of the resident's body and then write a description of the skin problem associated with that area.</p> <p>An Admission/Readmission Progress Note, dated 8/1/19, documented Resident #61 stated she did not want the skin assessment performed until after dinner in the evening. LPN #2 documented she received a verbal report from the hospital nurse that Resident #61 had a generalized rash on her abdomen and legs, edema blisters on her lower legs, and a surgical wound to her foot. The documentation did not include the description of the surgical wound or which foot.</p> <p>The Admission Skin Assessment, dated 8/2/19, documented Resident #61 had a surgical incision. The narrative at the bottom of the skin section documented Resident #61 had a surgical debridement to her right foot ulcer. The narrative did not clarify whether the surgical incision was the same as the surgical debridement. The narrative did not include information regarding the location of the wound on Resident #61's right foot or description of the wound and surrounding area including length, width, depth, color, drainage, and healing status.</p>	F 684			

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F 684	Continued From page 93 Resident #61's admission physician orders, dated 8/1/19, did not include wound care orders for Resident #61's right foot wound. The nurse's progress notes, from 8/1/19 through 8/4/19, did not include documentation of a description of Resident #61's right foot wound. A Fax Order Request/Notification Form, dated 8/5/19 at 1:15 AM, documented Resident #61 had a surgical incision wound with sutures to her left lateral foot. The requested action documented to "cleanse with normal saline, clean with betadine around the edges of the surgical wound, apply Alginate in wound bed, cover with ABD (absorbent/gauze) pad to left foot." The physician signed the request order on 8/5/19. Resident #61's 8/2/19 Admission Skin Assessment documented the wound was on her right foot, not the left. A nurse's progress note, dated 8/5/19 at 4:04 AM, documented Resident #61 was admitted to the facility on 8/1/19, following debridement and resection on her left foot and sutures were in place with no signs or symptoms of infection. The progress note documented wound care dressing change orders for Resident #61's left foot had been requested. The August 2019 MAR documented the above requested action from the 8/5/19 Fax Order Request/Notification Form, was initiated on 8/6/19. The MAR documented on 8/12/19 and 8/13/19 Resident #61 received the treatment to her left foot. The August MAR from 8/6/19 to 8/11/19, and 8/14/19 were left blank. Resident	F 684			

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F 684	<p>Continued From page 94</p> <p>#61's admission record documented she had a surgical wound to her right foot.</p> <p>On 11/7/19 at 11:32 AM, RN #6 stated Resident #61 had only the one wound and it was on her right foot. RN #6 stated the LPN that documented Resident #61's wound was on the left foot did so in error.</p> <p>A Weekly Skin Integrity Data Assessment, dated 8/13/19, documented Resident #61's skin had an open area/wound. The body diagram was left blank. The narrative at the bottom of the skin section documented Resident #61 had wounds to her lower extremities. The narrative documented Resident #61's wound care was completed at the physician's office. The documentation did not include where the wound was located on Resident #61's body.</p> <p>An infectious disease physician progress note, dated 8/13/19, documented Resident #61's right foot ulcer at the wound base had 100% slough (non-viable yellow, tan, gray, green, or brown tissue) with a tunnel (channels that extend from a wound into and through the tissue and/or muscle below) of 2.3 cm. The wound measurements were 7.4 cm x 3.0 cm x 1.6 cm. The progress note documented the physician was concerned Resident #61 may need a below the knee amputee of the right lower extremity due to limb threatening infection and a high risk of antibiotic usage.</p> <p>A physician's order by the surgeon, dated 8/14/19, documented the licensed nursing staff were to change the wound dressing daily and pack Resident #61's right foot wound with 1/4</p>	F 684			

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F 684	<p>Continued From page 95 inch plain gauze.</p> <p>A Fax Order Request/Notification Form, dated 8/14/19 at 1:25 PM, documented Resident #61 was seen by the surgeon and the surgeon requested to change the wound care orders to: cleanse with normal saline, apply betadine to the periwound (skin/tissue surrounding a wound), apply Alginate to the wound bed, apply 1/4 inch gauze packing, cover with an ABD pad, and secure the dressing with kerlix (gauze roll) every day. The primary physician signed the order on 8/15/19.</p> <p>The August 2019 MAR documented the above wound care orders were effective 8/16/19. The August MAR from 8/16/19 - 8/24/19 was left blank, without documentation the wound care and dressing changes were completed for Resident #61. The August MAR documented wound care dressing changes were completed on 8/25/19 through 8/30/19.</p> <p>A wound description for Resident #61's right foot, dated 8/21/19 and signed by the surgeon, documented Resident #61's right foot had eschar (dead or weakened tissue that is hard or soft in texture - usually black, brown, or tan in color) tissue and was debrided. The measurements were 6.5 cm x 2.5 cm x 2.5 cm. A wound VAC (vacuum assisted closure machine) was placed on Resident #61's right foot at 125 mmHg continuously with a white foam dressing and to be changed every 48 hours.</p> <p>A Weekly Skin Integrity Data Assessment, dated 8/22/19, documented Resident #61's skin had an open area/wound. The body diagram was left</p>	F 684			

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F 684	<p>Continued From page 96</p> <p>blank. The narrative at the bottom of the skin section documented Resident #61 had a wound to her right foot and the wound care was completed by the wound care team.</p> <p>The Wound Observation Tool, dated 8/23/19, documented Resident #61 was admitted with a diabetic ulcer. The visible tissue was improving with epithelial (pink) tissue and 30% was "slight" slough. There was a scant amount of serosanguineous (clear or yellowish fluid with small amounts of blood) drainage with measurements of 7.4 cm x 3.5 cm x 2.4 cm. The 2.4 cm was documented as the depth with tunneling and/or undermining (when the tissue under the wound edges becomes eroded, resulting in a pocket beneath the skin at the wound's edge). The documentation was not specific on the location of the tunneling or undermining. The Tool assessment documented there was no signs or symptoms of infection. The treatment plan was normal saline, Aquacel, ABD pad, and wrap with kerlix to Resident #61's right foot wound. The assessment was documented by RCM #2, who was an LPN.</p> <p>A Weekly Skin Integrity Data Assessment, dated 8/28/19, documented Resident #61's skin had an open area/wound. The body diagram documented Resident #61 had a wound to the bottom of her right foot that was infected and physician orders were in place.</p> <p>Another Weekly Skin Integrity Data Assessment, also dated 8/28/19, documented Resident #61's skin had an open area/wound. The body diagram was left blank. The narrative at the bottom of the skin section documented treatment was in place</p>	F 684			

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F 684	<p>Continued From page 97</p> <p>pending wound VAC orders to Resident #61's right foot or the front of the right lower leg.</p> <p>A Wound Observation Tool, dated 8/30/19, documented Resident #61 was admitted with a diabetic ulcer. The visible tissue was improving with epithelial (pink) tissue and 30% was "slight" slough. There was a scant amount of serosanguineous drainage with measurements of 2.5 cm x 7.0 cm x 2.5 cm. The 2.5 cm was documented as the depth with tunneling and/or undermining. The documentation was not specific on the location of the tunneling or undermining. The Tool assessment documented there was no signs or symptoms of infection. The treatment plan documented, "wound VAC to Resident #61's right foot." The assessment was documented by RCM #2, who was an LPN.</p> <p>Resident #61's record did not include documentation as to how daily wound dressings were completed from 8/25/19 to 8/30/19, when the surgeon documented a wound VAC was place on 8/21/19. There was no documentation in the August MAR that Resident #61 had a wound VAC and it was changed every 48 hours as ordered by the surgeon until 8/30/19, 9 days after the surgeon's order was written.</p> <p>A Wound Observation Tool, dated 9/16/19, documented Resident #61 was admitted with a diabetic ulcer. The visible tissue was improving with epithelial (pink) tissue and 30% was "slight" slough. There was a scant amount of serosanguineous drainage with measurements of 2.5 cm x 7.0 cm x 2.5 cm. The 2.5 cm was documented as the depth with tunneling and/or undermining. The documentation was not</p>	F 684			

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F 684	<p>Continued From page 98</p> <p>specific on the location of the tunneling or undermining. The Tool assessment documented there was no signs or symptoms of infection. The treatment plan was normal saline, Aquacel, ABD pad, and secure with kerlix to Resident #61's right foot wound. The assessment was documented by RCM #2, who was an LPN.</p> <p>A Weekly Skin Integrity Data Assessment, dated 9/19/19, documented Resident #61's skin had an open area/wound. The body diagram documented Resident #61 had a vascular wound to the front of her right lower leg. The documentation did not include the surgical incision to the bottom of Resident #61's right foot.</p> <p>A Wound Observation Tool, dated 9/23/19, documented Resident #61 was admitted with a diabetic ulcer. The visible tissue was improving with epithelial tissue with a small amount of serous drainage. The measurements were 3.25 cm x 2.2 cm with no depth, tunneling, and/or undermining. The tool assessment documented there was no signs or symptoms of infection. The treatment plan did not include treatment for the wound to the bottom of Resident #61's right foot. The assessment was documented by RN #1.</p> <p>A Weekly Skin Integrity Data Assessment, dated 9/24/19, documented Resident #61's skin had an open area/wound. The body diagram documented Resident #61 had a vascular wound to the front of her right lower leg and an open wound to her right heel. The documentation did not include the surgical incision to the bottom of Resident #61's right foot.</p> <p>A Weekly Skin Integrity Data Assessment, dated</p>	F 684			

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F 684	<p>Continued From page 99</p> <p>9/25/19, documented Resident #61 had an open area/wound. The body diagram documented Resident #61 had a right heel open wound. The documentation did not include the surgical incision to the bottom of Resident #61's right foot.</p> <p>A Weekly Skin Integrity Data Assessment, dated 10/1/19, documented Resident #61 had an open area/wound. The body diagram was left blank. The narrative documentation did not include where Resident #61's open area/wound was located.</p> <p>A Wound Observation Tool, dated 10/3/19, documented Resident #61 was admitted with a diabetic ulcer. The visible tissue was improving with epithelial tissue with a small amount of serous drainage. The measurements were 3.25 cm x 2.2 cm with no depth, tunneling, and/or undermining. The tool assessment documented there was no signs or symptoms of infection. The treatment plan did not include treatment for the wound to the bottom of Resident #61's right foot. The assessment was documented by RCM #2, who was an LPN. The description, measurements, and treatments of Resident #61's right foot wound had no changes for 10 days.</p> <p>A Weekly Skin Integrity Data Assessment, dated 10/22/19, documented Resident #61 had an open area/wound. The body diagram was left blank and the narrative documentation did not include where Resident #61's open area/wound was located.</p> <p>On 10/28/19 at 10:03 AM, RN #1 was observed changing the dressing on Resident #61's bottom right foot. Resident #61's wound to the bottom of</p>	F 684			

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F 684	<p>Continued From page 100</p> <p>her right foot was approximately 3.5 cm x 1.0 cm x 0.2 cm with granulating tissue (pink-red moist tissue that fills an open wound when it starts to heal) in the wound bed. The surrounding tissue was pink in color and RN #1 stated it was not hot to the touch, but did appear slightly infected. RN #1 washed her hands and applied clean gloves to provide wound care to Resident #61. She cleansed the wound with normal saline, then packed Aquacel AG into the wound bed, then wrapped Resident #61's right foot and leg with an UNNA boot (compression dressing). RN #1 removed her gloves and washed her hands. RN #1 stated she should have washed her hands and applied clean gloves after she cleansed Resident #61's right foot.</p> <p>A physician's order, dated 10/30/19, documented Clindamycin (antibiotic) 150 mg every 6 hours for increased erythema (redness) and edema (swelling) to her right lower extremity.</p> <p>A Weekly Skin Integrity Data Assessment, dated 11/4/19, documented Resident #61 had an open area/wound. The body diagram documented Resident #61 had an open area to the lateral bottom of her right foot. The measurements were 3.6 cm x 1.5 cm. The wound bed was 10% slough with a scant amount of serosanguineous drainage. Resident #61 had signs and symptoms of infection and was being treated with oral antibiotics.</p> <p>A Wound Observation Tool, dated 11/4/19, documented Resident #61 was admitted with a diabetic ulcer. The visible tissue was improving with 10% slough and scant amount of serous drainage. The measurements were 3.6 cm x 1.0</p>	F 684			

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F 684	<p>Continued From page 101</p> <p>cm with no depth, tunneling, and/or undermining. The tool assessment documented there was no signs and symptoms of infection with additional comments that Resident #61 had a wound to the bottom of her foot and was treated with oral antibiotics for a wound infection.</p> <p>On 11/7/19 at 10:39 AM, the Regional Director of Clinical Services stated Resident #61's August MAR for wound care to her right foot from 8/14/19 to 8/24/19 was left blank, which meant the treatment was not completed.</p> <p>On 11/7/19 at 11:52 AM, the DON stated Resident #61's lack of wound care treatments were unacceptable and should have been completed per the physician orders.</p> <p>c. Resident #61's October 2019 MAR documented Humalog insulin sliding scale to be administered before meals and Novolog 55 units before meals.</p> <p>On 10/29/19 at 9:30 AM, RN #1 entered Resident #61's room and stated she was here to administer her medications and check her blood sugar. Resident #61 told RN #1 the other nurse checked it this morning before breakfast and it was 203. RN #1 told Resident #61 she needed to administer her Novolog insulin and she injected the insulin in Resident #61's right thigh and left the room. Resident #61 stated the Novolog was to be given prior to breakfast and she ate breakfast at 7:50 AM. Resident #61 stated the nurses were too busy and did not have enough time to administer all the morning medications to the residents in a timely manner.</p>	F 684			

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F 684	<p>Continued From page 102</p> <p>On 10/29/19 at 10:26 AM, Resident #61's MAR documented she received Humalog 7 units of her sliding scale based on the blood sugar of 203 and also received Novolog 55 units at the same time. RN #1 stated she had forgotten LPN #2 told her that morning that Resident #61's blood sugar was 203. RN #1 stated she administered both the Humalog sliding scale of 7 units and the Novolog of 55 units together in one syringe for a total of 62 units. RN #1 stated the insulin doses were given late and should have been administered prior to her meals.</p> <p>Resident #61 was to be administered Novolog and Humalog insulin prior to meals. The amount of Humalog to administer was to be based on Resident #61's blood sugar level test completed before administration. Resident #61 received the Novolog and Humalog insulin 1 hour and 40 minutes after she ate breakfast. The Humalog insulin was administered based on the result of a blood sugar test obtained before she ate breakfast.</p> <p>5. Resident #131 was admitted to the facility on 8/20/19, with multiple diagnoses including infected pressure ulcers.</p> <p>A physician's order, dated 9/14/19, documented, "Leave PICC line in Place." A PICC line is a peripherally inserted central catheter (a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart).</p> <p>Resident #131's October 2019 MAR documented licensed staff were flushing normal saline 10 ml twice a day for PICC line maintenance from</p>	F 684			

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F 684	<p>Continued From page 103 10/1/19 to 10/6/19 and from 10/7/19 through 10/10/19.</p> <p>A nurse's progress note, dated 10/6/19 at 5:51 PM, documented LPN #3 was made aware Resident #131's PICC line was removed by a nurse in error. The P.A. was notified and Resident #131 was sent to the hospital. Resident #131 returned a few hours later without a replacement PICC line.</p> <p>Resident #131's record documented the PICC line was removed on 10/6/19 by an RN and was sent to the hospital for a change in condition. Resident #131 returned from the hospital a few hours later without a replacement PICC line. Resident #131's October MAR documented licensed nurses were flushing his PICC line from 10/7/19 through 10/10/19.</p> <p>On 10/30/19 at 10:08 AM, RCM #2 stated Resident #131's record had an order to discontinue his PICC line on 10/13/19. RCM #2 was unable to explain why the discontinued PICC line order was written on 10/13/19, when Resident #131's record documented the PICC line was removed on 10/6/19. RCM #2 stated the nurses who documented from 10/7/19 to 10/10/19 that Resident #131 had a PICC line did not assess Resident #131 to know that he did not have a PICC line since 10/6/19.</p> <p>On 10/30/19 at 3:53 PM, LPN #3 stated Resident #131's PICC line was removed without physician orders by an RN. LPN #3 stated she notified the P.A. the DON, and E.D. #1.</p> <p>On 10/30/19 at 4:15 PM, the P.A. stated Resident</p>	F 684			

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F 684	<p>Continued From page 104</p> <p>#131's PICC line should not have been removed because he was scheduled to have surgery on 10/16/19. The P.A. stated the RN removed the PICC line from the wrong resident.</p> <p>On 10/31/19 at 8:30 AM, the DON stated she was not aware Resident #131's PICC line was removed without an order. The DON stated an Incident report should have been completed.</p> <p>6. The facility's policy for Wound Care Treatment and Clean Dressing Change, undated, documented the following:</p> <ul style="list-style-type: none"> * Remove the soiled dressing and dispose of it in a bag. * Remove gloves, discard them, and perform hand hygiene. * Apply new gloves. * Cleanse the wound as directed. * Remove gloves, dispose of them, and perform hand hygiene. * Apply new gloves and perform wound care as ordered. * After wound care and patient care is complete, document the treatment performed. <p>Resident #65 was admitted to the facility on 10/9/19, with multiple diagnoses including cellulitis (a potentially serious bacterial skin infection) of the right leg, Type 2 diabetes mellitus, and chronic ulcer of the foot.</p> <p>a. Resident #65's November 2019 physician orders documented "cleanse entire lower leg daily with wound cleanser or unscented, dye free soap and water. [P]at to dry, then apply [V]aseline to dry skin. Place dry gauze in</p>	F 684			

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F 684	<p>Continued From page 105</p> <p>between each toe. [A]pply a thin layer of medihoney (a product used for burns and wounds) to all wounds, then cover with non bordered foam (a type of dressing). [W]rap foot and lower leg with roll gauze. [C]hange daily." The order started on 10/25/19.</p> <p>Resident #65's care plan, initiated on 10/13/19 and revised on 10/30/19, documented the following:</p> <ul style="list-style-type: none"> * He had a skin integrity impairment to his right lower leg/foot related to diabetic infection of the right leg with cellulitis, initiated on 10/13/19 and revised on 10/30/19. * Staff were directed to follow the facility's protocol for treatment of the skin injury. <p>On 10/31/19 at 2:55 PM, LPN #6 was observed performing wound care for Resident #65. Multiple wounds were present on Resident #65's right lower leg and heel. LPN #6 cleansed the wounds with Normal Saline (a sterile salt water solution), then she applied medihoney to the wounds and applied the dressings. LPN #6 did not use wound cleanser or unscented, dye free soap and water to cleanse Resident #65's wounds, and she did not apply Vaseline as ordered. LPN #6 said she used Normal Saline, not wound cleanser, to cleanse Resident #65's wounds, and she did not apply Vaseline. LPN #6 said previously she was applying Vaseline, but she thought the order was changed so she did not apply it during the observed wound care.</p> <p>On 11/4/19 at 10:03 AM, the DON said her expectation was to follow the physician's order for wound care, and if the order could not be</p>	F 684			

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F 684	<p>Continued From page 106</p> <p>followed because the supply was not available or because of something else, the physician should be notified.</p> <p>b. Resident #65's November 2019 physician orders documented an order to cleanse open areas on his buttocks with Normal Saline and apply Allevyn foam dressing (a type of wound dressing) until resolved, once a day. The order started on 10/29/19.</p> <p>Resident #65's care plan documented he had two open areas on his buttocks, noted on 10/26/19. Interventions included following facility protocols for treatment of skin injury.</p> <p>On 11/3/19 at 10:14 AM, LPN #7 said she thought Resident #65's dressing on his buttocks was to be changed every 3 days and as needed. LPN #7 said she would check to be sure, but the dressing was not due on her shift. Approximately 10 minutes later, the surveyor found the dressing change was signed on Resident #65's Treatment Administration Record (TAR) as completed by LPN #7.</p> <p>On 11/3/19 at 10:42 AM, LPN #7 said she signed Resident #65's TAR that she looked at the dressing on his buttocks, she did not change it or cleanse the area. LPN #7 said the order did not say cleanse the wound, so she looked at the dressing on Resident #65's buttocks and saw it was intact.</p> <p>On 11/3/19 at 11:39 AM, LPN #8 reviewed the order for wound care to Resident #65's wound on his buttocks. LPN #8 said if she was caring for Resident #65, she would remove the old</p>	F 684			

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F 684	Continued From page 107 dressing, cleanse the wound with Normal Saline, and apply a new dressing. On 11/3/19 at 11:44 AM, LPN #7 and LPN #8 observed Resident #65's dressing on his buttocks in the presence of the surveyor. The dressing was dated 11/2 and initialed "J." LPN #7 said that was the initial of the nurse who changed the dressing during the previous night. On 11/4/19 at 10:09 AM, the DON said she expected the order on Resident #65's TAR for wound care to his buttocks meant the dressing should be changed every day, and it did not say just to monitor the dressing. The DON said she thought if the order was initialed on the TAR, it meant the nurse changed the dressing.	F 684			
F 686 SS=J	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the	F 686	The facility submitted an IJ removal plan which was accepted and the immediacy	1/2/20	

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F 686	<p>Continued From page 108</p> <p>facility failed to prevent the development or worsening of pressure ulcers in the facility. This was true for 4 of 10 residents (#13, #36, #131, and #134) reviewed for pressure ulcers. Resident #131's health and safety was placed in Immediate Jeopardy when his sacral pressure ulcer worsened and required surgical intervention. Resident #13 was harmed when she developed a pressure ulcer to her left antecubital (crease of elbow) and a Stage II pressure ulcer to her left heel. Resident #36 was harmed when she developed an unstageable pressure ulcer to her to left heel. Resident #134 had a potential for harm when he was admitted to the facility with a pressure ulcer to his sacrum and no interventions or treatments were initiated. Findings include:</p> <p>The National Pressure Ulcer Advisory Panel (2016), defines pressure ulcers as follows:</p> <p>Stage 2 - Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough (non-viable yellow, tan, gray, green, or brown tissue) and eschar (dead or weakened tissue that is hard or soft in texture - usually black, brown, or tan in color) are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel.</p> <p>Stage 3 - Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage</p>	F 686	<p>removed as of 11/12/19. The following is a plan submitted as part of the plan of correction.</p> <p>Individual Residents: Residents #13 and 131 had the status of their pressure ulcers assessed and reviewed with the physician. Care plans were updated as needed. Residents #36 and 134 no longer reside in the facility.</p> <p>Other Residents in similar situations: Residents with pressure ulcers were assessed by the facility wound team weekly to ensure accurate and consistent assessment, measurements, treatments, notification and care plan interventions are in place.</p> <p>Measures to prevent reoccurrence: LNs were educated by Director of nursing or designee and had competencies on wound care, assessments, treatments, interventions and following physician orders. Education include wound care referrals to be initiated to wound team that assesses pressures ulcers weekly. Weekly wound rounds will be conducted by qualified wound care team who is responsible for measuring and ensuring accuracy with treatments, orders and interventions.</p> <p>Ongoing Monitoring: LNs will have wound care competencies completed upon hire, annually and as needed to ensure ongoing education and</p>		

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F 686	<p>Continued From page 109</p> <p>varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining (when the tissue under the wound edges becomes eroded, resulting in a pocket beneath the skin at the wound's edge) and tunneling (channels that extend from a wound into and through the tissue or muscle below) may occur. Fascia, muscle, tendon, ligament, cartilage or bone is not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.</p> <p>Stage 4 - Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury</p> <p>Unstageable - Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be softened or removed.</p> <p>Deep tissue pressure injury - Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in</p>	F 686	<p>skills assessment in there areas. An additional 5 nurses will have competencies completed for 3 months. Regional Director of Clinical Services will audit the wound care team assessments and documentation weekly x12 to ensure that the facility wound rounds and pressure ulcer program is effective in wound care processes. Negative findings of these audits will be submitted to the Director of Nursing for QAPI review x3 months.</p> <p>Individual to ensure compliance: Director of Nursing will ensure ongoing compliance.</p>		

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F 686	<p>Continued From page 110</p> <p>darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface.</p> <p>The facility's Wound/Skin Management policy and procedure, dated 2/6/19, documented, "Upon admission, a full-body skin assessment is conducted. If there is an abnormal skin condition, a Licensed Nurse must visualize and document, describing the skin conditions and update the Care Plan/Kardex." The physician and resident representative would be notified and treatment was obtained "immediately following identification of a wound." The policy documented the facility would complete weekly skin assessments and document on the "Weekly Skin Integrity Data Collection", the facility established a wound care team comprised of the DON or designated RN, dietary representative, a therapy representative, and additional team members could be added as needed. "It is encouraged that the RN on the wound team have advanced training in wound assessment and care, such as wound care competency, Wound Care Nurse training through [the facility's name] or actual certifications in wound care." The wound team completes weekly wound rounds and if the wound has not changed for two weeks or has deteriorated since the last assessment, the physician is notified for potential treatment changes. The facility failed to follow its policy.</p> <p>1. Resident #131 was admitted to the facility on 8/20/19, with multiple diagnoses including an unstageable necrotic (dead tissue) pressure ulcer to his sacrum (triangular bone at the base of the spine).</p>	F 686			

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F 686	<p>Continued From page 111</p> <p>The admission skin collection tool, dated 8/20/19 at 11:26 AM, documented Resident #131 had a large necrotic area to his coccyx and sacral areas. There were no measurements documented.</p> <p>Resident #131's skin integrity care plan, dated 8/22/19, documented to place an air mattress to Resident #131's bed and a gel cushion on the seat of his wheelchair. Staff were to assist Resident #131 with repositioning every 2 hours, perform weekly skin checks, and weekly treatment documentation including measurements and changes of the wound.</p> <p>A Wound Observation Tool, dated 8/26/19, documented Resident #131 was admitted with an unstageable deep tissue injury to his sacrum. The tool assessment documented the visible tissue was 100 % necrotic tissue in the wound bed. There was a small amount of sanguineous (fresh red blood when injury first occurs) drainage and a foul odor. The sacrum wound measurements were 9.0 cm x 8.0 cm. The depth was not documented. The assessment was completed by RCM #2, who was an LPN.</p> <p>Resident #131's admission MDS assessment, dated 8/27/19, documented he was moderately cognitively impaired and required extensive assistance of two staff members for bed mobility and transfers. The MDS documented Resident #131 was at risk for pressure ulcers and had eight stage 2 pressure ulcers and two unstageable pressure ulcers that were suspected deep tissue injuries.</p> <p>Resident #131's physician orders, dated 8/22/19,</p>	F 686			

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F 686	<p>Continued From page 112</p> <p>documented to clean his wounds with normal saline and apply Allevyn (absorbent foam dressing) to his bilateral knees, bilateral shins, bilateral heels, left posterior lower leg, bilateral elbows, left posterior shoulder, and coccyx (tailbone). The order instructed licensed staff to change the dressing every 3 days on the night shift and as needed for soiling or saturation.</p> <p>The August 2019 TAR documented all the dressings were changed on 8/22/19, 8/25/19, and 8/31/19. The TAR was left blank on 8/28/19.</p> <p>A physician's order, dated 9/3/19, documented, "Soonest Wound Clinic Consult" for Resident #131's coccyx wound.</p> <p>A physician's order, dated 9/9/19, documented, "General Surgery Consult" for Resident #131's coccyx wound.</p> <p>Another physician's order, dated 9/12/19, documented, Resident #131 was to have the soonest general surgery appointment to evaluate Resident #131 for a surgical debridement of his coccyx wound.</p> <p>A Wound Observation Tool, dated 9/12/19, documented Resident #131 was admitted with an unstageable deep tissue pressure ulcer to his sacrum. The visible tissue was improving with slough and necrotic tissue to 85% of the wound bed. There was no drainage and there was a foul odor. The measurements were 9.4 cm x 7.9 cm and the depth was not documented. The wound had tunneling at the 6:00 o'clock position with a 0.4 cm depth. The documentation to notify the physician was left blank. The assessment was</p>	F 686			

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F 686	<p>Continued From page 113 completed by RCM #2, who was an LPN.</p> <p>A Wound Observation Tool, dated 9/26/19, documented Resident #131 was admitted with an unstageable deep tissue pressure ulcer to his sacrum. The visible tissue was improving with slough and necrotic tissue to 85% of the wound bed. There was no drainage and there was a foul odor. The measurements were 9.4 cm x 7.9 cm and the depth was not documented. The wound had tunneling at the 6:00 o'clock position with a 0.4 cm depth. The documentation to notify the physician was left blank. The Wound Observation Tool was completed by LPN #3.</p> <p>An Operative Consult Report, dated 9/30/19, documented Resident #131 had a Stage 3 necrotic sacral pressure ulcer. The procedure was a wide excisional debridement (removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue) of necrotic skin, subcutaneous (inside layer of the skin that helps keep the body's temperature stable) tissue and some fascia (lowest layer of skin in the body) of the sacral pressure ulcer measuring 8.0 cm x 7.0 cm x 5.0 cm and a wound VAC (a device for advanced wound healing therapy) was placed.</p> <p>This was 27 days after a wound clinic consultation was ordered by Resident #131's physician and the wound had a 5.0 cm increase in depth.</p> <p>A Wound Observation Tool, dated 10/3/19, documented Resident #131 was admitted with an unstageable deep tissue pressure ulcer to his sacrum. The visible tissue was improving with</p>	F 686			

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F 686	<p>Continued From page 114</p> <p>slough and necrotic tissue to 85% of the wound bed. There was no drainage and there was a foul odor. The measurements were 22.23 cm x 26.1 cm (a 14.23 cm x 19.1 cm difference from the 9/30/19 measurements 3 days ago) and the depth was not documented. The tool documented the wound was undermining at the 6 o'clock position with a 4.6 cm depth and at the 1:00 o'clock position with a 5.9 cm depth and the tunnel was 5.0 cm. The documentation to notify the physician was left blank. The assessment was completed by RCM #2. The Wound Observation Tool was completed 3 days after the surgical debridement was completed with significant changes to the wound and the surgeon was not notified.</p> <p>The Wound Observation Tools were not completed weekly with assessments, measurements and staging wounds and were without oversight from RNs or the DON with wound care competency per the facility's policy.</p> <p>A Fax Order Request/Notification Form, dated 10/7/19, sent to the surgeon, requested an order clarification for the frequency of the wound VAC changes for Resident #131. This was seven days after the original order date. The surgeon responded with an order, dated 10/7/19, which documented to change the wound VAC every Monday, Wednesday, and Friday to Resident #131's sacral pressure ulcer.</p> <p>Resident #131's October 2019 MAR, initiated on 10/9/19, documented to change the wound VAC 3 times a week; Monday, Wednesday, and Friday for wound care. This was nine days after the original order date and two days after the</p>	F 686			

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F 686	<p>Continued From page 115 clarification order date.</p> <p>A Postoperative Follow Up, dated 10/10/19, documented, "Overall wound appears to be improving 10 days following excisional debridement and application of wound VAC to the sacral pressure ulcer. There is a moderate amount of slough remaining, too much to debride in the office, and I've recommended second debridement in the OR (Operating Room)." The plan documented to continue with the wound VAC and schedule a second debridement for 10/16/19.</p> <p>A Fax Order Request/Notification Form, dated 10/10/19, to Resident #131's primary physician, documented Resident #131 was continuously removing the wound VAC and refused to have the wound VAC replaced or a dressing placed.</p> <p>A physician's order, dated 10/11/19, documented to discontinue the wound VAC due to Resident #131's refusals, apply wet to dry dressing changes, and documented collagen (promotes wound healing) may be used.</p> <p>A surgeon's physician order, dated 10/11/19, documented to cleanse the sacral wound with normal saline, cut to fit Alginate dressing (removes dead or damaged skin and helps stabilize blood flow), place collagen powder on Alginate dressing and place in wound bed, and cover with an Allevyn dressing daily.</p> <p>The October 2019 TAR, dated 10/11/19, documented the Alginate dressing change was completed daily. The October TAR was left blank on 10/31/19.</p>	F 686			

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F 686	<p>Continued From page 116</p> <p>A Preoperative Consult, dated 10/15/19, documented a nurse at the facility stated Resident #131 was removing the wound VAC 4-5 times a day and he was scheduled for a second debridement of the sacral wound on 10/16/19.</p> <p>The nurse's progress notes from 9/30/19 to 10/9/19 documented Resident #131's wound VAC to his sacrum was running continuously without concerns. There was no documentation in Resident #131's record he was continuously removing the wound VAC.</p> <p>A Postoperative consult report, dated 10/16/19, documented Resident #131 had a Stage 3 necrotic sacral pressure ulcer. The procedure was an excisional debridement of all the nonviable subcutaneous tissue and fascia of the sacral pressure ulcer measuring 3.0 cm x 3.0 cm x 5.0 cm and a wound VAC was placed in the recovery room.</p> <p>A nurse's progress note, dated 10/16/19 at 6:00 PM, documented Resident #131 had wound debridement from the surgeon that morning and the wound VAC was secured and running continuously without concerns.</p> <p>A nurse's progress note, dated 10/16/19 at 9:48 PM, documented Resident #131 removed his wound VAC and wanted to be left alone with no dressing placed on his sacral wound.</p> <p>A nurse's progress note, dated 10/17/19 at 12:12 AM, documented Resident #131 allowed the licensed nurse to apply the Alginate dressing and cover with an Allevyn dressing.</p>	F 686			

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F 686	Continued From page 117 There was no documentation in Resident #131's record the surgeon was notified Resident #131 removed the wound VAC on 10/16/19, after the second surgical debridement was performed. On 10/27/19 at 4:14 PM, RN #1 was observed changing the dressing to Resident #131's sacral wound. RN #1 removed Resident #131's incontinent brief. The incontinent brief was saturated with a copious (large) amount of serous (yellowish tan in color) drainage. There was no dressing on Resident #131's sacrum wound. RN #1 stated with the amount of drainage in Resident #131's incontinent brief, the dressing was not on for very long. RN #1 washed her hands and applied gloves to provide wound care, and tucked the saturated incontinent brief under Resident #131's buttocks with her gloved hands. RN #1 did not remove her gloves or perform hand hygiene after she tucked the saturated incontinent brief under Resident #131. She then cleansed the sacral wound with normal saline and stated Resident #131's wound was increased in size and appeared worse. There was no foul odor noted. The wound bed had granulating tissue with a small amount of slough in the middle of the wound. RN #1 stated the left side and the center of Resident #131's wound bed had tunneling that was not there a week ago. RN #1 then sprinkled the collagen powder to her left contaminated glove and sprinkled it over the wound bed. RN #1 removed her gloves and replaced them with a clean pair of gloves without washing her hands between removing her contaminated gloves and applying a clean pair of gloves. She then packed three 4 x 5 inch Aquacel AG dressings into the wound bed, applied skin	F 686			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	<p>Continued From page 118</p> <p>prep to the peri-wound, and secured it with two Allevyn dressings. RN #1 removed her gloves and washed her hands. RN #1 stated Aquacel AG was the same as the Alginate dressing.</p> <p>On 10/27/19 at 4:50 PM, RN #1 stated she should have removed her gloves, washed her hands, and applied a clean pair of gloves after she tucked Resident #131's saturated incontinent brief under his buttocks, after she cleansed his wound with normal saline, and after she applied the collagen powder to Resident #131's wound bed.</p> <p>On 10/30/19 at 12:15 PM, RCM #2 stated the Wound Observation Tool assessments were completed by the three RCMs and the DON, weekly on Tuesdays. RCM #2 stated the Wound Observation Tool included assessments and measurements completed every Tuesday. RCM #2 stated the Wound Observation Tool assessments and measurements were not completed on 10/29/19 because the facility had state surveyors in the building. RCM #2 stated the last weekly Wound Observation Tool assessment was completed on 10/3/19. RCM #2 did not know why the Wound Observation Tool was completed on a Thursday and not on Tuesday and did not know why the 10/8/19 assessment was not completed. RCM #2 stated he was on vacation from 10/16/19 through 10/27/19 and did not complete the weekly Wound Observation Tool assessments and measurements. RCM #2 stated the DON was part of the weekly assessments and she had the binder with the documentation of the assessments for all the weekly rounds of residents with wounds.</p>	F 686			

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F 686	<p>Continued From page 119</p> <p>On 10/31/19 at 8:20 AM, the DON stated she was not part of the weekly Wound Observation assessments. The DON stated the three RCMs were completing the Wound Observation assessments every Tuesday. The DON stated she did not have a binder of all the residents wounds with assessments and measurements. The DON stated the weekly Wound Observation assessments and measurements were not completed weekly. The DON stated the Weekly Skin Integrity Data Collection were completed by the floor nurses weekly, but were not implemented for all the residents. The DON stated Resident #131's 10/3/19 Wound Observation Tool measurements were incorrect, and the physician should have been notified of the change of measurements from the debridement measurement on 9/30/19. The DON stated she expected floor nurses completed weekly skin assessments and notified the physician for skin impairments or if the wound worsened. The DON stated she expected the RCMs completed weekly Wound Observation Tool assessments and measurements every Tuesday and provided an update to the physician. The DON stated she was not aware of licensed staff members who were wound care certified. The DON stated the three RCMs and herself were not wound care certified.</p> <p>On 10/31/19 at 9:53 AM, RCM #1 stated the RCMs did not complete weekly Wound Observation Tool assessments and measurements for "quite a while."</p> <p>A Postoperative follow up Consult Report, dated 10/31/19, documented Resident #131's sacral</p>	F 686			

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F 686	<p>Continued From page 120</p> <p>wound measurements were 6.5 cm x 7.0, cm with undermining at 12:00 o'clock at 2.5 cm, 2:00 o'clock at 4.5 cm, and 9:00 and 11:00 o'clock at 2.5 cm. The surgeon scheduled a flap closure (tissue is removed or lifted from a donor site to cover the wound) on 11/20/19.</p> <p>Resident #131's sacral pressure ulcer had increased in size in 15 days. There was no assessments, measurements, or notification to Resident #131's surgeon or his primary physician the sacral pressure ulcer worsened in 15 days.</p> <p>On 11/5/19 at 11:30 AM, the P.A. stated Resident #131's flap surgery could have been prevented if the nurses were following the surgeon's wound care orders for daily dressing changes and followed infection control precautions.</p> <p>There was no documentation the wound surgeon was consistently notified of the wound measurements and progression. Resident #131's record documented LPNs were assessing and staging wounds without oversight of the RNs or DON in the facility.</p> <p>Resident #131's record documented his sacral wound continued to worsen related to the lack of consistent treatments ordered by the physician. The documentation also stated Resident #131's the wound continued to worsen due to care which did not follow standard practice and guidelines for wound treatments and dressing changes for prevention of potential contamination and infection which encouraged healing.</p> <p>The facility did not provide adequate ordered treatment and interventions for Resident #131's</p>	F 686			

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F 686	<p>Continued From page 121</p> <p>sacral pressure ulcer which placed him in Immediate Jeopardy when his sacral pressure ulcer worsened and required surgical intervention.</p> <p>E.D. #2 was notified verbally and in writing of the Immediate Jeopardy on 11/4/19 at 5:25 PM.</p> <p>2. Resident #134 was readmitted to the facility on 9/4/19 and discharged on 9/15/19, with multiple diagnoses including atrial fibrillation (irregular heartbeat), renal failure (condition which causes the kidneys to not filter waste from the blood well) and respiratory failure.</p> <p>Resident #134's hospital discharge orders, dated 9/4/19, documented therapy orders for pressure ulcer precautions.</p> <p>An Admission/Readmission Collection Tool, dated 9/5/19, documented Resident #134 had a 3 cm pressure ulcer on his coccyx and it was covered with an Allevyn dressing.</p> <p>Resident #134's baseline care plan, dated 9/4/19, documented he was at risk for skin breakdown.</p> <p>A Nutrition Data Collection Assessment, dated 9/9/19, documented Resident #134 had a pressure ulcer to his coccyx.</p> <p>The admission MDS assessment, dated 9/11/19, documented Resident #134 was moderately cognitively impaired and required extensive assistance of staff members for bed mobility, transfers, and dressing. The assessment documented he had one Stage 2 pressure ulcer present on admission.</p>	F 686			

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F 686	<p>Continued From page 122</p> <p>The nurse's progress notes, from 8/27/19 to 9/16/19, did not include documentation Resident #134 had a pressure ulcer to his coccyx.</p> <p>The September 2019 MAR and TAR did not include wound care documentation to Resident #134's coccyx.</p> <p>On 11/7/19 at 5:11 PM, the dietitian stated she collected her initial assessment from the admission assessment and from the nursing staff.</p> <p>On 11/7/19 at 5:27 PM, RCM #2 stated the nurse who documented the pressure ulcer on the admission assessment should have notified the physician for wound care orders. RCM #2 stated Resident #134's record did not include weekly skin assessments or wound observation assessments.</p> <p>3. Resident #13 was admitted to the facility on 7/30/19, with multiple diagnoses including dementia and age-related physical debility.</p> <p>Resident #13's skin breakdown care plan, dated 7/31/19, included interventions for weekly skin checks.</p> <p>Resident #13's weekly skin integrity data collection was completed 8/22/19 through 9/22/19. There was no documented skin integrity data collection on 9/29/19.</p> <p>A Braden Scale (tool used to assess a resident's risk for developing pressure ulcers) assessment, dated 9/5/19, documented Resident #13 was at</p>	F 686			

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F 686	<p>Continued From page 123</p> <p>high risk for developing a pressure ulcer, with additional risk factors including decreased bed mobility.</p> <p>Resident #13's annual MDS assessment, dated 10/14/19, documented she was severely cognitively impaired and required extensive assistance of two staff members for bed mobility and transfers. The MDS documented Resident #13 was at risk for pressure ulcers and had one Stage 2 pressure ulcer.</p> <p>a. Resident #13's Weekly Skin Checks, dated 8/22/19 through 9/22/19, did not include documentation of the pressure ulcer to Resident #13's left antecubital (elbow crease). Subsequent skin checks were as follows:</p> <ul style="list-style-type: none"> - A Weekly Skin Integrity Data Collection, dated 10/7/19, documented Resident #13 had an open sore, red and draining to the left antecubital. There was no documentation of measurements or a description of the appearance of the open sore to the left antecubital. - A Weekly Skin Integrity Data Collection, dated 10/13/19, documented Resident #13 had a wound in the left antecubital with no measurements or description of the appearance of the wound. Allevyn (absorbent foam dressing) was in place and documentation noted the wound was warm, red and draining. - A Weekly Skin Integrity Data Collection, with no date or signature, documented Resident #13 had a wound to the left antecubital, red, warm and draining with an Allevyn dressing in place. The skin check documentation did not include 	F 686			

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F 686	<p>Continued From page 124 appearance or measurements of the wound.</p> <p>A nurse progress note, dated 10/3/19 at 9:49 PM, documented a deep open wound in the crevice of the left elbow of Resident #13.</p> <p>The Wound Observation Tool, dated 10/4/19, documented Resident #13 had a deep open wound on the left arm, surrounded with pink skin, detailing the location as the left elbow crease.</p> <p>A physician's progress note, dated 10/4/19 at 9:30 AM, documented Resident #13 had a Stage 4 pressure ulcer to her left upper extremity antecubital, where the arm was contracting. The assessment and plan documented a pressure ulcer Stage 4 to Resident #13's left upper extremity antecubital due to contracture, apply Allevyn dressing with Medihoney (foam wound dressing with honey based wound care gel), change the dressing daily, and wound care team was to consult on 10/8/19.</p> <p>A physician's progress note, dated 10/14/19 at 8:00 AM, documented to continue with Resident # 13's wound care.</p> <p>The October TAR for Resident #13 documented the following:</p> <ul style="list-style-type: none"> * Resident #13's October 2019 TAR, dated 10/4/19 through 10/15/19, documented an order for an Allevyn dressing to be applied to her left antecubital, and to change the dressing daily and in the evening. * Resident #13's October TAR, dated 10/15/19 through 10/25/19, documented an order for 	F 686			

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F 686	<p>Continued From page 125</p> <p>"Allevyn dressing to left antecubital, change daily and in the evening, one time daily every 3 days for wound change, as needed, if necessary". The documentation included the order was not clear and needed clarification.</p> <p>On 10/30/19 at 12:15 PM, RCM #2 was asked what the above physician's order meant. RMC #2 stated he was on vacation during that time and was unable to answer the question.</p> <p>* Resident #13's October TAR included documentation treatments were completed on 10/18/19, 10/21/19, and was left blank on 10/24/19.</p> <p>On 10/30/19 at 12:18 PM, RCM #2 stated, when the TAR is left blank the task was not completed.</p> <p>* Resident #13's October 2019 TAR, dated 10/25/19, documented the Allevyn dressing to her left antecubital was to be changed every 3 days and in the evening.</p> <p>Resident #13's record did not include documentation a wound care team consult occurred.</p> <p>On 10/27/19 at 3:22 PM, RN #1 stated Resident #13's left antecubital open area was caused by a contracture, and there were two pressure ulcers, one resolved after treatment, and the other was open and draining.</p> <p>On 10/30/19 at 1:00 PM, RCM #2 stated wound care was not completed from 10/27/19 through 10/30/19 since the state surveyors were at the facility.</p>	F 686			

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F 686	<p>Continued From page 126</p> <p>On 10/30/19 at 1:30 PM, the DON stated RCM #1, RCM #2, and RCM #3 completed weekly wound care assessments and obtained measurements. The DON was unsure if anyone was wound care certified. The DON stated she expected wound care was completed as ordered, including when state surveyors were present.</p> <p>On 10/30/19 at 4:15 PM, the P.A. stated she wrote the orders for Resident #13 and they were never processed by RCM #2. The P.A. stated E.D. #1 and the DON were notified of orders not being processed in a timely manner.</p> <p>On 11/1/19 at 12:08 PM, the Medical Director evaluated Resident #13's wounds. After removing a dressing dated 10/29/19, he stated the wound bed was granulating (beefy, red), open, had discharge from the distal (farthest from the head) area, and the size was 1 cm. He also stated the RCMs should have continued with the weekly skin assessments and measurements and he wanted to have a wound clinic come into the facility to observe weekly and communicate with RCMs. The Medical Director stated the facility needed continuity of care and not a different nurse each day doing something differently or who does not have time to do the wound care. He said residents do not get the care they deserve. The Medical Director stated he talked to the DON and E.D. #1 on several occasions, as well as during QA (quality assurance) meetings to stop admissions until more staff was available to provide wound care, and suggested an in house wound team to manage the wounds in the facility. He stated he has not received a response.</p>	F 686			

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F 686	<p>Continued From page 127</p> <p>b. On 10/27/19 at 3:22 PM, RN #1 stated Resident #13's left heel was boggy upon admission, and then opened with drainage.</p> <p>Resident #13's Wound Observation Tool, dated 8/23/19, documented upon admission she had a stage 2 pressure ulcer to her left heel, with granulation tissue (beefy red), serosanguineous (pale red) drainage, measuring 2.1 cm x 1.3 cm x 0.0 cm. Further Wound Observation Tools documented the following:</p> <p>* 8/30/19: The overall impression of Resident #13's left heel was the wound was healed and resolved and there was no drainage. No measurements were taken by RCM #2.</p> <p>* 9/15/19: There was a stage 2 pressure ulcer with dimensions of 1.5 cm x 1.2 cm x 0.0 cm. An Allevyn dressing was applied to Resident #13's heel by RN #1.</p> <p>* 9/22/19: There was a stage 2 pressure ulcer with measurements of 2.5 cm x 3.0 cm x 0.0 cm, An Allevyn dressing was applied by RN #1 to Resident #13's heel, with a kerlix (gauze roll bandage). An air mattress and foot cradle (lifts bedding away from the legs to relieve pressure and friction from blankets) were also utilized.</p> <p>An order summary report of active orders, dated 11/1/19, documented an order on 8/1/19 for wound care to Resident #13's left heel, daily in the evening, and an order on 10/14/19 for weekly skin checks, and in the morning every Sunday.</p> <p>Resident #13's September 2019 TAR, did not</p>	F 686			

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F 686	<p>Continued From page 128</p> <p>include documentation wound care was provided to Resident #13's left heel.</p> <p>Resident #13's October 2019 TAR, documented wound care to her left heel daily in the evening. There was no documentation wound care was completed on 10/3/19.</p> <p>Resident #13's weekly skin integrity data collection, dated from 8/22/19 through 8/25/19, documented a stage 2 pressure ulcer to her left heel. Further skin checks for Resident #13's foot were documented as follows:</p> <ul style="list-style-type: none"> * On 9/1/19, the dressing was changed. * On 9/8/19, the ulcer was scabbed over. * On 9/15/19, an Allevyn dressing to the heel in was in place, and the heel was improving. * On 9/22/19, the blister was resolved and there were pressure prevention measures in place. * On 9/29/19, there were unopened areas, and the heel was pink and boggy. <p>The 9/22/19 wound observation tool documented Resident #13 had a stage 2 pressure ulcer with wound measurements of 2.5 cm x 3.0 cm x 0.0 cm. The weekly skin integrity data collection report also dated 9/22/19, documented the wound was resolved.</p> <p>On 10/28/19 at 2:01 PM, Resident #13's left heel was observed with no dressing in place and the wound was open with drainage.</p> <p>On 11/1/19 at 12:08 PM, the Medical Director was examining Resident #13's left heel and stated it was an open wound with drainage, at least 1 cm long. The Medical Director stated he</p>	F 686			

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F 686	<p>Continued From page 129</p> <p>would issue new orders for dressings to be applied to the left heel.</p> <p>On 11/1/19 at 3:41 PM, Resident #13 was observed positioned on her right side facing the window, with a Keen lift (device to keep heels from the mattress surface), with no dressing in place.</p> <p>4. The facility's Skin Integrity & Pressure Ulcer/Injury Prevention and Management policy, dated 10/3/19, documented, "A resident's risk [for pressure ulcer development] may increase due to an acute illness or condition change . . . and may require additional evaluation. The frequency of assessment should be based upon each resident's specific needs . . . Measures to protect the patient against the adverse effects of external mechanical forces, such as pressure, friction, and shear are implemented in the plan of care: a) reposition at least every 2-4 hours . . . as consistent with overall patient goal and medical condition; b) utilize positioning devices to keep bony prominence's from direct contact; . . . d) heel protection/suspension should be implemented while the patient is in bed."</p> <p>Resident #36 was readmitted on 12/11/15, with multiple diagnoses including, hemiplegia and hemiparesis (one-sided weakness and loss of feeling), stroke affecting her right dominant side, Alzheimer's Disease, dementia, muscle weakness, and difficulty walking.</p> <p>Resident #36's quarterly MDS, dated 12/16/18, documented she had moderately impaired cognitive skills for daily decision making, required limited assistance of one staff person for bed</p>	F 686			

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F 686	<p>Continued From page 130</p> <p>mobility and transfers, extensive assistance of one staff member for toilet use, and did not walk. The assessment documented the resident was frequently incontinent of bowel. The assessment documented Resident #36 had no pressure ulcers or other skin conditions present.</p> <p>Resident #36's care plan, initiated on 3/26/19, documented she had a potential for pressure ulcer development related to immobility, urinary incontinence, and frail elderly skin. The care plan directed staff to:</p> <ul style="list-style-type: none"> * Follow facility policies/protocols for the prevention/treatment of skin breakdown. * Assist Resident #36 to turn and reposition in bed every 1 to 2 hours. * Inform Resident #36 and her family of any new areas of skin breakdown. * Observe and report any changes in Resident #36's skin status including appearance, color, wound healing, signs and symptoms of infection, wound size, and wound stage. * Serve Resident #36 her diet as ordered and monitor intake and record. * Resident #36 required standard pressure relieving and reducing devices on her bed and chair. <p>Resident #36's Nurse Progress Notes, dated 5/28/19 at 1:43 AM, documented she was found sitting on her knees, at the head of her bed, up against her night stand. Upon further assessment and evaluation, it was determined Resident #36 sustained a fracture to her right ankle.</p> <p>LPN #6 documented in Resident #36's Nurse Progress Notes on 5/28/19 at 10:44 PM, on</p>	F 686			

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F 686	<p>Continued From page 131</p> <p>5/30/19 at 12:28 AM, and on 5/30/19 at 9:46 PM, Resident #36 had a soft cast to her right foot and was fearful of moving her foot and stayed very quiet in bed. LPN #6 also documented Resident #36 did not complain of discomfort with no movement.</p> <p>The Progress Notes and care plan for Resident #36 did not include documentation the nursing staff implemented new interventions to help prevent skin breakdown after her fall with fracture on 5/28/19 and prior to 6/3/19.</p> <p>Resident #36's Nurse Progress Notes, dated 6/3/19 at 2:25 PM, documented the shower aide notified the nurse of a pressure sore to her left heel. The wound was 2.0 cm x 2.0 cm and was non-blanchable. A Sage boot (a pressure relieving boot) was applied to her left heel and the physician, DON, and RCM were notified.</p> <p>Resident #36's care plan, revised on 6/3/19, documented she developed an unstageable pressure ulcer to her left posterior heel Interventions included:</p> <ul style="list-style-type: none"> * Resident #36 was normally independent with bed mobility with staff assistance to assure her heels were offloaded (raised up from surfaces to relieve pressure) at all times and a blanket (foot) cradle was in use when she was in bed. * Staff were to assist Resident #36 with weight shifting every 1 to 3 hours to assure her heels were offloaded. <p>Resident #36's Wound Observation Tool, dated 6/4/19, documented her left heel had an</p>	F 686			

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F 686	<p>Continued From page 132</p> <p>unstageable pressure ulcer and the heel was purple, had boggy tissue, which was round and raised under a clear, fluid filled blister. The wound measured 4.0 cm x 3.0 cm, with no depth. The treatment plan was to offload the heel at all times, and for a trial of a blanket [foot] cradle to hold the resident's bedcovers off of her left foot.</p> <p>Resident #36's physician orders documented the following:</p> <ul style="list-style-type: none"> * 6/4/19: DTI [deep tissue injury] to left heel. Apply lotion to foot and heel daily at bedtime. Assure heels are floated [not touching the bed surface] at all times when in bed (preferably with a cushion device, but may use sage boots) and to use a blanket [foot] cradle in place every shift. * 6/5/19: Off loader boot for left heel to wear with transfers and in bed to decrease pressure on the heel every shift for her left heel DTI. * 6/12/19: Daily wound check to left heel. Continue to keep pressure off heel every day shift for heel wound. <p>Resident #36's Wound Observation Tool, dated 6/12/19, documented she had an acquired unstageable pressure ulcer to the top of her right great toe and it was a "clear, flat, empty blister tan area [sic]." The wound was 1.0 cm x 0.9 cm, with no depth. The treatment plan was to, "apply Betadine" (an antiseptic solution).</p> <p>Resident #36's physician's order, dated 6/12/19, documented, "Betadine to left heel and right great toe daily every day shift for pressure wound."</p> <p>Resident #36's TARs from June 2019 to</p>	F 686			

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F 686	<p>Continued From page 133</p> <p>September 2019, documented Betadine was not applied to either wound. The October 2019 TAR, documented the Betadine was applied 1 out of 31 opportunities on 10/31/19.</p> <p>On 11/1/19 at 10:25 AM, RCM #1 stated staff were to treat Resident #36's pressure ulcers daily with Betadine.</p> <p>On 11/4/19 at 10:45 AM, Resident #36's wounds were observed. Her left heel wound measured 0.5 cm in diameter with no surrounding redness or drainage. On the top of her right great toe there was a faint, pinpoint sized darkened area with no surrounding redness or drainage. The nurse applied Betadine to both areas using separate pre-packaged Betadine swabs.</p> <p>On 11/7/19 at 1:30 PM, RCM #1 stated she did not recall the staff using heel protectors or a cushion to "float" (suspend the heels to relieve pressure) after Resident #36 fractured her right ankle. The RCM stated she was unaware of how the pressure ulcer occurred on the top of her right great toe. RCM #1 stated they now had a pressure relieving cushion and bed cover [foot] cradle in use to protect Resident #36's heels and toes.</p> <p>On 11/8/19 at 9:35 AM, the DON stated she expected staff turned and repositioned residents in need of mobility assistance every two hours, or as determined by the resident's specific care needs. The DON stated she expected staff looked into obtaining a pressure reducing mattress for residents, used lotions for the skin, used heel protectors and cushions to float heels, and used bed cover [foot] cradles.</p>	F 686			

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F 688 SS=G	<p>Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)</p> <p>§483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and</p> <p>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents received adequate services and monitoring to prevent a decrease in ROM (Range of Motion). This was true for 1 of 1 resident (Resident #13) reviewed for ROM and mobility. Resident #13 was harmed when she developed contractures to her upper extremities without receiving services or interventions to prevent the development of the contractures. Findings include:</p> <p>Resident #13 was admitted to the facility on 7/30/19, with multiple diagnoses including dementia, osteoporosis (bone disease that</p>	F 688	<p>Individual Residents: Resident #13 was evaluated and treated by therapy until transferred to Hospice per her choice. Resident was referred to the restorative program at that time for contracture management.</p> <p>Other Residents in similar situations: Current residents were audited by therapy for decrease in joint mobility and/or contractures. Residents who were identified had therapy orders requested for further evaluation and treatment. Care plans were updated to reflect current condition.</p>	1/2/20	

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F 688	<p>Continued From page 135</p> <p>causes bones to become weak and brittle), and osteoarthritis (occurs when the protective cartilage that cushions the ends of your bones wear down over time).</p> <p>The admission MDS assessment, dated 8/6/19, documented Resident #13 was cognitively intact and required extensive assistance of two staff members for bed mobility, transfers, and dressing. The assessment documented Resident #13 had no ROM impairment to either upper or lower extremities.</p> <p>The quarterly MDS assessment, dated 10/14/19, documented Resident #13 was severely cognitively impaired and required extensive assistance of two staff members for bed mobility and dressing. The assessment documented she had no ROM impairment to either upper or lower extremities.</p> <p>Resident #13's care plan, dated 8/12/19, documented staff were to monitor and report to the physician complications related to arthritis: Joint pain and stiffness, decline in mobility, and contracture formation/joint shape changes.</p> <p>On 10/27/19 at 3:22 PM, Resident #13 was laying on her back in bed with both of her arms bent with no devices in place. RN #1 stated Resident #13 did not wear devices to prevent further contractures to her upper extremities and was not receiving therapy or restorative therapy.</p> <p>On 11/1/19 at 12:08 PM, the Medical Director stated he should have been notified of Resident #13's ROM decline. The Medical Director stated he would have referred Resident #13 to therapy</p>	F 688	<p>Measures to prevent reoccurrence: Director of therapy and MDS department were educated by the Executive Director on ensuring communication and referrals are completed when residents are noted with decreased mobility or contractures. CNAs were educated by the Director of nursing on reporting change in condition in the area of decline in function, decrease in mobility.</p> <p>Ongoing Monitoring: Quality measures will be reviewed monthly x3 months to identify residents with decreased joint mobility/range of motion and decline in ADL function. Identified residents will be assessed by therapy for needed treatments or additional referrals. Findings of these audits will be reviewed through QAPI x3 months.</p> <p>Individual to ensure compliance: Director of Nursing to ensure ongoing compliance.</p>		

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F 688	Continued From page 136 to evaluate and provide treatment to prevent further contractures. On 11/05/19 at 2:42 PM, the MDS Coordinator stated Resident #13's quarterly assessment on 10/14/19, documented she had no ROM impairment to either her upper or lower extremities. The MDS Coordinator stated Resident #13's quarterly assessment was documented as an error. The MDS Coordinator stated Resident #13 did not have contractures to her upper extremities when she was admitted to the facility. On 11/05/19 at 4:33 PM, RN #6 stated Resident #13 developed contractures to her upper extremities in the facility. RN #6 was unable to provide documentation in Resident #13's record the physician was notified of the contractures for treatment and services to prevent further contractures.	F 688			
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and family, and staff interview, the facility failed to ensure residents received adequate supervision to prevent hazards, risks, accidents, and injuries to	F 689	The facility submitted an IJ removal plan during annual survey which was accepted with removal revisit. In addition to this plan, the following is being submitted as	1/2/20	

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F 689	<p>Continued From page 137</p> <p>residents. This was true for 5 of 10 residents (#8, #36, #72, #130, and #231) reviewed for supervision. These failures resulted in immediate jeopardy to Resident #8 who eloped from the facility without the awareness of staff. This placed the other residents at risk for serious impairment, harm or death when Resident #72 fell out of his wheelchair, Resident #130 wandered and exhibited aggressive behavior toward residents and staff, Resident #36 fell and fractured her right ankle, and Resident #231 fell resulting in a subdural hematoma. Findings include:</p> <p>1. Resident #8 was admitted on 10/5/17, with diagnoses including dementia, bipolar disorder, depression, and anxiety.</p> <p>Resident #8's care plan identified her exit seeking, or elopement, and included interventions to redirect her if she was heading towards the doors and if wearing a coat or jacket to reassure her she was in the right place, allow her to express her desire to go home, and assist with calling her son if that was she was exit seeking, initiated on 1/19/19.</p> <p>Resident #8's record included a progress note, dated 6/15/19 at 6:15 PM, which stated she had exited the facility and set off a door alarm near the 300 hall. Resident #8 was followed out to the parking lot by a CNA and she told the CNA her son was waiting for her in the car, which he was not. The CNA used a cell phone to contact other staff regarding the elopement. The facility had 1:1 supervision for Resident #8 for the 2:00 PM to 10:00 PM shift, and for the night shift it changed to 15 minute safety checks. Resident #8's record included an Elopement Risk Evaluation, dated</p>	F 689	<p>part of the ongoing plan of correction.</p> <p>Individual Residents: Residents #36, 130 and 231 no longer reside in the facility. Resident #8 had one to one supervision initiated while facility staff were educated to resident specific needs and care plan interventions. Resident #8 has since successfully tapered from one to one supervision and remains in the facility. Resident #72 had care plan reviewed and updated and one to one supervision initiated.</p> <p>Other Residents in similar situations: A review of the last 14 days of incidents and grievances was conducted to determine any trends related to a lack of supervision and none were noted.</p> <p>Measures to prevent reoccurrence: LNs, CNAs and facility leadership were educated by the executive director or designee on following the plan of care, following physician orders and ensuring supervision is provided to meet resident needs.</p> <p>Ongoing Monitoring: Incidents and grievances will be reviewed daily (M-F) to ensure that identification of trends related to supervision are identified and plans are implemented to address. Monthly review through QAPI to occur for incidents and grievance trends.</p> <p>Individual to ensure compliance:</p>		

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F 689	<p>Continued From page 138</p> <p>6/15/19, which documented she was at risk for elopement due to dementia and hallucinations.</p> <p>On 10/29/19 at 11:21 AM, Resident #8 was observed with her coat and a set of keys in her hands. Resident #8 stated to RN #4 she needed to get her car. RN #4 redirected Resident #8 and instructed other staff members to watch her. At 11:30 AM, Resident #8 was observed sitting on the seat of her wheeled walker, down the 200 hall, near the exit door without staff in view. Resident #8's room was also in the same area, two rooms away from the exit door.</p> <p>On 10/30/19 at 2:25 AM, LPN #5 stated Resident #8 was outside of the facility after dark. LPN #5 stated she saw Resident #8 walk by the nurses' station about 8:15 PM with her coat on. LPN #5 said she was unaware Resident #8 had left the facility. She stated a staff person from the 100 hall, returned with Resident #8 about 8:45 PM. The staff person stated Resident #8 was knocking on the side door. The weather was cold, and it was dark outside. LPN #5 stated there was one LPN and one CNA on the 200 unit with 42 residents.</p> <p>On 10/30/19 at 2:00 AM, there was one CNA and one LPN on the 200 hall to care for 42 residents. One LPN and two CNAs were on the 100 hall to care for 43 residents. E.D. #1 was in the facility standing outside of Resident #130's room providing 1:1 supervision. At 2:42 AM, CNA #4 said she had not yet seen all of her assigned residents. At 2:55 AM, CNA #4 said Resident #8's door was closed per Resident #8's request. CNA #5 said Resident #8 was to be checked every 15 minutes. She said the checks were not</p>	F 689	Executive Director will ensure compliance.		

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F 689	<p>Continued From page 139 being done because the corporate person who was doing them left.</p> <p>The facility did not provide adequate ordered supervision and interventions to prevent Resident #8 from elopement which placed her in Immediate Jeopardy of serious harm, impairment, or death.</p> <p>E.D. #1 was notified verbally and in writing of the Immediate Jeopardy on 10/30/19 at 7:10 PM.</p> <p>2. Resident #231 was initially admitted on 7/24/19, and readmitted on 9/20/19, with multiple diagnoses including difficulty walking, generalized muscle weakness, type 2 diabetes mellitus, morbid obesity (100 pounds over ideal body weight), acute and chronic respiratory failure with hypercapnia (too much carbon dioxide and not enough oxygen in the blood), and chronic obstructive pulmonary disease (a progressive lung disease).</p> <p>Resident #231's admission MDS assessment, dated 7/31/19, documented he required supervision of one person with physical assistance for transfers, walking in his room and corridor. The assessment also documented Resident #231 was cognitively intact. Resident #231's record did not include an admission MDS assessment for his readmission on 9/20/19.</p> <p>A Physical Therapy and Plan of Treatment note, dated 9/20/19, documented Resident #231's functional mobility assessment for transfers and level surfaces as contact guard assist (one or two hand contact to help steady the other person's body and help with balance) while using a</p>	F 689			

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F 689	<p>Continued From page 140 two-wheeled walker.</p> <p>Nurse's Progress Notes, dated 9/21/19 and 9/22/19, documented Resident #231 required "SBA [stand by assist] for transfers and ambulation" and he used a four-wheeled walker.</p> <p>A Physical Therapy Discharge Summary, dated 9/23/19, for dates of service 9/20/19 to 9/23/19, documented Resident #231's functional skills assessment for mobility was SBA for transfers and on level surfaces.</p> <p>Resident #231's care plan documented he was at risk for falls, had an unsteady gait related to disease process, and directed staff to assist with mobility and ADLs as needed. The care plan also documented staff were to orient Resident #231 to his room, and he required one-person assistance for toileting and transfers, initiated 9/23/19.</p> <p>On 11/6/19 at 3:21 PM, Physical Therapist #1 said SBA means "close enough to grab a resident by the gait belt if needed." He said the expectation was a resident had a gait belt on and staff were close enough to grab it if needed.</p> <p>A Progress Note, dated 9/23/19 at 12:40 PM, documented Resident #231 was found on the floor in a room other than his own and appeared to be having a seizure. An order received from the P.A. said to send Resident #231 to the Emergency Department (ED). The note stated Resident #231 was not responding appropriately, he vomited, had facial drooping on his right side, and was unable to grasp on his right side. He was transported to the hospital at 1:00 PM, and his wife was contacted. There were no</p>	F 689			

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F 689	<p>Continued From page 141 documented witnesses of the event.</p> <p>An Incident and Accident Report, dated 9/23/19, documented Resident #231 was found on the floor at 12:40 PM and was responsive only to vigorous stimulation. His eyes were open, but he was not responding to questions.</p> <p>A Witness Statement, dated 9/23/19, written by the Maintenance Director, documented he heard Resident #231 fall in room 314. Resident #231 was found lying on his left side and back with his walker out in front and the walker was leaning over his right side. Resident #231 was not responsive. He pulled Resident #231's walker off him and got nursing assistance.</p> <p>A Witness Statement, dated 9/23/19, written by RN #7, documented she interacted with Resident #231 several times prior to the incident and he exhibited normal behavior. He came to the dining room at 11:15 AM and he ate lunch with no problems. She wrote she observed him leave the dining room and no odd behaviors or concerns regarding his cognition were noted. RN #7 documented he was alert and oriented to person, place, time, and situation during her shift. RN #7 said she was called to assist with Resident #231 by the Maintenance Director, and Resident #231 was found on his back and it appeared he was having a seizure. Staff stayed with Resident #231 and RN #7 documented she called 911.</p> <p>A Staff Interview, dated 9/23/19, with PT #2, documented Resident #231 "looked the best I have seen" during therapy the day of the event, and had no noted concerns about his gait or balance. Resident #231 was at appropriate</p>	F 689			

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F 689	<p>Continued From page 142</p> <p>oxygen levels, was able to determine his resting periods while walking with his walker and was compliant with walker use during his therapy session. There were no noted concerns of confusion/change in level of consciousness during the therapy session.</p> <p>An ED note, dated 9/23/19, documented Resident #231 presented to the ED at 1:22 PM via Emergency Medical Services (EMS). Resident #231's family said the resident fell and they found him lying on the ground, he had seizure type activity, and EMS was able to stand Resident #231 up, assist him to his chair, and he was able to initially converse with EMS. EMS reported Resident #231 had right sided weakness and drift (diminishing strength) and was dragging his right foot. Resident #231's Glasgow Coma Scale (the scoring system used to describe the level of consciousness in a person following a traumatic brain injury), started to decline and EMS decided to intubate him (insert a tube into the throat for breathing). The family denied Resident #231 had a history of seizures.</p> <p>A subsequent ED note, dated 9/23/19, documented by the ED physician, stated Resident #231 arrived via ambulance with rapidly declining mental status after an unwitnessed fall and he was intubated in the field. Resident #231 was sent to CT (a computerized x-ray scan) from the ambulance where a large subdural hematoma (bleeding and increased pressure on the brain usually caused by severe head injuries which can be life-threatening) with midline shift (a shift of the brain past the midline) was found. It was determined the family members agreed with</p>	F 689			

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F 689	<p>Continued From page 143</p> <p>Resident #231's previous stated wishes for DNR/DNI (Do Not Resuscitate/Do Not Intubate) and the breathing tube was removed and he was monitored further in the ED. Resident #231 was discharged with the "expectation of imminent demise".</p> <p>The facility did not provide supervision and interventions to prevent Resident #231 from having an unwitnessed fall with injury.</p> <p>3. Resident #130 was admitted to the facility on 8/27/19, with multiple diagnoses including a stroke affecting his right side and difficulty walking.</p> <p>Resident #130's admission MDS assessment, dated 9/3/19, documented Resident #130 was severely cognitively impaired and required extensive assistance with two staff members for bed mobility and transfers. The assessment documented Resident #130 required extensive assistance with one staff member for ambulation.</p> <p>Resident #130's care plan, dated 8/27/19, documented Resident #130 was at risk for falls. The interventions were for staff to provide assistance with ADLs as needed, orient resident to his room, and have the call light within reach.</p> <p>An Incident and Accident Report, dated 8/27/19 at 11:55 PM, documented Resident #130 was sitting on his bed when he attempted to stand and lost his balance, and was lowered to the floor by the CNA. There were no injuries noted. The CNA's witness statement documented Resident #130 was restless and kept pulling on his PEG tube (a flexible tube placed through the</p>	F 689			

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F 689	<p>Continued From page 144</p> <p>abdominal wall and into the stomach that allows nutrition, fluids and/or medications to be put directly in the stomach) and the CNA was attempting to redirect him. The interventions were to move Resident #130 closer to the nurse's station.</p> <p>An Incident and Accident Report, dated 8/28/19 at 5:26 AM, documented the CNAs heard a loud "bump" and found Resident #130 on the floor beside his bed with feces on his hands and bedside table. The report documented Resident #130 was being checked every 15 minutes all night, "a second fall was expected."</p> <p>An Incident and Accident Report, dated 8/28/19 at 10:53 PM, documented Resident #130 was found lying on the floor with the bedside table tipped over and items from the bedside table were scattered on the floor next to his bed. The report documented Resident #130 was resistant of the nurse assessing him for injury and did not allow his vital signs to be checked. The report documented Resident #130 was moved to the 200 hall.</p> <p>Resident #130's care plan, dated 8/29/19, documented Resident #130 was to ambulate with therapy staff only, he required assistance with bed mobility and transfers with one staff member, and staff were to toilet Resident #130 every 2 hours.</p> <p>An Interdisciplinary Team (IDT) investigation note, dated 9/3/19, documented Resident #130 was moved into a different room closer to the nurse's station and he was encouraged to ask for assistance when transferring. The note</p>	F 689			

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F 689	<p>Continued From page 145</p> <p>documented fall mats were placed next to his bed as a new intervention.</p> <p>An Incident and Accident Report, dated 8/29/19 at 7:30 AM, documented Resident #130 was lying on the floor with a cut above his right eye. The immediate action taken was Resident #130 was placed on 1:1 supervision.</p> <p>An IDT investigation note, dated 9/3/19, documented new interventions for Resident #130 included having 1:1 supervision and his care plan was revised. The care plan was revised on 9/5/19, and stated "1:1 as ordered, after family departs for the day, have 1:1 in place with resident 1 hour prior to family departure."</p> <p>A Physical Therapy Discharge Summary Report, dated 10/10/19 at 2:31 PM, documented to continue Resident #130's 1:1 supervision for all mobility to decrease his risk for falls.</p> <p>A Physical Therapy Daily Summary Note, dated 10/10/19 at 4:25 PM, documented Resident #130 was impulsive, staff were to never leave him unattended, he attempted to stand and walk by himself, and he required 1:1 supervision 24 hours a day.</p> <p>A Care Plan Conference Note, dated 10/14/19, documented family, RCM #2, a therapy representative, the Director of Social Services, and LSW #1 were in attendance. The note documented Resident #130 needed 24/7 diligence for safety.</p> <p>A Nurse's Progress Note, dated 10/16/19 at 9:46 PM, documented Resident #130 required 1:1</p>	F 689			

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F 689	<p>Continued From page 146 supervision due to impulsive behaviors.</p> <p>A Fax Order Request/Notification Form for Resident #130, dated 10/17/19, documented it was okay to trial discontinuing 1:1 supervision and was signed by the P.A. on 10/17/19.</p> <p>A Nurse's Progress Note, dated 10/19/19 at 8:44 PM, documented Resident #130 required 1:1 supervision due to frequent wandering and impaired gait.</p> <p>A Nurse's Progress Note, dated 10/20/19 at 8:53 PM, documented Resident #130 required 1:1 supervision due to frequent wandering and impaired gait.</p> <p>A Nurse's Progress Note, dated 10/21/19 at 9:56 PM, documented Resident #130 was agitated when family left the facility for the evening and became verbally and physically aggressive. The note documented Resident #130 was attempting to enter other residents' rooms and safety checks were initiated every 15 minutes.</p> <p>An Incident and Accident Report, dated 10/22/19 at 12:00 PM, documented Resident #130 wandered without assistance into a female resident's bathroom, while she was receiving toileting assistance by a CNA. The report documented the CNA escorted Resident #130 to the dayroom. The physician was notified, and orders were received to resume 1:1 supervision.</p> <p>A Nurse's Progress Note, dated 10/22/19 at 12:04 PM, documented "New orders noted to resume one on one sitter; discontinuation failed." The note documented the DON was notified of</p>	F 689			

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F 689	<p>Continued From page 147 Resident #130 requiring 1:1 supervision.</p> <p>A Nurse's Progress Note, dated 10/22/19 at 12:55 PM, documented Resident #130 was "usually a 1:1, but has been trialed to be independent with walking around facility. [Resident #130] inadvertently walked into another resident's room and opened bathroom door while resident was in there." The note documented E.D. #1 and the DON were aware of the event.</p> <p>A Nurse's Progress Note, dated 10/22/19 at 6:43 PM, documented Resident #130 had 1:1 supervision during the evening shift to prevent wandering into other residents' rooms, prevent falls, and he required one-person assistance with ambulation due to impaired gait.</p> <p>The 200 Hall Daily Assignment Schedule documented there were times and shifts when there was no 1:1 supervision assigned to Resident #130 as ordered by his provider. Examples include:</p> <ul style="list-style-type: none"> * On 10/1/19, no 1:1 supervision assignment from 6:00 AM to 8:00 AM and 2:00 PM to 3:00 PM * On 10/2/19, no 1:1 supervision assignment from 6:00 AM to 7:00 AM * On 10/3/19, no 1:1 supervision assignment from 9:00 AM to 10:00 AM * On 10/4/19, no 1:1 supervision for assignment for day shift, evening shift, and night shift 	F 689			

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F 689	<p>Continued From page 148</p> <ul style="list-style-type: none"> * On 10/8/19, the aide assigned for 1:1 supervision was "at clinical" * On 10/12/19, no 1:1 supervision assignment for day shift, evening shift, and night shift * On 10/13/19, no 1:1 supervision assignment for night shift * On 10/15/19, no 1:1 supervision assignment from 6:00 AM to 7:00 AM * On 10/15/19, no 1:1 supervision assignment from 6:00 AM to 7:00 AM * On 10/16/19, no 1:1 supervision assignment from 6:00 AM to 8:00 AM * On 10/22/19, no 1:1 supervision assignment for night shift * On 10/24/19, no 1:1 supervision assignment on evening shift * On 10/25/19, no 1:1 supervision assignment for day shift or night shift * On 10/27/19, no 1:1 supervision assignment for the day and evening shift <p>On 10/27/19 at 12:30 PM, LPN #1 stated Resident #130 was not assigned to 1:1 supervision until after the survey team entered the facility. Resident #130 was sitting in the dayroom with the Activity Director assisting him with an activity. LPN #1 stated Resident #130 was required to have 1:1 supervision 24/7 due to his impulsiveness, wandering, poor safety</p>	F 689			

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F 689	<p>Continued From page 149</p> <p>awareness, and impaired gait. LPN #1 stated Resident #130 was more often without 1:1 supervision than he was with one for the past month.</p> <p>On 10/27/19 at 2:30 PM, Resident #130 was observed in bed resting without 1:1 supervision.</p> <p>On 10/27/19 at 2:45 PM, E.D. #1 was standing outside of Resident #130's room. E.D. #1 stated he was Resident #130's 1:1 supervision.</p> <p>On 10/28/19 at 2:20 PM, CNA #2, the facility's nursing scheduler, was reclined in Resident #130's recliner looking at her phone, while he was sleeping. CNA #2 stated she assigned herself as the 1:1 supervision for Resident #130 because she was unable to fill the position with anyone else. CNA #2 stated she had to be in the area of Resident #130 because he was a high fall risk.</p> <p>On 10/28/19 at 3:17 PM, LPN #1 stated Resident #130 required 1:1 supervision due to wandering into other resident rooms, but most of the time Resident #130 was not assigned 1:1 supervision. LPN #1 stated Resident #130 did not have 1:1 supervision assigned to him currently and she was responsible to keep an eye on him while she was passing medications to other residents. LPN #1 stated it was impossible to keep Resident #130 safe without being with him at all times.</p> <p>On 10/28/19 at 3:25 PM, Resident #130's spouse stated when she visited the staff member assigned to Resident #130's 1:1 supervision would leave the room and she assisted him. Resident #130's spouse also stated if she was</p>	F 689			

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F 689	<p>Continued From page 150</p> <p>unable to provide personal care for Resident #130, she asked for assistance from the staff. The spouse stated Resident #130 needed 1:1 supervision 24/7 due to his impulsiveness and wandering.</p> <p>On 10/30/19 at 2:05 AM, E.D. #1 was standing outside of Resident #130's doorway and Resident #130 was sleeping in bed. E.D. #1 stated he was assigned as Resident #130's 1:1 supervision for the night shift from 10:00 PM to 6:00 AM. E.D. #1 stated he was not a CNA. E.D. #1 stated he notified the CNA assigned to the hall to assist Resident #130 with personal cares. E.D. #1 stated he was there to assure Resident #130 did not wander into another resident's room. There was one CNA and one LPN assigned to 42 residents on the 200 hall for the night shift.</p> <p>On 10/30/19 at 3:05 AM, the BOM relieved E.D. #1 as Resident #130's 1:1 supervision. The BOM stated she was a CNA and was able to provide assistance for Resident #130. Resident #130 was in bed sleeping and the BOM was sitting in a chair close to the doorway.</p> <p>On 10/30/19 at 3:15 AM, E.D. #1 was standing outside Resident #130's doorway and stated he was back to provide 1:1 supervision for Resident #130.</p> <p>On 11/1/19 at 10:00 AM, the new scheduler stated he transferred from one of the sister facilities and was working on filling the holes in the schedule for Resident #130's 1:1 supervision for the evening shift. The 200 Hall Daily Assignment Sheet documented, "Need Help!!!" on the evening shift.</p>	F 689			

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F 689	<p>Continued From page 151</p> <p>On 11/2/19 at 7:20 PM, CNA #4 was sitting outside Resident #130's room assigned as his 1:1 supervision. CNA #4 stated she was instructed to assure Resident #130 did not fall or wander into other residents' rooms. Resident #130 was in bed sleeping.</p> <p>On 11/2/19 at 7:30 PM, CNA #4 was observed assisting Resident #130 to the bathroom.</p> <p>On 11/2/19 at 7:50 PM, CNA #4 was sitting next to Resident #130 on the side of his bed. Resident #130 was talking to CNA #4.</p> <p>On 11/3/19 at 10:30 AM, Sitter #1 was observed sitting outside of Resident #130's room while he was in bed sleeping. Sitter #1 stated she was not a CNA. Resident #130 was awake and attempting to get out of bed and Sitter #1 did not see him getting up. Sitter #1 was told Resident #130 was getting out of bed. Sitter #1 assisted him walking by holding his left hand with her right hand with their fingers interlocked and her left hand was holding his left bicep. Resident #130 had an unsteady gait and Sitter #1 was leading him to walk forward, while his right foot was shuffling. Resident #130 stated he needed to use the bathroom. Sitter #1 led him to his bathroom and asked another sitter to find a CNA to provide cares for Resident #130. Sitter #1 stated she was unable to provide personal cares and did not know if Resident #130's bathroom had a call light to activate. Resident #130's bathroom did have a call light in his bathroom.</p> <p>On 11/5/19 at 9:32 AM, the DON stated Resident #130's trial of not having 1:1 supervision failed in</p>	F 689			

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F 689	<p>Continued From page 152</p> <p>less than a day. She said Resident #130 had an unsteady gait and wandered into other residents' rooms and he needed 24/7 supervision.</p> <p>On 11/5/19 at 11:05 AM, the P.A. stated Resident #130 should not have been trialed without 1:1 supervision. The P.A. stated she was instructed to discontinue the 1:1 supervision by E.D. #1, he told her the facility did not have enough staff to provide 1:1 supervision for Resident #130 and he instructed the P.A. to discontinue the 1:1 supervision. The P.A. stated Resident #130 required 1:1 supervision due to having an unsteady gait, he was at risk for falls, and he had been wandering in and out of other residents' rooms. The P.A. stated after Resident #130 wandered into the female's bathroom while she was in there, she reinstated the 1:1 supervision and E.D. #1 was "not happy." The P.A. stated her priority was to keep all residents safe and she knew discontinuing the 1:1 supervision was a bad idea.</p> <p>On 11/5/19 at 2:08 PM, the P.A. stated the 1:1 supervision needed to be a CNA to provide personal cares and assist with transfers and they needed to be within arm's reach of Resident #130.</p> <p>The facility did not provide ordered supervision and interventions to prevent Resident #130 from falling and wandering into other residents' rooms.</p> <p>4. Resident #36 was admitted on 12/11/15, with diagnoses which included hemiplegia and hemiparesis (one-sided weakness and paralysis) following a cerebral infarction (stroke) affecting her right dominant side, Alzheimer's Disease,</p>	F 689			

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F 689	<p>Continued From page 153</p> <p>dementia, muscle weakness, and difficulty walking.</p> <p>Resident #36's quarterly MDS assessment, dated 12/16/19, documented she had moderately impaired cognitive skills for daily decision making, required limited assistance of one staff person for bed mobility and transfers, extensive assistance of one staff member for toilet use, and did not walk. The MDS assessment stated Resident #36 had no falls since her prior MDS assessment.</p> <p>Resident #36's Fall Risk Evaluation forms completed from 12/27/18 through 9/3/19, documented a score of 10 or above was considered a high-risk for falls. Resident #36's was assessed as a high risk for falls as follows:</p> <ul style="list-style-type: none"> - 12/27/18, score of 21 - 2/10/19, score of 16 - 5/10/19, score of 16 - 5/14/19, score of 13 - 5/28/19, score of 13 - 8/28/19, score of 13 - 9/3/19, score of 22 <p>Resident #36's Order Summary Report, dated 11/7/19, included an order to check her every thirty minutes for safety, anticipate her needs such as toileting, call light within reach, and to keep her bed in a low position six times a day for fall risk.</p> <p>Resident #36's care plan documented she had a history of falls with injury and remained a fall risk related to poor balance, poor communication/comprehension, weakness, and</p>	F 689			

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F 689	<p>Continued From page 154</p> <p>dementia with memory/safety deficits. The care plan documented Resident #36 had a fall with injury on 5/28/19, resulting in a right ankle fracture and a fall resulting in a hematoma (blood filled bruise) on 9/2/19.</p> <p>The interventions for Resident #36 on the care plan included the following:</p> <ul style="list-style-type: none"> * Fall risk assessment quarterly and after events * Wheelchair to be used for mobility, do not leave at beside * Referral for Physical Therapy/Occupational Therapy screen and treatment as needed * Provide frequent reminders to wait for assistance to transfer * Anti-roll back brakes on wheelchair * Check with resident in the morning to assist with morning ADLs and encourage resident to not attempt to do ADLs herself * Provide increased monitoring for falls during times of illness 2/10/19 * Re-educated [Resident #36] to call for help and wait for assistance prior to transferring for her safety 2/18/19 * Reminded [Resident #36] to wear non-skid footwear for transferring 2/28/19 * Ensure slippers are in reach as well as wheelchair to avoid her having to reach for them * If awake during the night, offer to toilet * Place [Resident #36] on one-hour safety checks, anticipate her needs such as toileting, drink/food, getting out of bed, and take her to meals * Call light within reach, bed in low position <p>Resident #36's orders, care plan interventions, and the interventions listed on her Visual/Bedside</p>	F 689			

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F 689	<p>Continued From page 155</p> <p>Kardex Report, included the following discrepancies:</p> <ul style="list-style-type: none"> * There were orders for frequent safety checks every 30 minutes, another intervention instructed CNAs to make one-hour safety checks, for care needs such as toileting, drink/food, getting out of bed, and taking Resident #36 to meals. * The interventions on the Kardex for bowel/bladder included offering and assisting Resident #36 with toileting before meals, after meals, at bedtime, and as needed. The care plan interventions stated to offer assistance to Resident #36 with toileting every two hours while awake (revised on 9/6/19), and if awake during the night, offering to assist her with toileting (revised on 9/4/19). <p>Resident #36's progress notes documented she had 4 falls between 2/10/19 and 9/2/19, as follows:</p> <ul style="list-style-type: none"> * A Nurse's Progress Note, dated 2/10/19 at 4:34 PM, documented Resident #36 was found in the bathroom laying on the floor next to the toilet and her wheelchair in a soiled brief. Resident #36 attempted to self-transfer to the toilet and lost her balance. Resident #36 complained of tenderness to her right hip. An assessment documented there were no abnormalities in voluntary movement/strength of either lower extremity, or abnormal findings. The nurse notified the physician and received orders to monitor and report back if Resident #36 had worsening pain to her right hip. <p>The two interventions added to the care plan on</p>	F 689			

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F 689	<p>Continued From page 156</p> <p>2/10/19, were to re-educate Resident #36, who has dementia, to call for help, wait for assistance prior to transferring, and remind Resident #36 to wear non-skid footwear for transferring.</p> <p>* A Nurse's Progress Note, dated 5/14/19 at 2:59 AM, documented Resident #36 was found on the floor laying on her back, parallel to her bed with her head at the head of the bed. Her wheelchair was pushed away to the side next to her. Resident #36 stated she rolled out of bed and denied trying to go to the bathroom. The progress note stated Resident #36 did not hurt herself. An assessment documented no injuries, and staff assisted Resident #36 back into bed. Neurological assessments were started, and the physician was notified.</p> <p>Resident #36's wheelchair was at her bedside, her care plan interventions were not followed. No changes or additions were made to Resident #36's care plan to prevent further falls.</p> <p>* A Nurse's Progress Note, dated 5/28/19 at 1:43 AM, documented staff were performing walking rounds at the end of the shift and were standing by Resident #36's room and heard her call out. The documentation stated upon investigation, Resident #36 was found sitting on her knees at the head of her bed up against her night stand. Her right arm was twisted behind her on the bed rail. The documentation stated staff slowly raised Resident #36 up to untwist her arm. An assessment of Resident #36's right arm documented normal range of motion (ROM) and Resident #36 denied having pain. A further physical assessment documented there were no problems found, all of Resident #36's joints had</p>	F 689			

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F 689	<p>Continued From page 157</p> <p>normal ROM, and she denied pain. The assessment also documented Resident #36 was then taken to the bathroom, and when she was assisted to bed and took off her shoes and socks, it was noted her right ankle was swollen and bent at a "weird" angle. At the time of the fall, it was noted Resident #36's call light was within reach and not turned on and she had shoes and socks on her feet.</p> <p>A Nurse's Progress Note, dated 5/28/19 at 3:18 PM, documented Resident #36 had a right ankle fracture, a soft cast was on the ankle, and it was elevated with ice applied. There were no new interventions added to the fall prevention care plan until 6/3/19. The interventions included placing Resident #36 on the "Falling Leaves Program" with no specific fall prevention measures documented. The plan also documented Resident #36 was placed on one-hour safety checks, and staff were to anticipate her needs such as toileting, drink/food, getting out of bed, and staff were to take her to meals. The plan also stated to keep Resident #36's call light within reach and keep her bed in low position.</p> <p>* A Nurse's Progress Note, dated 9/2/19 at 12:17 AM, documented she was called to Resident #36's room where she found her on the floor between her bed and her roommate's bed, laying on her right side. The nurse documented Resident #36 was able to move all extremities and denied pain. Staff assisted Resident #36 back to bed, and she asked for a bedpan. The nurse documented Resident #36 had a quarter-size hematoma/bruise to her right shoulder bone, and a small bump on her head.</p>	F 689			

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F 689	<p>Continued From page 158</p> <p>The nurse documented Resident #36 stated she did not remember hitting her head. Neurological assessments were initiated.</p> <p>The care plan intervention added on 9/6/19, instructed staff to toilet Resident #36 every two hours while awake, offer her a bedpan, and to educate staff to anticipate her needs. The interventions were not new or changed from the previous interventions.</p> <p>On 11/1/19 from 10:30 AM to 11:30 AM, Resident #36 was observed lying in bed on her back. The two CNAs on the unit conducting resident rounds did not enter Resident #36's room or check on her needs every 30 minutes as ordered.</p> <p>On 11/7/19 at 1:30 PM, RCM #1 stated Resident #36 fell in her room and sustained a fracture to her right ankle on 5/28/19. RCM #1 stated for residents who were high-risk for falls, she expected staff to check on the resident frequently for supervision and to anticipate and assist with their care needs. The RCM #1 stated Resident #36 had every 30-minute checks and then every one-hour checks ordered after her fall, but both the 30-minute and one-hour checks were discontinued.</p> <p>On 11/8/19 at 9:35 AM, the DON stated after each fall staff should reassess residents to determine the root cause of the fall and have a therapy evaluation for rehabilitation or for the Restorative Nurse Aide (RNA) program, and for other resident-specific interventions appropriate to help prevent future falls.</p> <p>The facility did not follow care plan interventions,</p>	F 689			

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F 689	<p>Continued From page 159</p> <p>physician orders, or implement new interventions to prevent Resident #36 from falling.</p> <p>5. Resident #72 was admitted on 10/2/19, with diagnoses including a right hip replacement, Alzheimer's Disease, and a history of falling.</p> <p>The MDS admission assessment, dated 10/9/19, documented his cognitive skills for daily decision making were moderately impaired. The assessment documented Resident #72 required extensive assistance to total dependence for ADLs.</p> <p>A Fax Order Request/Notification Form, dated 10/16/19, documented Resident #72 was found sitting on the floor with no clothes on after sitting on the garbage can to have a bowel movement. The form documented the physician ordered to monitor Resident #72 per protocol. There was no further documentation or clarification what protocol the physician had ordered to be monitored.</p> <p>A second Fax Order Request/Notification form, dated 10/17/19, documented the physician ordered 1:1 supervision as needed for Resident #72.</p> <p>On 10/27/19 between 11:30 AM and 12:10 PM, Resident #72 was observed in a tilt back wheelchair in the dayroom on the 200 hall without 1:1 staff. Resident #72 was observed repositioning the leg rests and moving his legs over the side of the wheelchair.</p> <p>On 10/27/19 at 11:20 AM, LPN #1 said Resident #72 was supposed to have 1:1 supervision. At</p>	F 689			

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F 689	<p>Continued From page 160</p> <p>11:30 AM, RN #4 also said Resident #72 was supposed to have 1:1 supervision. Both verified no one was assigned for 1:1 supervision as evidenced by the daily assignment sheet. RN #4 stated the facility used the tilt back wheelchair to attempt to prevent Resident #72 from falls or give staff enough time to get to him before he fell. LPN #1 and RN #4 said they were unaware of what "monitor per protocol" meant. The nurses also verified the order for "1:1 as needed" had no parameters.</p> <p>On 10/27/19 at 3:30 PM, CNA #1 said there was not enough staff for 1:1 supervision.</p> <p>On 10/27/19 at 3:40 PM and 3:50 PM, CNA #2 and CNA #3 respectively, confirmed there was not enough staff for 1:1 supervision.</p> <p>A Nurse's Progress Note, dated 10/27/19, documented Resident #72 propelled himself to the 100 unit via his manual wheelchair. The note documented Resident #72 entered the private room of another resident and attempted to self-transfer. The progress note further documented Resident #72 fell out of his wheelchair due to his inability to bear weight.</p> <p>Resident #72's physician order was for him to receive 1:1 supervision due to his frequent attempts to self-transfer and his poor memory.</p> <p>On 10/28/19 at 9:00 AM, RN #4 verified Resident #72 fell at 5:50 PM on 10/27/19 on another unit, in another resident's room.</p> <p>On 10/28/19 at 9:30 AM, Resident #72 was in a tilt back wheelchair in the 200 hall dayroom</p>	F 689			

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F 689	<p>Continued From page 161</p> <p>without staff present in the room. At 9:40 AM, a staff member pushed Resident #72 to a table in the dayroom and gave him a cup of coffee then left the room. At 9:43 AM, Resident #72 told a visitor he needed to go to the bathroom. The visitor informed a CNA, who stated she would be back. Resident #72 again told the visitor and another resident he needed to go to the bathroom. At 9:55 AM, another CNA came into the dayroom and removed him. The CNA returned Resident #72 to the dayroom in the tilt back wheelchair at 10:00 AM and left. There was no 1:1 staff with him. Resident #72 was moving the wheelchair around the dayroom from 10:00 AM to 10:40 AM with his legs hanging over the side of the wheelchair and dangling under the leg rests. At 10:40 AM, a CNA entered the dayroom and repositioned Resident #72 in the wheelchair. Resident #72 was observed continuously in the dayroom from 9:30 AM to 10:50 AM without 1:1 supervision by staff as ordered by the physician.</p> <p>A Nurse's Progress Note, dated 10/28/19 at 1:05 PM, documented Resident #72 was sitting at a table in the dayroom eating lunch when he pushed his wheelchair back and stood up. Resident #72 then sat himself on the edge of wheelchair cushion and slid off the cushion and onto the floor in between the footrests of his wheelchair. The note documented Resident #72 was assessed by the nurse and he denied pain, but there were two small reddened areas observed, one on his lower back and one on his left thigh. The note documented his physician was notified.</p> <p>On 10/30/19 at 3:14 PM, the Medical Director said the order for "1:1 as needed" was not a</p>	F 689			

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F 689	Continued From page 162 definitive order. He stated he was not notified of Resident #72's recent falls on 10/27/19 and 10/28/19. On 10/30/19 at 3:35 PM, the P.A. said she wrote an order for 1:1 supervision of Resident #72 due to his high fall risk. She stated she was instructed by E.D. #1 he would not pay for two residents on the same unit to have 1:1 supervision and she wrote the order as "as needed." The P.A. stated staff were not notifying her or documenting when Resident #72 fell. The facility did not provide the ordered supervision and interventions to prevent Resident #72 from falling.	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 record reviews and interviews, it was determined the facility failed to provide care and services for 2 of 2 residents (Residents #430 and #481) reviewed for oxygen therapy. This resulted in residents not receiving oxygen as ordered. Findings include: 1. Resident #430 was admitted on 7/25/19, with	F 695	Individual Residents: Residents #430 and 481 no longer reside in the facility. Other Residents in similar situations: Residents receiving oxygen therapy were reviewed for delivery in conjunction with their current orders. Needed changes	1/2/20	

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F 695	<p>Continued From page 163</p> <p>diagnoses which included below knee amputation of the right leg, Chronic Obstructive Pulmonary Disease (COPD), Atherosclerotic Heart Disease, and heart failure.</p> <p>Resident #430's Order Summary Reports for July and August 2019 included an order for oxygen (O2) at four liters/minute continuously via nasal cannula every shift for COPD with an order date of 7/25/19.</p> <p>Resident #430's admission MDS, dated 8/1/19, stated he had moderately impaired cognitive skills and required extensive assistance of 2 or more staff for bed mobility and transfers. The MDS stated he received oxygen prior to admission and while a resident of the facility.</p> <p>A Facility Reported Incident concerning Resident #430, dated 8/13/19, stated he ". . . was found on the floor, face down with no vital signs. CPR was initiated but resident was not [able to be] resuscitated." The report stated the night shift CNA, CNA #9, reported that while performing the last rounds of her shift, she checked on Resident #430 at 5:05 AM and found him on the floor next to the bed with no pulse. CNA #9 summoned and received assistance from staff that included fellow night shift CNA #10 and the oncoming day shift nurse, RN #4. Staff performed CPR while a call to 911 was placed with Emergency Medical Services (EMS) responding. Resident #430 was pronounced dead at 5:40 AM.</p> <p>During an interview with CNA #9 on 10/30/19 at 2:30 AM, the CNA stated Resident #430 was his "usual self" during the night shift (8/12/19 to 8/13/19). CNA #9 stated she checked on him at</p>	F 695	<p>were reported to the physician and orders updated as needed.</p> <p>Measures to prevent reoccurrence: LNs were educated by the Director of Nursing on following physician orders related to oxygen therapy.</p> <p>Ongoing Monitoring: Audits will be conducted weekly x4 and monthly x2 on ensuring residents with orders for oxygen are receiving it in conjunction with the physician order. Negative findings of these audits will be reviewed through monthly QAPI x3 months.</p> <p>Individual to ensure compliance: Director of nursing will ensure ongoing compliance.</p>		

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F 695	<p>Continued From page 164</p> <p>4:30 AM, and he wanted his remote control, his covers adjusted, and the door closed to his room. CNA #9 stated around 5:05 AM, during her final rounds for that night, she found Resident #430 face down on the floor beside his bed. CNA #9 stated she shook Resident #430's shoulder and called his name with no response. She then checked for a pulse and found none. CNA #9 stated she went to the nurses' station for the charge nurse, LPN #8, and to get CNA #10. They went to Resident #430's room, but LPN #8 did not stay and start CPR. LPN #8 went back to the nurses' station to call the "Code" overhead but did not know how to use the overhead paging system. Another nurse from a different hallway came to Resident #430's room and started CPR with CNA #10. CNA #9 stated she went to get the emergency cart. When EMS arrived, they took over the code, but were not able to bring back Resident #430. After completion of the code and Resident #430 was pronounced deceased, she and CNA #10 did the post-mortem (after death) care for Resident #430. It was during this time that CNA #10 noted and told her Resident #430's oxygen flowmeter was turned off at the wall. CNA #9 stated she did not check Resident #430's oxygen saturation level during her shift. CNA #9 stated the facility later provided O2 administration training to her and other staff.</p> <p>During an interview on 11/4/19 at 1:15 PM, RN #4 stated when she entered Resident #430's room during CPR, she saw his oxygen tubing was, ". . . coiled around the oxygen flow meter on the wall and the O2 flow meter was turned off." RN #4 stated the agency nurse responsible for Resident #430's care the previous night, LPN #8, did not address the code situation and death of</p>	F 695			

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F 695	<p>Continued From page 165</p> <p>Resident #430 during the shift-to-shift report that morning. RN #4 stated the facility had not provided CPR or "code" training since the departure of ED #1. RN #4 added the facility provided no orientation training, specific to the building and residents, to the agency staff, "There is a book at each nurses' station that includes information on the agency staffs' responsibilities, but that's all."</p> <p>During an interview on 11/8/19 at 10:30 AM, CNA #10 stated she worked her night shift on the hall with CNA #9, the same hall with Resident #430's room. CNA #10 stated CNA #9 came up to her and told her Resident #430 was on the floor in his room face down and he had no pulse. CNA #10 stated when she entered Resident #430's room, he did not have his oxygen tubing on. She and a nurse started CPR. EMS took over the code when they arrived but were unable to revive Resident #430. After the code and Resident #430 was pronounced dead, she and CNA #9 performed his post-mortem care. CNA #10 stated this was when she noticed Resident #430's oxygen flow meter on the wall was turned off. CNA #10 stated that no one in the room during or after the code touched the flow meter to turn off the oxygen, "It was already off."</p> <p>2. Resident #481's was admitted to the facility on 3/20/17, with diagnoses which included shortness of breath, hypoxemia, and asthma.</p> <p>A quarterly MDS assessment, dated 6/19/19, stated Resident #481 was cognitively intact with no behaviors exhibited and required extensive assistance with Activities of Daily Living (ADLs).</p>	F 695			

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F 695	<p>Continued From page 166</p> <p>Resident #481's record included a Physician Order, dated 3/21/17, which stated "Oxygen [O2] at 1-3 liters/minute continuously via NC [nasal cannula]. Document every shift. Oxygen Saturation rates every shift."</p> <p>Resident #481's MAR, dated 7/1/2019 through 7/31/19, did not include documentation each shift she wa using her oxygen and there was no documentation of her oxygen saturation. There was no documentation of O2 checks from 7/13/19 to 7/31/19 as ordered.</p> <p>A Progress Note, dated 7/13/19 at 6:45 PM, documented a CNA reported to RCM #1 that Resident #481 was not "looking good." RCM #1 went into Resident #481's room and found her non-responsive...oxygen saturations were 61% on room air (normal range is greater than 92%).</p> <p>On 11/7/19 at 1:29 PM, RCM #1 stated one of the aides told her to come quick, her [Resident #481] saturations were low. Resident #481 was found non-responsive with the nasal cannula still intact. RCM #1 followed the oxygen tubing back to the concentrator, found the oxygen was turned off and was "not sure how it got turned off or was even on." RCM #1 turned Resident #481's oxygen back on, notified the physician and received orders to send Resident #481 to the emergency room for evaluation.</p> <p>On 11/7/19 at 2:15 PM, CNA #15 was interviewed via telephone. CNA #15 was asked if she recalled the incident with Resident #481. CNA #15 responded she recalled Resident #481 was alert and oriented that day. CNA #15 assisted CNA #14 to put Resident #481 back to bed after</p>	F 695			

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F 695	Continued From page 167 Resident #481's shower. CNA #15 stated Resident #481 had a terrible roommate and the roommate's spouse would turn off the oxygen concentrator because it was noisy. CNA #15 was asked if she recalled if the oxygen was turned on. CNA #15 responded that she left the room after assisting CNA #14 to place Resident #481 in bed. On 11/7/19 at 3:32 PM, CNA #14 was interviewed via telephone. CNA #14 was asked if she recalled the incident with Resident #481. CNA #14 responded after placing Resident #481 back in bed, she put Resident #481's nasal cannula on. CNA #14 was asked if she recalled if she turned the oxygen concentrator on. CNA #14 stated "thought it was on, but not sure." The facility failed to ensure staff provided Resident #481 with oxygen as ordered by the physician.	F 695			
F 725 SS=L	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725		1/2/20	

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F 725	<p>Continued From page 168</p> <p>by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, review of grievances, review of the Facility Assessment, review of I&A Reports, review of staffing schedules, and interviews with residents, family, and staff, it was determined the facility failed to ensure there were sufficient numbers of competent staff to meet supervision, ADL needs, medication administration, and answer call lights in a timely manner for residents. This was true for 27 of 97 residents (#4, #7, #8, #13, #14, #17, #19, #20, #23, #24, #25, #32, #35, #46, #49, #53, #59, #61, #62, #65, #72, #130, #131, #180, #333, #380, and #480) reviewed for staffing concerns, and had the potential to affect all residents in the facility. These systemic deficient practices placed the 97 residents residing in the facility at imminent risk of serious harm, impairment, or death, from delayed call light response times, elopement, falls, or other adverse events due to lack of staff monitoring, and medication errors. The lack of sufficient staff also placed residents at risk of skin breakdown and embarrassment due to lack of</p>	F 725	<p>The facility submitted an IJ removal plan during the annual survey which was accepted during removal revisit. In addition to this, the facility submitting the following as part of the ongoing plan of correction.</p> <p>Individual Residents: Residents and/or responsible parties #4, 7, 8, 13, 14, 17, 19, 20, 23, 24, 25, 32, 35, 46, 53, 59, 61, 62, 65, 72 and 131 were interviewed regarding concerns related to staffing and showers and general care. Grievances were filed and addressed per policy. Shower schedules were edited to meet resident individual preference and care plans were updated as needed.</p> <p>Other Residents in similar situations: Residents/resp. parties were interviewed regarding shower preferences and had their care plans reviewed and updated. Executive Director attended resident</p>		

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F 725	<p>Continued From page 169 bathing/showers. Findings include:</p> <p>The facility's policy for Staffing, dated 4/24/19, stated the facility maintained adequate staff on each shift to meet residents' needs and utilized the Facility Assessment to determine staffing levels needed to ensure residents' needs were met.</p> <p>This policy was not followed.</p> <p>Facility staffing was insufficient to meet the care and needs of the residents and to respond to resident concerns. Examples include:</p> <p>a. Resident #8 was admitted on 10/5/17, with diagnoses including dementia, bipolar disorder, depression, and anxiety.</p> <p>Resident #8's care plan identified her exit seeking, or elopement, and included interventions to redirect her if she was heading towards the doors and if wearing a coat or jacket to reassure her she was in the right place, allow her to express her desire to go home, and assist with calling her son if that was she was exit seeking, initiated on 1/19/19.</p> <p>Resident #8's record included a progress note, dated 6/15/19 at 6:15 PM, which stated she had exited the facility and set off a door alarm near the 300 hall. Resident #8 was followed out to the parking lot by a CNA and she told the CNA her son was waiting for her in the car, which he was not. The CNA used a cell phone to contact other staff regarding the elopement. The facility had 1:1 supervision for Resident #8 for the 2:00 PM to 10:00 PM shift, and for the night shift it changed</p>	F 725	<p>council to discuss staffing concerns, grievance process and resident general care concerns. Residents are interviewed weekly through manager rounds to ensure concerns related to staffing are addressed and resolution is reviewed.</p> <p>Measures to prevent reoccurrence: Facility staff were educated by the Executive Director and Director of Nursing on ensuring that resident care needs are met to include showers, call light response, grievances, customer service, medication and treatment administration. Staffing levels were assessed and modified as needed and education was provided to agency associates. The facility assessment was updated and reviewed the QAPI committee to address staffing levels, competencies and needs of the facility.</p> <p>Ongoing Monitoring: Shower audits will be completed weekly x4 and monthly x2 to ensure that showers are completed per resident preference. Daily staffing meetings will be held (M-F) x4 weeks to ensure that the facility leadership is adjusting staffing levels to meet acuity and ensure orientation and training is occurring as indicated. . Grievances and incidents will be reviewed daily (M-F) to identify trends and staffing concerns timely. Findings of these audits will be reviewed monthly x3 in QAPI.</p> <p>Individual to ensure compliance: The Executive Director will ensure</p>		

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F 725	<p>Continued From page 170</p> <p>to 15 minute safety checks. Resident #8's record included an Elopement Risk Evaluation, dated 6/15/19, which documented she was at risk for elopement due to dementia and hallucinations.</p> <p>On 10/29/19 at 11:21 AM, Resident #8 was observed with her coat and a set of keys in her hands. Resident #8 stated to RN #4 she needed to get her car. RN #4 redirected Resident #8 and instructed other staff members to watch her. At 11:30 AM, Resident #8 was observed sitting on the seat of her wheeled walker, down the 200 hall, near the exit door without staff in view. Resident #8's room was also in the same area, two rooms away from the exit door.</p> <p>On 10/30/19 at 2:25 AM, LPN #5 stated Resident #8 was outside of the facility after dark. LPN #5 stated she saw Resident #8 walk by the nurses' station about 8:15 PM with her coat on. LPN #5 said she was unaware Resident #8 had left the facility. She stated a staff person from the 100 hall, returned with Resident #8 about 8:45 PM. The staff person stated Resident #8 was knocking on the side door. The weather was cold, and it was dark outside. LPN #5 stated there was one LPN and one CNA on the 200 unit to care for 42 residents.</p> <p>On 10/30/19 at 2:00 AM, there was one CNA and one LPN on the 200 hall to care for 42 residents. One LPN and two CNAs were on the 100 hall to care for 43 residents. E.D. #1 was in the facility standing outside of Resident #130's room providing 1:1 supervision. At 2:42 AM, CNA #4 said she had not yet seen all of her assigned residents. At 2:55 AM, CNA #4 said Resident #8's door was closed per Resident #8's request.</p>	F 725	ongoing compliance.		

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F 725	<p>Continued From page 171</p> <p>CNA #5 said Resident #8 was to be checked every 15 minutes. She said the checks were not being done because the corporate person who was doing the checks left.</p> <p>The facility did not provide adequate ordered supervision and interventions to prevent Resident #8 from elopement which placed her in Immediate Jeopardy of serious harm, impairment, or death.</p> <p>b. Residents were interviewed and stated the facility did not have sufficient staff to meet their needs.</p> <p>- On 10/27/18 at 11:51 AM, resident #53 said the facility was short of staff.</p> <p>- On 10/27/19 at 3:05 PM, Resident #25 said she was tired of waiting for assistance, and sometimes it took 30 minutes to an hour to get assistance. Resident #25 also said there was not enough help in the dining room.</p> <p>- On 10/28/19 at 9:07 AM, Resident #59 said the facility was short on help, so the residents tried to do more for themselves.</p> <p>- On 10/27/19 at 11:45 AM, Resident #49 was asked if she felt there was sufficient staff to take care of her and the other residents, the resident emphatically stated, "No," and added that staffing was worse on the day and evening shifts. Resident #49 stated she has had to wait 20 to 30 minutes for the staff to provide her with pain medication. The resident stated she has talked to Social Services about the short staffing, but that staffing has worsened, "the past two months."</p>	F 725			

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F 725	<p>Continued From page 172</p> <p>- On 10/27/19 at 11:55 AM, Resident #4 was asked if there were enough staff to take care of her and the other residents' needs, the resident gestured with a closed fist up and down and emphatically stated, "No, no, no," and then began to cry and put her head in her left hand. When asked if anything negative had occurred with her care due to insufficient staffing, the resident stated, "No." The resident continued to cry but was unable to vocalize what if any negative event(s)/outcome(s) she had experienced due to short staffing.</p> <p>- On 10/27/19 at 2:16 PM, Resident #7 stated staff made her feel degraded and had "made me cry" in the last month, the last time was about two weeks ago. She said staff talked down to her and acted like she was "out of bounds" with them. Resident #7 was asked if she could recall any staff member or names and Resident #7 stated "It's all the CNAs, on every shift." Resident #7 was asked if she had reported these incidents to the Executive Director and she stated no, she wanted to remain anonymous because she was afraid of retaliation from staff after the survey team left. Resident #7 requested the team lead and this surveyor's business card, "just in case." When asked why, Resident #7 added "just in case the staff does something to me after you leave."</p> <p>- On 10/27/19 at 3:00 PM, Resident #480 reported CNA #13 yelled at him to "hurry up, we have 16 people and there is only two of us." Resident #480 stated he felt the staff member was getting angry with him. Due to this interaction Resident #480 said he avoided going</p>	F 725			

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F 725	<p>Continued From page 173</p> <p>to the dining room when CNA #13 was there and went to another dining/public area. Resident #480 stated he also kept his door closed, so he knew whenever someone entered his room.</p> <p>- On 10/27/19 at 3:08 PM, Resident #23 was asked if there were enough staff to take care of her and the other residents' needs, the resident stated that meals were not always served on time, her pain medication and other medications were not administered on time, and that scheduled showers were not routinely provided.</p> <p>- On 10/27/19 at 3:17 PM, Resident #180 said he asked for assistance to urinate, and by the time staff came to help him it was too late. Resident #180 said staff were often working double shifts.</p> <p>- On 10/28/19 at 9:25 AM, Resident #65 said there was not enough staff. Resident #65 said the staff would "get rushing around," it could take 45 minutes to an hour to get assistance, and it was worse at mealtimes.</p> <p>- On 10/28/19 at 12:00 PM, a family member reported overhearing an unnamed staff member tell Resident #35 "If you don't eat, you are not going to dialysis." Per the family member they wished to remain anonymous because they were afraid of what would happen if someone found out they said anything and that their family member would not receive care if the staff knew they reported it. The incident was reported to E.D. #1 and the Director of Clinical Services to investigate.</p> <p>- On 10/30/19 at 12:30 PM, Resident #333 stated she was afraid to say anything to the staff,</p>	F 725			

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F 725	<p>Continued From page 174</p> <p>because she did not trust them. Resident #333 stated a CNA threatened to turn her water off, so she could not shower without facility knowledge which made her "feel like a child." Resident #333 stated a CNA failed to follow through when she made a request, and she was told "you can just leave" in a "nasty" tone by the CNA. When asked who the staff member was, Resident #333 refused to say any more about the incident.</p> <p>c. Staff were interviewed and stated there was not sufficient staff to provide the cares required and to meet the needs of the residents.</p> <p>- On 10/27/19 at 11:25 AM, CNA #12 stated she has worked at the facility for two years and was transferred to work in Activities for the past six months. CNA #12 stated that today was not her normal shift; she was held over due to short staffing. CNA #12 stated the facility has been short of staff for a while now. When asked about how this staff shortage affected resident care, CNA #12 stated, "You'd have to ask management about that." When asked how it affected her ability provide care for her residents, CNA #12 stated, "You'll have to talk with management about any staffing issues."</p> <p>- On 10/27/19 at 11:45 AM, RN #1 and LPN #1 stated the residents who were scheduled for a shower did not receive one because there was not a shower aide scheduled. They stated to be fully staffed for the day and evening shift was 1 RN, 1 LPN, 4 CNAs, 1:1 supervision for Resident #130, and 1 shower aide for the day shift.</p> <p>- On 10/28/19 at 2:53 PM, CNA #3 said a lot of staff recently quit, resulting in use of agency staff</p>	F 725			

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F 725	<p>Continued From page 175</p> <p>who were unfamiliar with the residents. CNA #3 said E.D. #1 was notified of the staffing concerns, and he "did not want to hear it." CNA #3 said during the previous night there were 2 CNAs working on her hall until 5:30 AM, and when both aides were assisting a resident at the same time there was nobody to watch the floor. CNA #3 also said at times there was only 1 CNA on the 300 hall. CNA #3 said she brought her concerns to the DON and was told to "work short" with a smile. CNA #3 said resident care suffered due to lack of staff.</p> <p>- On 10/28/19 at 4:11 PM, the scheduler said she did not like the facility staffing, and 3 CNAs for 46 residents was not okay.</p> <p>- On 10/29/19 at 4:52 PM, the DON said the facility had some struggles with staffing.</p> <p>- On 10/30/19 at 2:10 AM, CNA #2 said staffing was not good, and there was only 1 CNA on the 200 hall at that time.</p> <p>- On 10/30/19 at 2:15 AM, LPN #5 said staffing was "pretty rough." LPN #5 said there were a lot of residents who required 2-person assistance on her hall, and from 2:00 until 10:00 PM there was supposed to be 4 CNAs but there were only 3 CNAs working at that time.</p> <p>- On 10/30/19 at 3:50 PM, E.D. #1 said the facility was facing a "staffing crunch." E.D. #1 said at times a shower aide was pulled from giving showers to work on the floor, but now they were "catching up on showers." E.D. #1 said the facility needed CNAs and had not been successful in finding more CNAs. He said evening shift was</p>	F 725			

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F 725	<p>Continued From page 176</p> <p>difficult to cover, so they used agency staff. On 10/31/19 at 8:47 AM, E.D. #1 said the residents were concerned with the amount of agency staff, and residents felt the facility's regular staff knew them better.</p> <p>- On 10/30/19 at 2:10 AM, CNA #11 stated she was assigned to work at the facility the past month. CNA #11 stated the facility did not provide her with any training related to its policies and procedures, or where certain items, like the automatic external defibrillators, were located or with instructions on how to use the overhead paging system.</p> <p>- On 10/30/19 at 2:30 AM, CNA #9 stated she was hired by the facility four to five months ago, and that the first night she worked, "I was thrown to the floor because an agency CNA did not show up" for work. CNA #9 stated that she then had "three to five days training" with two of the facility's experienced CNAs before working her shift independently.</p> <p>- On 11/1/19 at 2:58 PM, LPN #4 said on that day there was 1 NA and 2 CNAs for 100 hall, and during the previous evening there was 1 CNA and 1 NA (Nursing Assistant) for the 100 hall.</p> <p>d. The Resident Council expressed concerns regarding lengthy call light response times, assistance with meals which were not addressed by the facility.</p> <p>The Concern & Comment Forms, known as "the blue cards", were organized by month in two binders for the year 2019.</p>	F 725			

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F 725	<p>Continued From page 177</p> <p>Five facility blue cards, dated 2/14/19 (2 on this date), 6/19/19, 7/17/19 and 8/14/19, documented the Resident Council filed grievances regarding call light wait times on each date.</p> <p>- The blue card, dated 2/14/19, documented "per Resident Council", Resident #7 was told staff was sent home early due to low census - she is upset because she feels it causes her a longer wait time in getting her call light answered. The facility documented on the back the investigation findings were: staffing was adjusted to resident acuity and census. Facility continued to monitor staffing levels and call light audits. Actions taken to resolve/respond to the concern was: continue to monitor through QAPI. The date the findings/action plan were shared with the concerned party was 2/26/19, 12 days after complaint was filed, and the concerned party's reaction was checked as "cautious but optimistic."</p> <p>- The blue card, dated 2/14/19, written "per Resident Council", documented Resident #32 agreed that call lights were not being answered in a very timely manner. The facility documented investigation findings on the back side as: continue to work with QAPI plan and conduct call light audits and daily Angel Rounds (manager makes rounds to talk with residents).</p> <p>- The blue card, dated 6/19/19, documented the grievance was filed on behalf of the Resident Council, and described the concern as "residents feel call lights are getting to be slower lately", and they reported the concern to a staff member. The facility documented the person designated to investigate/follow-up with the concern was the</p>	F 725			

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F 725	<p>Continued From page 178</p> <p>MDS Coordinator, and investigation findings were: "Have received multiple C/O [complaints] call light wait times; will address in QAPI 7/9/19". Actions taken were documented as: "Audit completed, we are addressing the call light response time, Angel Rounds [implemented</p> <p>- The blue card, dated 7/17/19, documented the grievance was filed on behalf of the Resident Council, and described the concern as: "[Resident Council] would like us to do our audits at off times, like during meals and after meals when residents want to lay down, to show us just how long they really have to wait for help." It was documented the complaint was reported to a staff member. The facility documented the person designated to investigate/follow-up with the concern was the MDS Coordinator, and investigation findings were: "Talked with department heads about doing call light audit with PM Manager."</p> <p>- The blue card, dated 8/14/19, documented the grievance was filed on behalf of the Resident Council, provided resident name as "100 and 200 Hall", and described the concern as: "call lights are still slow to answer", and that the concern was reported to a staff member. The facility documented the person designated to investigate/follow-up with the concern was the MDS Coordinator. The blue card did not document a date/time of initial contact with the concerned party (Resident Council President) and the investigation findings were: "Work in progress, this needs to be all team members, See QAPI." Actions taken were documented as: "Off hour call light audits continuing with PM Managers."</p>	F 725			

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F 725	<p>Continued From page 179</p> <p>The facility failed provide sufficient staff to meet resident needs when identify by the Resident Council and through the complaint/grievance process.</p> <p>e. Residents were not able to voice grievances about care and services without fear of reprisal and the facility did not respond to grievances, investigate them, and take prompt corrective action to resolve them.</p> <p>i. Resident #61 was admitted on 11/12/18, with multiple diagnoses including diabetes mellitus and arthritis.</p> <p>Resident #61's quarterly MDS assessment, dated 9/28/19, documented she was cognitively intact.</p> <p>On 10/29/19 at 10:33 AM, Resident #61 said on 10/2/19 "the staff took 2 hours to answer her call light "from 6:45 PM to 8:40 PM", she called the facility and "the phone rang 25 times with no answer" and she hung up. Resident #61 became teary eyed and upset and said that she "loves it here, but not right now - it keeps getting worse and I am tired of hearing it will get better when in fact it gets worse every day." She said the worst time was the evening shift 2:00 -10:00 PM, especially after dinner, "it's a ghost town out in the hallway, you can't find anyone to help you."</p> <p>Two Comment and Concern blue cards, dated 10/2/19, were completed by Resident #61 regarding lack of staff assistance. On one she wrote: "I have never been treated so poorly. The last two nights I had my call light on for more than two hours without any assistance. I went out to</p>	F 725			

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F 725	<p>Continued From page 180</p> <p>the [200 hall] nurse's station and no one could be found. Is anyone even working here anymore? I even called the facility and the phone rang 25 times and no answer." She wrote on the blue card that she reported the concerns to two nurses on the 200 Hall.</p> <p>On Resident #61's second blue card, dated 10/2/19, she wrote: "We are constantly denied a shower. It has been a week this time and has been as many as 12-14 days. Hygiene is just as important to my healthcare. I am disappointed in the overall care I have gotten during my stay this time. I have always requested Post Falls Life Care." She wrote she reported the concern to two nurses on the 200 Hall. There was no facility response included on the card copy.</p> <p>On 11/7/19 at 1:38 PM, regarding the grievance procedure, Resident #61 said people were now reluctant to complete a blue card - residents were turning in blue cards but when nothing happened, no action was taken, they quit filing them. Resident #61 said she filed two grievances on 10/2/19 regarding her inability to get a response when she sought assistance and lengthy delays between showers. Resident #61 said E.D. #1 "fired staff who expressed concerns, he just wanted it to be happy."</p> <p>ii. Resident #7 was admitted on 4/28/19, with multiple diagnoses including diabetes mellitus.</p> <p>Resident #7's quarterly MDS assessment, dated 7/19/19, documented she was cognitively intact.</p> <p>A Comment & Concern blue card, dated 8/24/19, documented by LPN #4 on behalf of Resident #7,</p>	F 725			

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F 725	<p>Continued From page 181</p> <p>said "I think it is totally ridiculous" that my scheduled Friday shower - "she [shower aide] couldn't do it because she was pulled to the floor". The card documented Resident #7 said the shower aide told her she would do the shower on Saturday and she was pulled to the floor again, so she did not receive a shower on Saturday. The card documented "Why don't they have enough staff? I shouldn't have to miss my shower." "What about agency working? Never see them on days, only evenings."</p> <p>On 11/5/19 at 11:17 AM, the P.A. said in January 2019 the E.D. separated from the facility and things got worse. The P.A. said the new E.D. (E.D. #1) requested only positive attitudes from staff and would fire those who complained.</p> <p>f. The facility did not provide 1:1 supervision for residents as ordered by their provider. Examples include:</p> <p>i. Resident #130 was admitted to the facility on 8/27/19, with multiple diagnoses including a stroke affecting his right side and difficulty walking.</p> <p>An IDT investigation note, dated 9/3/19, documented new interventions for Resident #130 included having 1:1 supervision and his care plan was revised. The care plan was revised on 9/5/19, and stated "1:1 as ordered, after family departs for the day, have 1:1 in place with resident 1 hour prior to family departure."</p> <p>A Care Plan Conference Note, dated 10/14/19, documented family, RCM #2, a therapy representative, the Director of Social Services,</p>	F 725			

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F 725	<p>Continued From page 182 and LSW #1 were in attendance. The note documented Resident #130 needed 24/7 diligence for safety.</p> <p>Resident #130 did not have 1:1 supervision as follows:</p> <ul style="list-style-type: none"> * On 10/1/19, no 1:1 supervision assignment from 6:00 AM to 8:00 AM and 2:00 PM to 3:00 PM * On 10/2/19, no 1:1 supervision assignment from 6:00 AM to 7:00 AM * On 10/3/19, no 1:1 supervision assignment from 9:00 AM to 10:00 AM * On 10/4/19, no 1:1 supervision for assignment for day shift, evening shift, and night shift * On 10/8/19, the aide assigned for 1:1 supervision was "at clinical" * On 10/12/19, no 1:1 supervision assignment for day shift, evening shift, and night shift * On 10/13/19, no 1:1 supervision assignment for night shift * On 10/15/19, no 1:1 supervision assignment from 6:00 AM to 7:00 AM * On 10/15/19, no 1:1 supervision assignment from 6:00 AM to 7:00 AM * On 10/16/19, no 1:1 supervision assignment from 6:00 AM to 8:00 AM 	F 725			

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F 725	<p>Continued From page 183</p> <ul style="list-style-type: none"> * On 10/22/19, no 1:1 supervision assignment for night shift * On 10/24/19, no 1:1 supervision assignment on evening shift * On 10/25/19, no 1:1 supervision assignment for day shift or night shift * On 10/27/19, no 1:1 supervision assignment for the day and evening shift <p>On 10/27/19 at 12:30 PM, LPN #1 stated Resident #130 was not assigned to 1:1 supervision for 22 day, until after the survey team entered the facility. Resident #130 was sitting in the dayroom with the Activity Director assisting him with an activity. LPN #1 stated Resident #130 was required to have 1:1 supervision 24/7 due to his impulsiveness, wandering, poor safety awareness, and impaired gait. LPN #1 stated Resident #130 was more often without 1:1 supervision than he was with one for the past month.</p> <p>On 10/27/19 at 2:30 PM, Resident #130 was observed in bed resting without 1:1 supervision.</p> <p>On 10/27/19 at 2:45 PM, E.D. #1 was standing outside of Resident #130's room. E.D. #1 stated he was Resident #130's 1:1 supervision.</p> <p>On 10/28/19 at 2:20 PM, CNA #2, the facility's nursing scheduler, was reclined in Resident #130's recliner looking at her phone, while he was sleeping. CNA #2 stated she assigned herself as the 1:1 supervision for Resident #130 because she was unable to fill the position with</p>	F 725			

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F 725	<p>Continued From page 184</p> <p>anyone else. CNA #2 stated she had to be around Resident #130 because he was a high fall risk.</p> <p>On 10/28/19 at 3:17 PM, LPN #1 stated Resident #130 required 1:1 supervision due to wandering into other resident rooms, but most of the time Resident #130 was not assigned 1:1 supervision. LPN #1 stated Resident #130 did not have 1:1 supervision assigned to him currently and she was responsible to keep an eye on him while she was passing medications to other residents. LPN #1 stated it was impossible to keep Resident #130 safe without being with him at all times.</p> <p>On 10/28/19 at 3:25 PM, Resident #130's spouse stated when she visited the staff member assigned to Resident #130's 1:1 supervision would leave the room and she assisted him. Resident #130's spouse also stated if she was unable to provide personal care for Resident #130, she asked for assistance from the staff. The spouse stated Resident #130 needed 1:1 supervision 24/7 due to his impulsiveness and wandering.</p> <p>On 10/30/19 at 2:05 AM, E.D. #1 was standing outside of Resident #130's doorway and Resident #130 was sleeping in bed. E.D. #1 stated he was assigned as Resident #130's 1:1 supervision for the night shift from 10:00 PM to 6:00 AM. E.D. #1 stated he was not a CNA. E.D. #1 stated he notified the CNA assigned to the hall to assist Resident #130 with personal cares. E.D. #1 stated he was there to assure Resident #130 did not wander into another resident's room. There was one CNA and one LPN assigned to 42 residents on the 200 hall for the night shift.</p>	F 725			

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F 725	<p>Continued From page 185</p> <p>On 10/30/19 at 3:05 AM, the BOM relieved E.D. #1 as Resident #130's 1:1 supervision. The BOM stated she was a CNA and was able to provide assistance for Resident #130. Resident #130 was in bed sleeping and the BOM was sitting in a chair close to the doorway.</p> <p>On 10/30/19 at 3:15 AM, E.D. #1 was standing outside Resident #130's doorway and stated he was back to provide 1:1 supervision for Resident #130.</p> <p>On 11/1/19 at 10:00 AM, the new scheduler stated he transferred from one of the sister facilities and was working on filling the holes in the schedule for Resident #130's 1:1 supervision for the evening shift. The 200 Hall Daily Assignment Sheet documented, "Need Help!!!" on the evening shift.</p> <p>On 11/2/19 at 7:20 PM, CNA #4 was sitting outside Resident #130's room assigned as his 1:1 supervision. CNA #4 stated she was instructed to assure Resident #130 did not fall or wander into other residents' rooms. Resident #130 was in bed sleeping.</p> <p>On 11/2/19 at 7:30 PM, CNA #4 was observed assisting Resident #130 to the bathroom.</p> <p>On 11/2/19 at 7:50 PM, CNA #4 was sitting next to Resident #130 on the side of his bed. Resident #130 was talking to CNA #4.</p> <p>On 11/3/19 at 10:30 AM, Sitter #1 was observed sitting outside of Resident #130's room while he was in bed sleeping. Sitter #1 stated she was not</p>	F 725			

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F 725	<p>Continued From page 186</p> <p>a CNA. Resident #130 was awake and attempting to get out of bed and Sitter #1 did not see him getting up. Sitter #1 was told Resident #130 was getting out of bed. Sitter #1 assisted him walking by holding his left hand with her right hand with their fingers interlocked and her left hand was holding his left bicep. Resident #130 had an unsteady gait and Sitter #1 was leading him to walk forward, while his right foot was shuffling. Resident #130 stated he needed to use the bathroom. Sitter #1 led him to his bathroom and asked another sitter to find a CNA to provide cares for Resident #130. Sitter #1 stated she was unable to provide personal cares and did not know if Resident #130's bathroom had a call light to activate. Resident #130's bathroom did have a call light in his bathroom.</p> <p>On 11/5/19 at 9:32 AM, the DON stated Resident #130's trial of not having 1:1 supervision failed in less than a day. She said Resident #130 had an unsteady gait and wandered into other residents' rooms and he needed 24/7 supervision.</p> <p>On 11/5/19 at 11:05 AM, the P.A. stated Resident #130 should not have been trialed without 1:1 supervision. The P.A. stated she was instructed to discontinue the 1:1 supervision by E.D. #1, he told her the facility did not have enough staff to provide 1:1 supervision for Resident #130 and he instructed the P.A. to discontinue the 1:1 supervision. The P.A. stated Resident #130 required 1:1 supervision due to having an unsteady gait, he was at risk for falls, and he had been wandering in and out of other residents' rooms. The P.A. stated after Resident #130 wandered into the female's bathroom while she was in there, she reinstated the 1:1 supervision</p>	F 725			

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F 725	<p>Continued From page 187 and E.D. #1 was "not happy." The P.A. stated her priority was to keep all residents safe and she knew discontinuing the 1:1 supervision was a bad idea.</p> <p>On 11/5/19 at 2:08 PM, the P.A. stated the 1:1 supervision needed to be a CNA to provide personal cares and assist with transfers and they needed to be within arm's reach of Resident #130.</p> <p>The facility did not provide ordered supervision and interventions to prevent Resident #130 from falling and wandering into other residents' rooms.</p> <p>ii. Resident #72 was admitted on 10/2/19, with diagnoses including a right hip replacement, Alzheimer's Disease, and a history of falling.</p> <p>A Fax Order Request/Notification form, dated 10/17/19, documented the physician ordered 1:1 supervision as needed for Resident #72.</p> <p>On 10/27/19 between 11:30 AM and 12:10 PM, Resident #72 was observed in a tilt back wheelchair in the dayroom on the 200 hall without 1:1 staff. Resident #72 was observed repositioning the leg rests and moving his legs over the side of the wheelchair.</p> <p>On 10/27/19 at 11:20 AM, LPN #1 said Resident #72 was supposed to have 1:1 supervision. At 11:30 AM, RN #4 also said Resident #72 was supposed to have 1:1 supervision. Both verified no one was assigned for 1:1 supervision as evidenced by the daily assignment sheet. RN #4 stated the facility used the tilt back wheelchair to attempt to prevent Resident #72 from falls or give</p>	F 725			

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F 725	<p>Continued From page 188</p> <p>staff enough time to get to him before he fell. LPN #1 and RN #4 said they were unaware of what "monitor per protocol" meant. The nurses also verified the order for "1:1 as needed" had no parameters.</p> <p>On 10/27/19 at 3:30 PM, CNA #1 said there was not enough staff for 1:1 supervision.</p> <p>On 10/27/19 at 3:40 PM and 3:50 PM, CNA #2 and CNA #3 respectively, confirmed there was not enough staff for 1:1 supervision.</p> <p>A Nurse's Progress Note, dated 10/27/19, documented Resident #72 propelled himself to the 100 unit via his manual wheelchair. The note documented Resident #72 entered the private room of another resident and attempted to self-transfer. The progress note further documented Resident #72 fell out of his wheelchair due to his inability to bear weight.</p> <p>Resident #72's physician order was for him to receive 1:1 supervision due to his frequent attempts to self-transfer and his poor memory.</p> <p>On 10/28/19 at 9:00 AM, RN #4 verified Resident #72 fell at 5:50 PM on 10/27/19 on another unit, in another resident's room.</p> <p>On 10/28/19 at 9:30 AM, Resident #72 was in a tilt back wheelchair in the 200 hall dayroom without staff present in the room. At 9:40 AM, a staff member pushed Resident #72 to a table in the dayroom and gave him a cup of coffee then left the room. At 9:43 AM, Resident #72 told a visitor he needed to go to the bathroom. The visitor informed a CNA, who stated she would be</p>	F 725			

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F 725	<p>Continued From page 189</p> <p>back. Resident #72 again told the visitor and another resident he needed to go to the bathroom. At 9:55 AM, another CNA came into the dayroom and removed him. The CNA returned Resident #72 to the dayroom in the tilt back wheelchair at 10:00 AM and left. There was no 1:1 staff with him. Resident #72 was moving the wheelchair around the dayroom from 10:00 AM to 10:40 AM with his legs hanging over the side of the wheelchair and dangling under the leg rests. At 10:40 AM, a CNA entered the dayroom and repositioned Resident #72 in the wheelchair. Resident #72 was observed continuously in the dayroom from 9:30 AM to 10:50 AM without 1:1 supervision by staff as ordered by the physician.</p> <p>A Nurse's Progress Note, dated 10/28/19 at 1:05 PM, documented Resident #72 was sitting at a table in the dayroom eating lunch when he pushed his wheelchair back and stood up. Resident #72 then sat himself on the edge of wheelchair cushion and slid off the cushion and onto the floor in between the footrests of his wheelchair. The note documented Resident #72 was assessed by the nurse and he denied pain, but there were two small reddened areas observed, one on his lower back and one on his left thigh. The note documented his physician was notified.</p> <p>On 10/30/19 at 3:14 PM, the Medical Director said the order for "1:1 as needed" was not a definitive order. He stated he was not notified of Resident #72's recent falls on 10/27/19 and 10/28/19.</p> <p>On 10/30/19 at 3:35 PM, the P.A. said she wrote an order for 1:1 supervision of Resident #72 due</p>	F 725			

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F 725	<p>Continued From page 190</p> <p>to his high fall risk. She stated she was instructed by E.D. #1 he would not pay for two residents on the same unit to have 1:1 supervision and she wrote the order as "as needed." The P.A. stated staff were not notifying her or documenting when Resident #72 fell.</p> <p>The facility did not provide the ordered supervision and interventions to prevent Resident #72 from falling.</p> <p>g. Residents did not receive showers and bathing consistent with their needs.</p> <p>The 200 Hall Daily Assignment Schedule for October 2019 included a section for the shower aide which was left blank on 10/1/19, 10/3/19, 10/5/19, 10/6/19, 10/9/19, 10/12/19, 10/13/19, 10/14/19, 10/17/19, 10/20/19, 10/21/19, 10/26/19, 10/27/19, and 10/30/19.</p> <p>On 10/31/19 at 3:06 PM, Shower Aide #2 said when she started working in the facility 2 months ago, she interviewed each resident on the unit to learn when residents preferred showers and created/documented a schedule. Shower Aide #2 said she worked in the facility Monday through Friday from 5:00 AM to 3:00 PM. She said she showered 15 people a day maximum, it varied due to resident bathing type preferences, and CNAs helped with transfers. Shower Aide #2 said twice weekly showers were planned for residents, Wednesdays were scheduled as open days to shower residents who had missed a shower, and if a resident refused, she informed the RN. Shower Aide #2 said she worked 10-11 hours a day and did not have time to provide showers twice a week, she offered showers once</p>	F 725			

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F 725	<p>Continued From page 191</p> <p>a week, and sometimes offered afternoon showers but the residents did not want that, they wanted a shower before breakfast.</p> <p>On 11/4/19 at 1:29 PM, Shower Aide #1 stated 4-5 month ago she started as the shower aide for Monday through Friday schedule. The weekend showers were to be completed by someone else, she said that did not happen. Six weeks prior to 10/31/19 she was on light duty, working as a hospitality aide. The facility did not schedule a shower aide for the week, but residents were scheduled 7 days a week to receive 2 showers per week unless the care plan documented specific times. If a resident missed a shower, the charge nurse was to be notified and the resident was added to the next day's list, which was kept in the shower room. If a shower was not completed, she would not document it, leaving the entry blank. Shower Aide #1 stated when she was on light duty the residents were not consistently receiving their showers because they did not have a shower aide scheduled or the shower aide was pulled to work the floor as a CNA.</p> <p>On 11/4/19 at 1:40 PM, RCM #2 stated the nursing scheduler was responsible to schedule the shower aides for each hall. RCM #2 stated he was unaware the residents on the 200 Hall were not receiving their showers twice a week when the shower aide was on light duty and was unable to perform the task as a shower aide.</p> <p>i. Resident #180 was admitted to the facility on 9/13/19, with multiple diagnoses including heart failure, respiratory failure with hypoxia (low oxygen level), chronic kidney disease, atrial</p>	F 725			

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F 725	<p>Continued From page 192</p> <p>fibrillation (irregular heartbeat), and Parkinson's disease (a progressive nervous system disorder that affects movement).</p> <p>Resident #180's admission MDS assessment, dated 9/20/19, documented he was cognitively intact, he required extensive assistance of one person for personal hygiene, and bathing did not occur during the assessment period.</p> <p>Resident #180's care plan documented he required extensive assistance from staff with bathing/showering 2 to 3 times per week, initiated on 9/25/19.</p> <p>Resident #180's ADL Reports for September and October 2019 documented he refused bathing on 9/15/19, 9/24/19, 9/25/19, and 10/30/19. He was not available on 10/16/19.</p> <p>There was no documentation of bathing being offered or performed from 9/16/19 through 9/24/19, 8 days. There was no documentation Resident #180 was offered or received a bath or shower from 9/26/19 through 10/29/19, 34 days.</p> <p>On 10/27/19 at 3:26 PM, Resident #180 was lying in bed. He appeared unshaven and disheveled. Resident #180's family member said he was not getting shaved and he did not appear clean.</p> <p>On 11/1/19 at 11:10 AM, the Regional Consultant Nurse said Resident #180 went 2 weeks without a documented shower, and she would see if there was additional documentation of showers elsewhere.</p>	F 725			

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F 725	<p>Continued From page 193</p> <p>On 11/4/19 at 9:49 AM, the DON said she expected each resident to be offered a shower twice a week.</p> <p>ii. Resident #20 was admitted to the facility on 5/4/18, with multiple diagnoses including diabetes mellitus, cerebral palsy (impaired muscle coordination), generalized muscle weakness, polyneuropathy (degeneration of nerves in extremities), and morbid obesity.</p> <p>A quarterly MDS assessment, dated 8/12/19, documented Resident #20 was cognitively intact, and required extensive physical assistance of 2 persons with transfers, dressing, toilet use, and physical assistance of 1 person with personal hygiene. Resident #20 had total dependence and required physical assistance of 1 person with bathing.</p> <p>Resident #20's Care Plan documented she was to receive a shower or bath twice a week per the shower schedule, date initiated 11/6/18.</p> <p>On 10/28/19 at 10:03 AM, Resident #20 was observed with greasy and uncombed hair. Resident #20 said she got a shower once a week, and had no options to ask for more, or when they were scheduled.</p> <p>On 10/30/19 at 3:31 PM, Resident #20 was observed with clean hair this day. Resident #20 said she got showers every Wednesday, and got a shower that day (10/30/19), but had not had one on Saturdays as scheduled. She said she refused a shower last Wednesday.</p> <p>On 10/31/19 at 3:05 PM, RCM #1 said Shower</p>	F 725			

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F 725	<p>Continued From page 194</p> <p>Aide #2 was in charge of showers on the 100 Hall and she would know more about them than herself.</p> <p>On 10/31/19 at 3:06 PM, Shower Aide #2 said Resident #20 got a shower once a week and PRN (as needed), she got a shower on Wednesdays, and if she refused it was documented. The DON joined the discussion and said Shower Aide #2's internal notes were reflected in the electronic record Task Notes. Regarding provision of twice weekly showers the DON asked Shower Aide #2 if she documented when residents refused, and Shower Aide #2 said no, she did not. Shower Aide #2 said Resident #20 "sometimes refused a shower, but the refusals were not documented." Shower Aide #2 said "I am only one person, I tried to get to them."</p> <p>The bathing Task Sheets documented Resident #20 had a shower on 9/27/19 at 10:00 AM, refused a shower on 9/30/19 at 11:30 AM, had a shower on 10/1/19 at 6:00 AM, on 10/11/19 at 1:59 PM, and on 10/16/19 at 2:30 PM.</p> <p>The Task Sheets documented Resident #20 went 9 days without a shower (10/2/19 - 10/10/19) and 13 days without a shower (10/17/19 - 10/29/19). The Task Sheets documented no PRN shower was provided to Resident #20 between her 10/16/19 and 10/30/19 showers. Resident #20 did not receive showers as documented on her care plan.</p> <p>On 10/31/19 at 3:25 PM, RCM #1 said the October shower task documented Resident #20 had not had showers twice a week per the care</p>	F 725			

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F 725	<p>Continued From page 195 plan.</p> <p>iii. Resident #61 was admitted to the facility on 8/1/19, with multiple diagnoses, including type 2 diabetes mellitus with a foot ulcer, lymphedema (edema in lower and upper extremities, due to removal or damage to lymph nodes), hypertension, and chronic pain.</p> <p>An admission MDS assessment, dated 8/8/19, documented Resident #61 was cognitively intact and she required extensive assistance for transferring from one person and set up only for bathing.</p> <p>Resident #61's care plan documented she required extensive assistance from one staff with showering twice weekly, and as necessary.</p> <p>Resident #61's September 2019 ADLs Report documented she did not receive a bath from 9/21/19 through 9/26/19, 6 days.</p> <p>On, 10/2/19 Resident #61 completed a Comment and Concern card: "We are constantly denied a shower. It has been a week this time and has been as many as 12-14 days. Hygiene is just as important to my healthcare..."</p> <p>On 10/28/19 at 10:32 AM, Resident #61 stated she was not consistently receiving showers twice a week as scheduled.</p> <p>On 11/6/19 at 4:37 PM, RCM #2 stated that according to the documentation Resident #61 did not receive showers twice a week as scheduled.</p> <p>iv. Resident #24 was admitted to the facility on</p>	F 725			

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F 725	<p>Continued From page 196</p> <p>7/9/13 with multiple diagnoses including dementia, generalized muscle weakness, and neuropathy (damage to the nerves outside of the brain and spinal cord which often causes weakness, numbness and pain).</p> <p>A quarterly MDS assessment, dated 8/17/19, documented Resident #24 was severely cognitively impaired, and required extensive physical assistance from 1 person with transfers, personal hygiene, and bathing.</p> <p>Resident #24's care plan documented she required extensive assistance of 1 staff with showering twice weekly and PRN. Resident #24 resided on 100 Hall, and Shower Aide #2 was her shower aide.</p> <p>The bathing Task Sheets documented Resident #24 was to receive a bath or shower twice weekly. The Task Sheets documented Resident #24 refused a shower on 10/23/19 at 11:45 AM, received a shower on 10/24/19 at 12:30 PM and on 10/30/19 at 10:59 AM, refused a shower on 11/6/19 at 12:31 PM, and received a shower on 11/7/19 at 10:59 AM.</p> <p>Resident #24 was not offered a shower and did not receive a shower from:</p> <ul style="list-style-type: none"> * 10/1/19 through 10/23/19, 22 days, * 10/31/19 to 11/6/19, 7 days <p>Resident #24 did not receive showers per her care plan.</p> <p>On 11/7/19, E.D. #2 said Resident #24 did not get 2 showers a week per her care plan.</p>	F 725			

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F 725	<p>Continued From page 197</p> <p>v. Resident #13 was admitted to the facility on 7/30/19, with multiple diagnoses, which included dementia and age-related physical debility.</p> <p>Resident #13's admission MDS assessment, dated 8/6/19, documented her cognition was intact and she required extensive assistance from one person for bathing.</p> <p>A significant change in status MDS assessment, dated 10/14/19, documented Resident #13 was severely cognitively impaired and required extensive assistance from two-persons while bathing.</p> <p>Resident #13's care plan, dated 8/12/19, documented extensive assistance of one staff for showering, twice a week and as necessary.</p> <p>Resident #13's August 2019 ADL Report documented she did not receive a bath from 8/1/19 through 8/8/19, 8 days.</p> <p>Resident #13's September 2019 ADL Report documented she did not receive a bath from 9/6/19 through 9/17/19, 12 days.</p> <p>Resident #13's October 2019 ADL Report documented she did not receive a bath from 10/5/19 through 10/24/19, 20 days.</p> <p>On 11/5/19 at 4:30 PM, the DON stated Resident #13 should have a bed bath 2 times a week since she did not want to get out of bed.</p> <p>vi. Resident #131 was admitted to the facility on 8/20/19, with multiple diagnoses including an</p>	F 725			

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F 725	<p>Continued From page 198</p> <p>unstageable necrotic (dead tissue) pressure ulcer to his sacrum (a triangular bone in the lower back situated between the two hipbones of the pelvis).</p> <p>An MDS assessment, dated 9/3/19, documented Resident #131 was moderately cognitively impaired and required extensive assistance from two people for bathing.</p> <p>Resident #131's care plan documented he required assistance from one person with showering twice weekly, and as necessary.</p> <p>Resident #131's August 2019 ADLs Report documented he did not receive a bath from 8/23/19 through 8/27/19, 5 days.</p> <p>Resident #131's September 2019 ADLs Report documented he did not receive a bath from 9/5/19 through 9/16/19, 12 days, and did not receive a bath from 9/18/19 through 9/29/19, 12 days.</p> <p>Resident #131's October 2019 ADLs Report documented his bathing schedule. Resident #131 did not receive bathing from 10/1/19 through 10/14/19, 14 days and from 10/16/19 through 10/27/19, 12 days.</p> <p>On 11/4/19 at 1:29 PM, Shower Aide #reviewed the showering task and stated Resident #131 did not receive showers 2 times a week as scheduled.</p> <p>vii. Resident #46 was admitted to the facility on 1/2/19, with multiple diagnoses including essential hypertension, dementia, and overactive bladder.</p>	F 725			

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F 725	<p>Continued From page 199</p> <p>An MDS assessment, dated 9/20/19, documented Resident #46 was cognitively intact and was totally dependent on one-person assistance for personal hygiene, including bathing.</p> <p>The care plan area addressing Resident #46's ADL care, revised 1/24/19, documented Resident #46 was to receive showers twice a week.</p> <p>Resident #46's September and October 2019 ADL Report documented she did not receive a bath from 9/4/19 through 9/10/19, 7 days. She also did not receive a bath from 9/25/19 through 10/7/19, 13 days.</p> <p>On 10/30/19 at 3:50 PM, E.D. #1 said the facility was facing a "staffing crunch." E.D. #1 said at times a shower aide was pulled from giving showers to work on the floor, but now they were "catching up on showers."</p> <p>h. Medications were not administered to residents at the times scheduled on their MARs or as ordered by their physicians. Examples include:</p> <p>* Resident #14 was eating lunch when RN #4 performed a blood sugar check and then gave him insulin, Novolog 11 units by subcutaneous injection. Resident #14's blood sugar was 291.</p> <p>Resident #14's record included orders for Novolog 7 units before meals for Type II diabetes mellitus. The orders also included a sliding scale for Novolog which stated if his blood sugar was 251-300 he was supposed to receive an</p>	F 725			

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F 725	<p>Continued From page 200 additional 6 units of Novolog by injection.</p> <p>Resident #14 did not receive his insulin prior to lunch as ordered by his physician for either dose. He also received a total of 11 units of Novolog when he was supposed to receive 13 units per his physician's sliding scale order.</p> <p>RN #4 stated the medication was given late it should have been given prior to Resident #14 having lunch.</p> <p>* At 12:40 PM, RN #4 administered the following medications to Resident #38:</p> <ul style="list-style-type: none"> - Keppra 1000 mg (an anti-seizure medication) - Tylenol 500 mg 2 tablets - Senna 8.6 mg (a laxative) - Docusate Sodium 100 mg (a stool softener) - Magnesium Oxide 400 mg (a supplement) - Brilinta 90 mg (a blood thinner to prevent the formation of new clots) - Coreg 6.25 mg (a medication used to treat high blood pressure and heart failure) - Lacosamide 100 mg (an anti-seizure medication) <p>* At 12:55 PM, RN #4 administered the following medications to Resident #380:</p> <ul style="list-style-type: none"> - Aspirin 81 mg - Colace 100 mg - Flovent HFA 220 mcg 2 puffs (an inhaled steroid to prevent asthma attacks) - Senna 8.6 mg - Coreg 12.5 mg - Potassium Chloride ER 10 mEq (an extended release potassium supplement) 	F 725			

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F 725	<p>Continued From page 201</p> <ul style="list-style-type: none"> - Torsemide 10 mg (a medication to reduce water retention) <p>RN #4 stated these were the morning medications, scheduled for 8:00 AM. She stated there were only two nurses on the unit for 43 residents, which was not enough to get medications to the residents on time. She stated physicians were not notified of medications being given so late.</p> <p>* On 11/1/19 beginning at 11:40 AM, RN #1 was observed administering the following medications for Resident #19 via a gastrostomy tube (a tube inserted directly into the stomach):</p> <ul style="list-style-type: none"> - Lamotrigine 200 mg (an anti-seizure medication) - Lisinopril 5 mg (a blood pressure medication) - Amantadine 15 ml (a medication used to prevent tremors) - Acetaminophen elixir 650 mg - Cal-gest 750 mg (a medication to reduce stomach acid) - Fish Oil 1000 mg - Ibuprofen 30 ml - Vitamin D3 5000 units - Metoprolol 25 mg (a blood pressure medication) - Lacosamide 20 ml - Systane Ultra eye drops, 1 drop each eye - Acetylcysteine 10% eye drops, 1 drop each eye - Fluorometholone 0.1% eye drops, 1 drop right eye - Restasis 0.05% eye drops, 1 drop each eye <p>At 12:30 PM, RN #3 administered Lantus insulin 40 units, which was scheduled to be given at 8:00 AM.</p>	F 725			

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F 725	<p>Continued From page 202</p> <p>RN #3 stated the medications were scheduled to be given at 8:00 AM.</p> <p>* On 11/01/19 at 12:20 PM, Resident #32 requested RN #3 check her blood sugar and give her insulin.</p> <p>At 1:10 PM, Resident #32 was eating her lunch in her room when RN #3 returned and checked her blood sugar, which was 231. RN #3 administered Humalog insulin 2 units via injection. Resident #32 was scheduled to receive the Humalog before meals.</p> <p>RN #3 stated the insulin was scheduled to be given prior to meals. *Resident #61's October 2019 MAR documented Humalog insulin sliding scale to be administered before meals and Novolog 55 units before meals.</p> <p>On 10/29/19 at 9:30 AM, RN #1 entered Resident #61's room and stated she was here to administer her medications and check her blood sugar. Resident #61 told RN #1 the other nurse checked it this morning before breakfast and it was 203. RN #1 told Resident #61 she needed to administer her Novolog insulin and she injected the insulin in Resident #61's right thigh and left the room. Resident #61 stated the Novolog was to be given prior to breakfast and she ate breakfast at 7:50 AM. Resident #61 stated the nurses were too busy and did not have enough time to administer all the morning medications to the residents in a timely manner.</p> <p>On 10/29/19 at 10:26 AM, Resident #61's MAR documented she received Humalog 7 units of her</p>	F 725			

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F 725	<p>Continued From page 203</p> <p>sliding scale based on the blood sugar of 203 and also received Novolog 55 units at the same time. RN #1 stated she had forgotten that LPN #2 told her this morning that Resident #61's blood sugar was 203. RN #1 stated she administered both the Humalog sliding scale of 7 units and the Novolog of 55 units together in one syringe for a total of 62 units. RN #1 stated the insulin doses were given late and should have been administered prior to her meals.</p> <p>*On 11/1/19 at 12:08 PM, the Medical Director stated the facility needed continuity of care and not a different nurse each day doing something differently or who does not have time to do the wound care. He said residents do not get the care they deserve. The Medical Director stated he talked to the DON and E.D. #1 on several occasions, as well as during QA (Quality Assurance) meetings to stop admissions until more staff was available to provide wound care and suggested an in house wound team to manage the wounds in the facility. He stated he has not received a response.</p> <p>i. The facility's policy for Facility Assessment, reviewed 2/4/19, stated the assessment must be reviewed and updated as necessary, and at least annually. The policy also stated the facility-wide assessment would be utilized to help determine sufficient nursing staff with the appropriate competencies and skills to provide nursing and related services in the facility.</p> <p>This policy was not followed.</p> <p>The Facility Assessment Tool documented it was updated on 10/27/19, the day of survey entrance.</p>	F 725			

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F 725	<p>Continued From page 204</p> <p>It was also documented the facility assessment was last reviewed with the QAA/QAPI committee on 10/29/17, 2 years prior. The name of a previous E.D. was crossed out, and the name of E.D. #1 was written in. The name of the previous DON was crossed out, and the name of the current DON was written in.</p> <p>The Facility Assessment Tool did not include sufficient information necessary to ensure residents' increased supervision needs were taken into consideration when determining the facility's staffing needs. Examples included the following:</p> <ul style="list-style-type: none"> - Part 1 of the Facility Assessment Tool documented the facility's average daily census was 98 residents and included assessment areas of common diagnoses, acuity, and ethnic, cultural, or religious factors. Part 1.7 of the Facility Assessment Tool documented "Describe other pertinent facts or descriptions of the resident population that must be taken into account when determining staffing and resource needs (e.g. residents' preferences with regard to daily schedules, walking, bathing, activities, naps, food, going to bed, etc.)." <p>The section documented, "The populations [sic] needs can vary depending on the ADLs and time/equipment needed to help perform these ADLs for patients."</p> <p>The section did not include additional information related to the specific individualized staffing needs of the residents in the facility (e.g. current residents' need for increased supervision due to falls risks, elopement risks, aggressive</p>	F 725			

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F 725	<p>Continued From page 205 behaviors, etc.).</p> <p>- Part 2 of the Facility Assessment Tool, documented "Resident Support/Care Needs ...List the types of care that your resident population requires and that you provide for your resident population. List by general categories, adding specifics as needed." The section of the Facility Assessment Tool included multiple categories which general information such as:</p> <p>* A "Mobility and fall/fall with injury prevention" category which stated "Transfer, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in doing as much of these activities by himself/herself."</p> <p>* A "Mental health and behavioral" category which stated "manage [sic] medical conditions for individuals with cog [cognitive] impairment, depression, PTSD, intellectual or psychiatric [sic]."</p> <p>The section did not include additional information related to the specific individualized staffing needs of the residents in the facility (e.g. current residents' need for increased supervision due to falls risks, elopement risks, aggressive behaviors, etc.).</p> <p>- Part 3 of the Facility Assessment Tool, stated "Resources." Part 3 included a "Staffing Plan" section which stated, "Based on your resident population and their needs for care and support, describe your general approach to staff to ensure that you have sufficient staff to meet the needs of the residents at any given time." The section listed staff positions and the total number of staff</p>	F 725			

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F 725	Continued From page 206 needed, as follows: *Licensed nurses providing direct care: 15 *Nurse aides: 35 *Other nursing personnel (e.g. those with administrative duties): 5 *Other staff needed in addition to nursing staff for behavioral healthcare and services: 3 *Dietitian or other clinically qualified nutrition professional: 2 *Food and nutrition staff: 15 *Respiratory care services staff: 1 The Facility Assessment Tool documented "Units are staffed per state requirements. Acuity is then looked at and additional staff is added per what is needed to provide quality care." The Facility Assessment Tool did not include additional information related to how the staffing numbers were determined or what monitoring took place to ensure the numbers were sufficient.	F 725			
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours	F 732		1/2/20	

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F 732	<p>Continued From page 207</p> <p>worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <p>(A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure the nurse staffing information was posted daily for each shift for 97 of 97 residents in the facility. This failed practice had the potential to affect all residents in the facility and their representatives, visitors, and those who wanted</p>	F 732	<p>Individual Residents: None were identified in this deficiency.</p> <p>Other Residents in similar situations: Residents have the potential to be effected by this practices, however, there were no noted concerns related to this</p>		

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F 732	<p>Continued From page 208</p> <p>to know the facility's staffing levels. Findings include:</p> <p>The facility's policy for Staffing, dated 4/24/19, stated "The facility must post the nurse staffing data...on a daily basis at the beginning of each shift." The policy stated, "The facility posts daily staffing information in a clear readable format in a prominent place that is easily accessible to residents and visitors at any given time."</p> <p>On Sunday 10/27/19 at 11:20 AM, the daily staffing for all three shifts for the entire facility was posted by the reception desk, and it was dated Friday, 10/25/19. The posted staffing information documented the following:</p> <ul style="list-style-type: none"> * For day shift, 1 RN, 4 LPNs, and 12 CNAs were scheduled. * For evening shift, 2 RNs, 6 LPNs, and 9 CNAs were scheduled. * For night shift, 1 RN, 2 LPNs, and 6 CNAs were scheduled. * The facility census was 102 residents. <p>On 10/27/19 at 12:45 PM, E.D. #1 said the facility census at that time was 100 residents.</p> <p>On Tuesday, 10/29/19 at 9:05 AM, the posted staffing for all three shifts was dated Monday, 10/28/19. The posted staffing information documented the following:</p> <ul style="list-style-type: none"> * For day shift, 2 RNs, 3 LPNs, and 12 CNAs were scheduled. * For evening shift, 2 RNs, 6 LPNs, and 11 CNAs were scheduled. * For night shift, no RNs, 3 LPNs, and 6 CNAs 	F 732	<p>upon review of the last 30-days of grievances.</p> <p>Measures to prevent reoccurrence: The Executive Director educated the facility leadership and staffing coordinator on the process for staff posting and updating to ensure that it is reflected timely each day.</p> <p>Ongoing Monitoring: The Weekend Manager or Executive Director will audit the staff posting daily x12 weeks to ensure compliance. Negative findings will be reviewed through QAPI x3 months.</p> <p>Individual to ensure compliance: The Executive Director will ensure compliance.</p>		

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

PRINTED: 12/31/2019
FORM APPROVED
OMB NO. 0938-0391

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F 732	Continued From page 209 were scheduled. * The facility census was 96 residents. On 10/29/19 at 9:24 AM, the DON said the census was 97 residents when the surveyors entered the facility on 10/27/19. The DON said the facility was starting a new process where the manager on duty was responsible to post the daily staffing, and she was not sure who was previously doing that. The facility's retained posted staffing records from 2/1/19 through 10/29/19, did not include documentation of posted staffing for 111 out of 300 opportunities. On 10/29/19 at 11:19 AM, the DON provided copies of the past 6 months of posted daily staffing, and she acknowledged there were days where the posted daily staffing was missing. On 10/30/19 at 3:50 PM, E.D. #1 said he was aware it was required to have the daily staffing posted, but he was not aware it was not being done.	F 732			
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		1/2/20	

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F 755	<p>Continued From page 210</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, it was determined the facility failed to ensure residents' medications were filled and delivered as ordered to meet the needs of each resident. This was true for 1 of 3 residents (Resident #61) reviewed for medications. This failure created the potential for Resident #61 to have complications from infection. Findings include: Resident #61 was readmitted to the facility on 8/1/19, with multiple diagnoses including diabetes and aftercare of an infected surgical incision to her right foot.</p>	F 755	<p>Individual Residents: Resident #61 received ordered medications and has had no negative outcome following the delay.</p> <p>Other Residents in similar situations: An audit was conducted of the last 7 days of physician ordered medications to verify that there was no delay in filling and receiving medication. Any delays were reported to the physician per policy.</p> <p>Measures to prevent reoccurrence: LNs were educated by the Director of</p>		

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F 755	<p>Continued From page 211</p> <p>Resident #61's admission orders, dated 8/1/19, documented Ampicillin-Sulbactam Sodium Solution reconstituted (antibiotic) 3 grams via IV (intravenously) every 6 hours until 8/8/19.</p> <p>The August 2019 MAR documented the times for the antibiotics were scheduled at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Resident #61 was to receive the first dose of the Ampicillin IV at 6:00 PM on 8/1/19. The August MAR documented Resident #61 did not receive the prescribed antibiotic from 8/1/19 at 6:00 PM to 8/6/19 at 12:00 PM, 5 days.</p> <p>The admission progress note, dated 8/1/19, documented LPN #2 verified the physician orders were received for the pharmacy to fill the medications. The progress note documented the pharmacy was going to fill the medications and send them out that night and the physician was notified the medications were going to be started later on 8/1/19.</p> <p>A Fax Order Request/Notification Form, dated Fiday, 8/1/19 at 6:40 PM, documented Resident #61 was admitted on 8/1/19 at 4:00 PM and the pharmacy would not be able to deliver her medications until later that night. The request form was signed by the physician on 8/5/19.</p> <p>The nurse's progress notes from 8/2/19 through 8/4/19, did not include documentation the physician or the pharmacy was notified Resident #61 did not receive 18 doses of the IV antibiotic medication for the infection of her right foot.</p> <p>On 10/28/19 at 10:30 AM, Resident #61 stated</p>	F 755	<p>nursing on filling and administering medications per orders. Education included how to order medications and notifying physician with any delays in administration. Pharmacy consultant provided ekit audit and inventory to ensure medications were available.</p> <p>Ongoing Monitoring: The Director of nursing and resident care managers will audit physician orders weekly x12 weeks to ensure timely administration and pharmacy fills. The pharmacy consultant will audit the ekit monthly x3 months to identify trends and increased needs of the facility. Negative findings of these audits will be reviewed through QAPI x3 months.</p> <p>Individual to ensure compliance: The Director of Nursing will ensure ongoing compliance.</p>		

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F 755	<p>Continued From page 212</p> <p>when she was readmitted to the facility on 8/1/19, the facility was delayed in treating her infection to her right foot with IV antibiotics.</p> <p>On 11/1/19 at 12:05 PM, the Medical Director stated the facility did not notify him the pharmacy was unable to provide the Ampicillin IV antibiotic for Resident #61 until 5 days later. The Medical Director stated there was a shortage of Ampicillin IV antibiotic and the pharmacy was unable to fill the order for Resident #61. The Medical Director stated he, or one of his colleagues, was on-call 24/7 and the pharmacy was on-call 24/7 and the antibiotic could have changed to a different one. The Medical Director stated there should not have been a delay in treatment for Resident #61's infection to her right foot.</p> <p>On 11/6/19 at 11:31 AM, LPN #1 provided an inventory list of medications in the emergency kit that should have been stocked in the facility. The inventory list, dated 8/27/19, documented Ampicillin-Sulbactam 3 grams was one of the medications stocked in the emergency kit. The inventory list documented the emergency kit did not have the Ampicillin-Sulbactam available at the time of Resident #61's readmission.</p> <p>On 11/6/19 at 11:41 AM, the DON stated the pharmacy delivered medications to the facility Monday through Friday at 5:00 PM and 12:30 AM, Saturdays at 5:00 PM, and no delivery on Sundays. The DON stated the pharmacy consultant came to the facility once a month to restock the emergency kit. The DON was unable to provide an inventory list of medications prior to 8/27/19. The DON stated the nurses should have notified the physician by phone and not by fax.</p>	F 755			

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F 755	Continued From page 213 The DON stated the pharmacy should have notified the facility right away if there was a shortage of the IV antibiotic and was unable to fill the prescription order.	F 755			
F 759 SS=F	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure the medication error rate was less than 5% for 32 of 35 medications, an error rate of 91.4%. This affected 5 of 6 residents (#14, #19, #32, #38, and #380) whose medication administration was observed. This failed practice placed residents at risk of not receiving medications as ordered by their physician and had the potential to affect the therapeutic levels and effectiveness of the medications administered. Findings include: According to the U.S. Food and Drug Administration (FDA) website, fda.gov, taking medications at the correct time and frequency is important because it could lead to worsening of disease, hospitalization, or an adverse event. The Nursing 2019 Drug Handbook stated the eight rights of medication administration were right drug, right patient, right dose, right time, right route, right reason, right response, and right documentation. The handbook stated to ensure	F 759	Individual Residents: Residents #14, 19, 32 and 38 had their medical records reviewed for negative outcomes related to delayed medication administration and none were noted. Resident #380 no longer resides in the facility. Other Residents in similar situations: Residents had the potential to be affected by this practice and medication administration times were reviewed and a flex medication policy was initiated. Measures to prevent reoccurrence: LNs were educated by the Director of Nursing or designee on compliance with medication pass timeliness and accuracy. A flexible medication policy was implemented within the center to adjust medication pass and meet individual needs. Policy was reviewed with Medical Director for appropriateness and agreed upon.	1/2/20	

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F 759	<p>Continued From page 214</p> <p>the drug was administered at the correct time and frequency.</p> <p>Medications were not administered to residents at the times scheduled on their MARs or as ordered by their physicians. Examples include:</p> <p>1. On 10/27/19 beginning at 12:15 PM, RN #4 was observed administering medications to Resident #14, Resident #38, and Resident #380.</p> <p>a. Resident #14 was eating lunch when RN #4 performed a blood sugar check and then gave him insulin, Novolog 11 units by subcutaneous injection. Resident #14's blood sugar was 291.</p> <p>Resident #14's record included orders for Novolog 7 units before meals for Type II diabetes mellitus. The orders also included a sliding scale for Novolog which stated if his blood sugar was 251-300 he was supposed to receive an additional 6 units of Novolog by injection.</p> <p>Resident #14 did not receive his insulin prior to lunch as ordered by his physician for either dose. He also received a total of 11 units of Novolog when he was supposed to receive 13 units per his physician's sliding scale order.</p> <p>RN #4 stated the medication was given late it should have been given prior to Resident #14 having lunch.</p> <p>b. At 12:40 PM, RN #4 administered the following medications to Resident #38:</p> <ul style="list-style-type: none"> - Keppra 1000 mg (an anti-seizure medication) - Tylenol 500 mg 2 tablets 	F 759	<p>Ongoing Monitoring: Medication pass completion will be audited weekly x12 to ensure compliance with timeliness as per physician orders. Negative findings of these audits will be reviewed through QAPI monthly x3.</p> <p>Individual to ensure compliance: The Director of Nursing will ensure ongoing compliance.</p>		

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F 759	<p>Continued From page 215</p> <ul style="list-style-type: none"> - Senna 8.6 mg (a laxative) - Docusate Sodium 100 mg (a stool softener) - Magnesium Oxide 400 mg (a supplement) - Brilinta 90 mg (a blood thinner to prevent the formation of new clots) - Coreg 6.25 mg (a medication used to treat high blood pressure and heart failure) - Lacosamide 100 mg (an anti-seizure medication) <p>c. At 12:55 PM, RN #4 administered the following medications to Resident #380:</p> <ul style="list-style-type: none"> - Aspirin 81 mg - Colace 100 mg - Flovent HFA 220 mcg 2 puffs (an inhaled steroid to prevent asthma attacks) - Senna 8.6 mg - Coreg 12.5 mg - Potassium Chloride ER 10 mEq (an extended release potassium supplement) - Torsemide 10 mg (a medication to reduce water retention) <p>RN #4 stated these were the morning medications, scheduled for 8:00 AM. She stated there were only two nurses on the unit for 43 residents, which was not enough to get medications to the residents on time. She stated physicians were not notified of medications being given so late.</p> <p>2. On 11/1/19 beginning at 11:40 AM, RN #1 was observed administering the following medications for Resident #19 via a gastrostomy tube (a tube inserted directly into the stomach):</p> <ul style="list-style-type: none"> - Lamotrigine 200 mg (an anti-seizure 	F 759			

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F 759	<p>Continued From page 216 medication)</p> <ul style="list-style-type: none"> - Lisinopril 5 mg (a blood pressure medication) - Amantadine 15 ml (a medication used to prevent tremors) - Acetaminophen elixir 650 mg - Cal-gest 750 mg (a medication to reduce stomach acid) - Fish Oil 1000 mg - Ibuprofen 30 ml - Vitamin D3 5000 units - Metoprolol 25 mg (a blood pressure medication) - Lacosamide 20 ml - Systane Ultra eye drops, 1 drop each eye - Acetylcysteine 10% eye drops, 1 drop each eye - Fluorometholone 0.1% eye drops, 1 drop right eye - Restasis 0.05% eye drops, 1 drop each eye <p>At 12:30 PM, RN #3 administered Lantus insulin 40 units, which was scheduled to be given at 8:00 AM.</p> <p>RN #3 stated the medications were scheduled to be given at 8:00 AM.</p> <p>3. On 11/01/19 at 12:20 PM, Resident #32 requested RN #3 check her blood sugar and give her insulin.</p> <p>At 1:10 PM, Resident #32 was eating her lunch in her room when RN #3 returned and checked her blood sugar, which was 231. RN #3 administered Humalog insulin 2 units via injection. Resident #32 was scheduled to receive the Humalog before meals.</p> <p>RN #3 stated the insulin was scheduled to be given prior to meals.</p>	F 759			

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F 760 SS=E	<p>Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)</p> <p>The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure medications were administered as ordered and at the appropriate time for 3 of 6 residents (#14, #19, and #38) who were observed during medication administrations. This failure placed the residents at risk of their medications being less effective and the therapeutic dose at low levels, which may increase the risk of seizures, high blood sugar, or heart attack. Findings include:</p> <p>The Nursing 2019 Drug Handbook stated the eight rights of medication administration were right drug, right patient, right dose, right time, right route, right reason, right response, and right documentation. The handbook stated to ensure the drug was administered at the correct time and frequency.</p> <p>1. Resident #14 was admitted to the facility on 12/29/16, with diagnoses which included atrial fibrillation (irregular heart beat), heart failure, high blood pressure, and diabetes mellitus.</p> <p>Resident #14's physician orders included 7 units of Novolog Insulin before meals and a sliding scale for additional Novolog Insulin to be given before meals and at bedtime based on his blood sugar results when checked at the bedside. The University of California San Francisco Medical</p>	F 760	<p>Individual Residents: Residents #14, 19 and 38 had their medical records reviewed for negative outcomes related to delayed medication administration and none were noted.</p> <p>Other Residents in similar situations: Residents had the potential to be affected by this practice and medication administration times were reviewed and a flex medication policy was initiated.</p> <p>Measures to prevent reoccurrence: LNs were educated by the Director of Nursing or designee on compliance with medication pass timeliness and accuracy. A flexible medication policy was implemented within the center to adjust medication pass and meet individual needs. Policy was reviewed with Medical Director for appropriateness and agreed upon.</p> <p>Ongoing Monitoring: Medication pass completion will be audited weekly x12 to ensure compliance with timeliness as per physician orders. Negative findings of these audits will be reviewed through QAPI monthly x3.</p>	1/2/20	

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F 760	<p>Continued From page 218</p> <p>Center website, accessed 11/29/19, states a sliding scale refers to the progressive increase in the pre-meal or nighttime insulin dose based on pre-defined blood glucose ranges by a physician. The sliding scale for Resident #14 was ordered as follows:</p> <ul style="list-style-type: none"> - Blood sugar of 0-149, no insulin - Blood sugar of 150-200, 2 units - Blood sugar of 201-250, 4 units - Blood sugar of 251- 300, 6 units - Blood sugar of 301-350, 8 units - Blood sugar of 351-400, 10 units - Blood sugar of 401+, 12 units and notify MD <p>According to the Mayo Clinic website, accessed 11/29/19, blood sugar should be tested before meals and at bedtime if using insulin to manage type 2 diabetes mellitus.</p> <p>On 10/27/19 at 12:15 PM, RN #4 was observed providing insulin to Resident #14. Resident #14 was eating lunch when RN #4 checked his blood sugar with a glucose meter and his blood sugar was 291. RN #4 then administered 11 units of Novolog via an injection. Resident #14 should have received 7 units of Novolog and an additional 6 units, per the sliding scale with his blood sugar reading, per his physician's orders.</p> <p>After RN #4 left Resident #14's room she stated the insulin and blood sugar reading were late and should have been done prior to lunch.</p> <p>2. Resident #38 was admitted to the facility on 11/30/18, with diagnoses which included high blood pressure and seizures.</p>	F 760	<p>Individual to ensure compliance: The Director of Nursing will ensure ongoing compliance.</p>		

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F 760	<p>Continued From page 219</p> <p>Resident #38's physician orders included Lacosamide 100 mg to be given twice a day for seizures, Kepra 1000 mg to be given twice a day for seizures, Brilinta 90 mg to be given twice a day for coronary artery disease, and Coreg 6.25 mg to be given twice a day for ischemic heart disease (less blood and oxygen to the heart from narrowed arteries).</p> <p>On 10/27/19 at 12:40 PM, RN #4 was observed administering the above medications to Resident #38.</p> <p>The Epilepsy Foundation of Chicago website, accessed 12/2/19, states it is particularly important to take anti-seizure medications as directed by the physician to ensure medication levels do not fall too low which places the patient at risk for seizures.</p> <p>Davis' Drug Guide, accessed on 12/2/19, states Coreg needs to be taken at the same time each and not to skip or double up on missed doses. The drug guide also stated abrupt withdrawal may precipitate life-threatening heart arrhythmias, high blood pressure, or heart attack.</p> <p>The manufacturer website for Brilinta, accessed on 12/2/19, states to take it exactly as instructed by the physician around the same time every day and not to take two doses at the same time if a dose is forgotten.</p> <p>RN #4 was interviewed after administering the medications and stated the above medications were scheduled for administration at 8:00 AM. She stated there were only two nurses on the unit for 43 residents, which was not enough to</p>	F 760			

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F 760	Continued From page 220 get medications to the residents on time. She stated physicians were not notified of medications being given so late. 3. Resident #19 was admitted to the facility on 5/23/18, with diagnoses which included seizures and high blood pressure. Resident #19's physician orders included Lamotrigine 200 mg two times a day for seizures, Lacosamide 20 ml two times a day for seizures, Metoprolol 25 mg two times a day for tachycardia (fast heart rate), and Lantus insulin 40 units via injection two times a day. Lantus insulin is a long-acting insulin which is to be given at the same time every day according to Drugs.com, accessed on 12/2/19. Lantus is intended to have a long duration of action over a 24-hour period of time to control blood sugar levels. On 11/1/19 at 11:40 AM, RN #1 was observed administering Lamotrigine, Lacosamide, and Metoprolol to Resident #19. After administering the medications RN #1 stated the medications were scheduled to be given at 8:00 AM. At 12:30 PM, RN #3 was observed administering Lantus insulin 40 units via injection. After administering the insulin RN #3 stated the insulin was scheduled to be given at 8:00 AM.	F 760			
F 761 SS=E	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	F 761		1/2/20	

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F 761	<p>Continued From page 221 instructions, and the expiration date when applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure medication refrigerator temperatures were routinely monitored. This was true for 1 of 2 medication refrigerators reviewed and had the potential to affect all residents who received medications which were stored in the medication refrigerator. This created the potential for harm if residents received vaccines or medications which had reduced efficacy from improper storage. Findings include: The facility's policy for Storage of Medications, Biologicals, Syringes, and Needles, revised on 4/5/19, stated "The facility should ensure that medications and biologicals are stored at their</p>	F 761	<p>Individual Residents: No individual residents were impacted by this practice.</p> <p>Other residents in similar situations: Residents had the potential to be affected, however, no noted concerns with this deficiency.</p> <p>Measures to prevent reoccurrence: LNs were educated by the director of nursing on ensuring that medication refrigerator temps were taken twice daily in accordance with policy and nursing standards.</p>		

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F 761	<p>Continued From page 222</p> <p>appropriate temperatures...Facility Staff should monitor the temperature of vaccines twice a day." The recommended temperatures for medications and biologicals were:</p> <ul style="list-style-type: none"> * Room temperature = 59 to 77 degrees Fahrenheit, or 15 to 25 degrees Celsius. * Refrigeration = 36 to 46 degrees Fahrenheit, or 2 to 8 degrees Celsius. * Freezer = -4 to 14 degrees Fahrenheit, or -20 to -10 degrees Celsius. <p>On 11/7/19 at 2:24 PM, the medication refrigerator in the 100 hall medication room was inspected in the presence of LPN #4. Upon review of the Temperature Log for Vaccines, dated November 2019, there were no temperatures or initials documented on 11/1/19, 11/2/19, and 11/3/19, and there was no information documented for the PM temperature checks on 11/4/19 and 11/5/19. There were multiple medications, including various forms of insulin, in the medication and vaccine refrigerator. LPN #4 said the temperature of the refrigerator should be checked every night shift, and it looked like it was not done for several days.</p> <p>On 11/7/19 at 5:30 PM, the DON reviewed the Temperature Log for Vaccines and said she thought the refrigerator temperature should be checked every day. The DON said the staff needed to do that more often.</p> <p>On 11/7/19 at 6:27 PM, the DON provided the Temperature Log for Vaccines, dated September 2019, which included September 16 through September 30. Upon review of the Temperature Log, there was no information documented on</p>	F 761	<p>Ongoing monitoring: Temperatures will be audited weekly x4 and monthly x2 by nursing management to ensure accuracy and completion. Findings will be submitted to the Director of Nursing for review and submitted to QAPI x3.</p> <p>Individual to ensure compliance: Director of Nursing will ensure ongoing compliance.</p>		

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F 761	Continued From page 223 9/27/19, 9/28/19, or 9/29/19. There were no temperatures or initials documented for the PM temperature checks for any day in September. On 11/7/19 at 6:38 PM, the DON said RCM #1 told her she could not find any other medication refrigerator temperature logs.	F 761			
F 812 SS=F	The facility did not provide documentation of the Temperature Log for Vaccines [and medications] from September 1 through 15, 2019, or for the month of October 2019. Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, it was determined the facility failed	F 812	Individual Residents: No individual residents were identified in	1/2/20	

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F 812	<p>Continued From page 224</p> <p>to provide safe and sanitary food storage and distribution for 97 of 97 residents who received dietary services from the facility's kitchen. This resulted in the potential for food borne illness to occur. Finding include:</p> <p>1. The facility's policy, titled Food Temperature Control, undated, stated hot food was to be maintained at 135 degrees Fahrenheit (F) or higher and cold food was to be held at or below 41 degrees F.</p> <p>Meal service was observed on 10/31/19 between 11:30 AM and 1:20 PM. The following was noted:</p> <ul style="list-style-type: none"> - A pan of pureed chicken was on the steam table and ready to serve. The temperature was 119 degrees F prior to meal service. Upon completion of the meal service, the pureed chicken was 109 degrees F. - A pan of ground chicken was 121.8 degrees F at end of meal service while held on the steam table. - The lemon cream pie was plated and on trays on a rolling cart. At the beginning of meal service, the pie was 46.4 degrees F. At the end of the meal service the pie was 44 degrees F. - A pitcher of V8 juice on the juice table was 53 degrees F, a pitcher of cranberry juice on the juice table was 51.8 degrees F, and a pitcher of lemonade on the juice table was 54.4 degrees F. <p>Additionally, the "Food Temperature Log" for 9/27/19 through 10/31/19 documented the beverages served were warmer than 41 degrees</p>	F 812	<p>this deficiency.</p> <p>Other residents in similar situations: Resident had the potential to be affected by this practice. A review of the last month of infection control line listing was completed with no negative trends related to foodborne illnesses noted.</p> <p>Measures to prevent reoccurrence: The Dietary department was educated by the Registered Dietician on food storage and safe temperatures for serving and holding food.</p> <p>Ongoing monitoring: Audits will be conducted weekly x12 on food temperatures with holding food and serving along with test tray completion. Audits will include food storage for expired items. Audits will be submitted to the Executive Director weekly x12 for review and negative findings will be reviewed in QAPI x3 months.</p> <p>Individual to ensure compliance: The Dietary Manager will ensure ongoing compliance.</p>		

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F 812	Continued From page 225 F for at least one meal service (of three) on 35 of 35 days. The Dietary Manager was interviewed on 10/27/19 at 2:30 PM. The Dietary Manager confirmed the hot and cold food items were held and served at inappropriate temperatures. 2. During a kitchen tour on 10/27/19 at 11:30 AM, the walk in refrigerator was observed to contain the following: - Five unopened cartons of honey thickened dairy drink with an expiration date of 4/2/19. - Five unopened cartons of honey thickened dairy drink with an expiration date of 5/5/19. On 10/27/19 at 11:30 AM, the Dietary Manager confirmed the items were available for resident use, and the facility had failed to remove the outdated items from potential resident use well beyond the expiration date.	F 812			
F 835 SS=1	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, review of grievances, and interviews with residents and staff, it was determined the facility failed to provide services that maintained residents' highest practicable level of well-being for 40 out	F 835	Individual Residents: Residents #4, 7, 8, 13, 14, 17, 18, 19, 20, 23, 24, 25, 28, 35, 38, 46, 53, 54, 57, 59, 61, 62, 65, 72 and 131 were interviewed to identify any new concerns not	1/2/20	

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F 835	<p>Continued From page 226</p> <p>of 40 residents (#4, #7, #8, #13, #14, #17, #18, #19, #20, #23, #24, #25, #28, #31, #32, #35, #36, #38, #46, #49, #53, #54, #57, #59, #61, #62, #65, #72, #75, #130, #131, #134, #180, #231, #333, #380, #430, #4311, #480, and #481) who were reviewed, and affected the other 57 residents in the facility. The administration failed to act when they had knowledge of issues and concerns pertaining to the receipt of appropriate care and services and lack of sufficient staff. Findings include:</p> <p>The facility's policy for Administrative Responsibility, dated 4/30/19, stated the E.D. was responsible for supervision and overall implementation of facility policies, with input from consultants, medical staff, and department staff. The policy also stated "The Executive Director will be responsible for all implications of the facility operation as it effects the residents, staff, families, and community." The responsibilities and duties of the E.D. included:</p> <ul style="list-style-type: none"> - Managing the ongoing functions within the facility. - Assuring the public information describing the facility's services was "accurate and fully descriptive." - Ensuring each resident's right to fair and equal treatment, self-determination, individuality, privacy, property and civil rights, including the right to file a complaint, was "strictly enforced." - Implementing established policies and procedures to remain in compliance with required laws, regulations, and guidelines. - Evaluating and implementing recommendation from committees within the facility. 	F 835	<p>previously identified or sufficiently addressed. Grievances were completed and addressed with individual residents as indicated.</p> <p>Residents #36, 49, 75, 130, 134, 180, 231, 333, 380, 430, 431, 480 and 481 no longer reside in the facility.</p> <p>Other residents in similar situations: Residents were affected by this practice. The Executive Director attended resident council to identify resident concerns related to care and services and provided education to council on the changes to the grievance process, leadership and systems that impact care.</p> <p>Measures to prevent reoccurrence: Education was provided to the facility staff by the Executive Director or designee on meeting the needs of residents and resident rights. Grievance education was completed and the new Executive Director assumed responsibility of this program. The Executive Director will attend council as invited to ensure resolution is addressed and satisfaction with system changes is made known.</p> <p>Ongoing monitoring: Audits will be conducted on grievances to verify timely completion and thorough resolution. Audits will be conducted weekly x12 weeks. Results of these audits will be trended and reviewed monthly through QAPI by the Executive Director. Regional oversight will monitor compliance with this process monthly x3</p>		

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F 835	Continued From page 227 This policy was not followed. Administration was aware of the issues and concerns with resident care and did not act to ensure residents attained and/or maintained physical, mental, and psychosocial well-being. Examples include: 1. On 10/30/19 at 3:50 PM, E.D. #1 said the facility was facing a "staffing crunch." E.D. #1 said at times a shower aide was pulled from giving showers to work on the floor, but now they were "catching up on showers." E.D. #1 said the facility needed CNAs and had not been successful in finding more CNAs. E.D. #1 said evening shift was difficult to cover, so they used agency staff. He said there were issues with the facility's staffing coordinator, so a new staffing coordinator was being brought on. E.D. #1 said overall the residents' care needed to be better, and other issues he was aware of included falls and wounds. E.D. #1 said the facility did not have a wound team or wound nurse at that time. E.D. #1 said call light response times and showers were also a concern, but the facility was not able to get more help due to a nationwide shortage of medical staff. E.D. #1 said when he received grievance cards, he gave a copy to the department head and they were to address the grievance and return the grievance card back to him. E.D. #1 said the RCMs were to come up with effective interventions regarding falls and accidents. E.D. #1 said he was aware of an RN working in the facility who was not licensed in Idaho, and she was kept from working on the floor until her license was "good," but the decision was made outside of his knowledge to let her work on the floor one shift without an	F 835	months. Please refer to other plans related to F725, 600, 686, 689, 677 and 684. Individual to ensure compliance: The Executive Director will ensure ongoing compliance.		

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F 835	<p>Continued From page 228</p> <p>appropriate license. On 10/31/19 at 8:47 AM, E.D. #1 said the residents were concerned with the amount of agency staff in the facility, and residents felt the regular staff knew them better.</p> <p>On 11/1/19 at 12:08 PM, the Medical Director stated the facility needed continuity of care and not a different nurse each day doing something differently or who does not have time to do the wound care. He said residents do not get the care they deserve. The Medical Director stated he talked to the DON and E.D. #1 on several occasions, as well as during QA (Quality Assurance) meetings to stop admissions until more staff was available to provide wound care and suggested an in house wound team to manage the wounds in the facility. He stated he has not received a response.</p> <p>On 10/30/19 at 4:15 PM, the P.A. stated she notified E.D. #1 and the DON provider orders were not being processed in a timely manner. On 11/5/19 at 11:17 AM, the P.A. said in January 2019 the E.D. separated from the facility and things got worse. The P.A. said the new E.D. (E.D. #1) requested only positive attitudes from staff and would fire those who complained.</p> <p>Staff were interviewed and stated there was not sufficient staff to provide the cares required and to meet the needs of the residents.</p> <p>- On 10/27/19 at 11:25 AM, CNA #12 stated she had worked at the facility for two years and was transferred to work in Activities for the past six months. CNA #12 stated that today was not her normal shift; she was held over due to short staffing. CNA #12 stated the facility was short of</p>	F 835			

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

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F 835	<p>Continued From page 229</p> <p>staff for a while now. When asked about how this staff shortage affected resident care, CNA #12 stated, "You'd have to ask management about that." When asked how it affected her ability provide care for her residents, CNA #12 stated, "You'll have to talk with management about any staffing issues."</p> <p>- On 10/28/19 at 2:53 PM, CNA #3 said a lot of staff recently quit, resulting in use of agency staff who were unfamiliar with the residents. CNA #3 said E.D. #1 was notified of the staffing concerns, and he "did not want to hear it." CNA #3 said during the previous night there were 2 CNAs working on her hall until 5:30 AM, and when both aides were assisting a resident at the same time there was nobody to watch the floor. CNA #3 also said at times there was only 1 CNA on the 300 hall. CNA #3 said she brought her concerns to the DON and was told to "work short" with a smile. CNA #3 said resident care suffered due to lack of staff.</p> <p>- On 10/29/19 at 4:52 PM, the DON said the facility had some struggles with staffing.</p> <p>- On 10/30/19 at 2:10 AM, CNA #11 stated she was assigned to work at the facility the past month. CNA #11 stated the facility did not provide her with any training related to its policies and procedures, or where certain items, like the automatic external defibrillators, were located or with instructions on how to use the overhead paging system.</p> <p>- On 10/30/19 at 2:30 AM, CNA #9 stated she was hired by the facility four to five months ago, and that the first night she worked, "I was thrown</p>	F 835			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2019
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F 835	<p>Continued From page 230</p> <p>to the floor because an agency CNA did not show up" for work. CNA #9 stated that she then had "three to five days training" with two of the facility's experienced CNAs before working her shift independently.</p> <p>- On 11/4/19 at 1:15 PM, RN #4 stated the facility had not provided CPR or "code" training since the departure of the previous E.D. in January 2019. RN #4 added that the facility did not provide agency staff orientation training specific to the building and residents. RN #4 stated "There is a book at each nurses' station that includes information on the agency staffs' responsibilities, but that's all."</p> <p>During an observation on 10/30/19 at 2:05 AM, E.D. #1 was standing outside of Resident #130's doorway and Resident #130 was sleeping in bed. E.D. #1 stated he was assigned as Resident #130's 1:1 supervision for the night shift from 10:00 PM to 6:00 AM. E.D. #1 stated he was not a CNA. E.D. #1 stated he notified the CNA assigned to the hall to assist Resident #130 with personal cares. E.D. #1 stated he was there to assure Resident #130 did not wander into another resident's room. There was one CNA and one LPN assigned to 42 residents on the 200 hall for the night shift.</p> <p>2. The facility's Grievance Procedures and Concern and Comment Program, effective date 5/6/19, documented the policies and procedures, including:</p> <p>* The Social Services staff and/or the E.D. was responsible for the following: - Maintaining a recordkeeping system of all</p>	F 835			

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F 835	<p>Continued From page 231</p> <p>complaints reported via Concern & Comment Program or any other means of reporting that included the steps taken to investigate the grievance and a statement as to whether the grievance was confirmed or not confirmed.</p> <p>* Administrative staff were responsible for the following: - The appointed manager would contact the concerned party within 24 hours, to share the status of the investigation and resolution.</p> <p>* E.D. and/or Designee were responsible for the following: - Ensuring that all grievances and Concern & Comment Reports were reviewed and addressed in a timely and appropriate manner and that concerned individuals felt that some type of resolution had been communicated, achieved and maintained. - Collaborating with the interdisciplinary team to identify and address repeated concerns from residents and families.</p> <p>The completed Concern & Comment Forms, known as "the blue cards," stated, "A facility manager will contact you as soon as possible to discuss the concern, and any subsequent investigation and measures to resolve the concern." The back side of the card with the facility response included space to write the name of the person designated to investigate and follow-up with the concern, the date/time the concerned party was initially contacted, investigation findings, actions taken to resolve/respond to the concern, the date/time the findings/action plan was shared with the concerned party, and the concerned party's</p>	F 835			

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F 835	<p>Continued From page 232 response to the action outcome, and space for the E.D.'s signature and date.</p> <p>The Resident Council filed grievances regarding call light wait times as follows:</p> <ul style="list-style-type: none"> - The blue card, dated 6/19/19, documented the grievance was filed on behalf of the Resident Council, and described the concern as "residents feel call lights are getting to be slower lately", and they reported the concern to a staff member. The facility documented the person designated to investigate/follow-up with the concern was the MDS Coordinator, and investigation findings were: "Have received multiple C/O [complaints] call light wait times; will address in QAPI 7/9/19." Actions taken were documented as: "Audit completed, we are addressing the call light response time, Angel Rounds [implemented]." Date findings/action plan shared with the concerned party was documented as: next Resident Council meeting. The document was signed by E.D. #1 on 7/16/19. - The blue card, dated 7/17/19, documented the grievance was filed on behalf of the Resident Council, and described the concern as: "[Resident Council] would like us to do our audits at off times, like during meals and after meals when residents want to lay down, to show us just how long they really have to wait for help." It was documented the complaint was reported to a staff member. The facility documented the person designated to investigate/follow-up with the concern was the MDS Coordinator, and investigation findings were: "Talked with department heads about doing call light audit with PM Manager." Actions Taken: "See above." 	F 835			

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F 835	<p>Continued From page 233</p> <p>Date findings/action plan was shared with concerned party documented as the next Resident Council meeting. The document was signed by E.D. #1 on 9/11/19.</p> <p>- The blue card, dated 8/14/19, documented the grievance was filed on behalf of the Resident Council, provided resident name as "100 and 200 Hall", and described the concern as: "call lights are still slow to answer," and that the concern was reported to a staff member. The facility documented the person designated to investigate/follow-up with the concern was the MDS Coordinator. The blue card did not document a date/time of initial contact with the concerned party (Resident Council President) and the investigation findings were: "Work in progress, this needs to be all team members, See QAPI." Actions taken were documented as: "Off hour call light audits continuing with PM Managers." The date the action was shared with the concerned parties and their response was not documented. The document was signed by E.D. #1 without a date.</p> <p>Two Comment and Concern blue cards, dated 10/2/19, were completed by Resident #61 regarding lack of staff assistance. On one she wrote: "I have never been treated so poorly. The last two nights I had my call light on for more than two hours without any assistance. I went out to the [200 hall] nurse's station and no one could be found. Is anyone even working here anymore? I even called the facility and the phone rang 25 times and no answer." She wrote on the blue card that she reported the concerns to two nurses on the 200 Hall. There was no facility response included on the card copy.</p>	F 835			

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F 835	<p>Continued From page 234</p> <p>On Resident #61's second blue card, dated 10/2/19, she wrote: "We are constantly denied a shower. It has been a week this time and has been as many as 12-14 days. Hygiene is just as important to my healthcare. I am disappointed in the overall care I have gotten during my stay this time. I have always requested Post Falls Life Care." She wrote she reported the concern to two nurses on the 200 Hall. There was no facility response included on the card copy.</p> <p>On 10/29/19 at 10:16 AM, the Resident Council meeting attendees had these comments regarding grievances: Resident #32 said "They do not respond to the blue cards." Resident #61 said she "gave [blue cards] to the CFO on 10/2/19. I had not heard back. There is no response if the administration doesn't respond." Resident #333 said "I was never made aware of where to file my concerns/complaints."</p> <p>On 11/7/19 at 1:38 PM, regarding the grievance procedure, Resident #61 said people were now reluctant to complete a blue card - residents were turning in blue cards but when nothing happened, no action was taken, they quit filing them. Resident #61 said she filed two grievances on 10/2/19 regarding her inability to get a response when she sought assistance and lengthy delays between showers. Resident #61 said she completed two blue cards, received no answers, and no explanation was provided to her. Resident #61 said E.D. #1 "fired staff who expressed concerns, he just wanted it to be happy."</p> <p>3. Please refer to F725 as it related to lack of</p>	F 835			

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F 835	Continued From page 235 sufficient staff to meet residents' needs, placing residents in immediate jeopardy. 4. Please refer to F600 as it related to failure to ensure residents are free from abuse, placing residents in immediate jeopardy. 5. Please refer to F686 as it related to failure to provide treatment and services to prevent and heal pressure ulcers, placing residents in immediate jeopardy. 6. Please refer to F689 as it related to failure to provide 1:1 supervision, resulting in falls with injury, wandering into other residents' rooms, and elopement, placing residents in immediate jeopardy. 7. Please refer to F677 as it related to failure to provide bathing and showers to meet the residents' needs. 8. Please refer to F684 as it related to failure to provide care and services in a manner which enhanced and promoted each resident's highest practicable physical, mental, and psychosocial health and well-being.	F 835			
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and	F 838		1/2/20	

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F 838	<p>Continued From page 236</p> <p>update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:</p> <p>§483.70(e)(1) The facility's resident population, including, but not limited to,</p> <ul style="list-style-type: none"> (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. <p>§483.70(e)(2) The facility's resources, including but not limited to,</p> <ul style="list-style-type: none"> (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; 	F 838			

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F 838	<p>Continued From page 237</p> <p>(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and</p> <p>(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.</p> <p>§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, Facility Assessment review, and staff interview, it was determined the Facility Assessment failed to; thoroughly evaluate the staff resources and competencies need to care for the resident population to meet each resident's care and service needs and to review and update the assessment at least annually. These failures place residents at risk for unidentified and unmet care and behavioral needs, infection, and a diminished quality of life. This was true for 5 of 5 residents (#8, #36, #72, #130, and #231) who required increased supervision due to behavioral symptoms and had the potential to affect the remaining 92 residents in the facility. This failure created the potential for residents to experience falls and other adverse events due to the facility's failure to provide the staff resources necessary to appropriately supervise residents. Findings include:</p> <p>1. The facility's Facility Assessment policy, reviewed 2/4/19, documented the purpose was "To provide guidance to facilities in the</p>	F 838	<p>Individual Residents:</p> <p>Resident #8 had increased supervision initiated and maintained to ensure safety. Resident #72 had one to one supervision initiated. Residents #36, 130 and 231 no longer reside in the facility.</p> <p>Other residents in similar situations: Residents had the potential to affected by this practice. A review of the last 14 days of incidents and grievances was completed to ensure that there were no noted trends related to supervision.</p> <p>Measures to prevent reoccurrence: Facility leadership was educated by the Executive Director on the regulations related to the Facility Assessment. The facility assessment was updated and reviewed through the QAPI committee and ensured supervision, staffing and competencies were addressed.</p>		

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F 838	<p>Continued From page 238</p> <p>development of a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies."</p> <p>a. The Facility Assessment policy documented, "The facility must conduct and document a facility-wide assessment. This assessment must be reviewed and updated as necessary, and at least annually."</p> <p>The Facility Assessment Tool provided by the facility documented the following: The name of a previous E.D. was crossed out, and the name of E.D. #1 was written in. The name of the previous DON was crossed out, and the name of the current DON was written in. The date of the assessment or update was 11/16/2017 with a line marked through the date, then 10/27/19 was written in.</p> <p>The Facility Assessment Tool was not updated annually.</p> <p>b. The Facility Assessment policy documented the facility assessment must address or include:</p> <ul style="list-style-type: none"> - The care required by the resident population. - Staff competencies necessary to provide the level and type of care needed for the resident population. - All personnel, their education/training, and any competencies related to resident care. <p>The Facility Assessment policy also documented, "The facility-wide assessment will be utilized to help determine sufficient nursing staff with the appropriate competencies and skills sets to</p>	F 838	<p>Ongoing monitoring: The Executive Director will review incidents, grievances, council minutes and the facility assessment through the monthly QAPI meeting to ensure compliance and identification of trends and changes needed within the center. The assessment will be updated at a minimum annually and as needed with system changes.</p> <p>Individual to ensure compliance: The Executive Director will ensure ongoing compliance.</p>		

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F 838	<p>Continued From page 239</p> <p>provide nursing and related services in the facility." The facility's policy for Staffing, dated 4/24/19, also documented the facility utilized the Facility Assessment to determine staffing levels needed to ensure residents' needs were met.</p> <p>Resident #8, #36, #130, #72, and #231's records documented they required increased supervision, as follows:</p> <ul style="list-style-type: none"> - Resident #8 required every 15-minute checks due to elopement behaviors. - Resident #36 required frequent safety checks every 30-minutes due to falls. - Resident #72 required monitoring "per protocol" and 1:1 observation as needed due to falls. - Resident #130 required 1:1 supervision due to falls. - Resident #231 required standby assistance with transfers and ambulation due to falls. <p>However, the Facility Assessment Tool did not include sufficient information necessary to ensure residents' increased supervision needs were taken into consideration when determining the facility's staffing needs. Examples included the following:</p> <ul style="list-style-type: none"> - Part 1 of the Facility Assessment Tool documented the facility's average daily census was 98 residents and included assessment areas of common diagnoses, acuity, and ethnic, cultural, or religious factors. Part 1.7 of the Facility Assessment Tool documented "Describe other pertinent facts or descriptions of the resident population that must be taken into account when determining staffing and resource needs (e.g., residents' preferences with regard to 	F 838			

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F 838	<p>Continued From page 240 daily schedules, walking, bathing, activities, naps, food, going to bed, etc.)."</p> <p>The section documented, "The populations [sic] needs can vary depending on the ADLs and time/equipment needed to help perform these ADLs for patients."</p> <p>The section did not include additional information related to the specific individualized staffing needs of the residents in the facility (e.g., current residents' need for increased supervision due to fall risks, elopement risks, aggressive behaviors, etc.).</p> <p>- Part 2 of the Facility Assessment Tool, documented "Resident Support/Care Needs ...List the types of care that your resident population requires and that you provide for your resident population. List by general categories, adding specifics as needed." The section of the Facility Assessment Tool included multiple categories which general information such as:</p> <p>* A "Mobility and fall/fall with injury prevention" category which stated "Transfer, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in doing as much of these activities by himself/herself."</p> <p>* A "Mental health and behavioral" category which stated "manage [sic] medical conditions for individuals with cog [cognitive] impairment, depression, PTSD, intellectual or psychiatric [sic]."</p> <p>The section did not include additional information related to the specific individualized staffing</p>	F 838			

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F 838	<p>Continued From page 241</p> <p>needs of the residents in the facility (e.g., current residents' need for increased supervision due to falls risks, elopement risks, aggressive behaviors, etc.).</p> <p>- Part 3 of the Facility Assessment Tool, titled, "Resources" included a "Staffing Plan" section which stated, "Based on your resident population and their needs for care and support, describe your general approach to staff to ensure that you have sufficient staff to meet the needs of the residents at any given time." The section listed staff positions and the total number of staff needed, as follows:</p> <ul style="list-style-type: none"> *Licensed nurses providing direct care: 15 *Nurse aides: 35 *Other nursing personnel (e.g. those with administrative duties): 5 *Other staff needed in addition to nursing staff for behavioral healthcare and services: 3 *Dietitian or other clinically qualified nutrition professional: 2 *Food and nutrition staff: 15 *Respiratory care services staff: 1 <p>The Facility Assessment Tool documented "Units are staffed per state requirements. Acuity is then looked at and additional staff is added per what is needed to provide quality care." The Facility Assessment Tool did not include additional information related to how the staffing numbers were determined or what monitoring took place to ensure the numbers were sufficient.</p> <p>Facility records documented Residents #8, #36, #130, #172, and #231 experienced adverse outcomes including falls, aggressive behaviors</p>	F 838			

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854		
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F 838	<p>Continued From page 242</p> <p>toward other residents and staff, elopement, incontinence, lack of assistance with activities of daily living, and lack of receiving wound treatment and medications timely.</p> <p>- Part 3 of the Facility Assessment Tool included a "Staff Training/Education and Competencies" section which documented staff trainings were conducted multiple times each month with all staff. Individual training was conducted one on one with the manager as needed. Evaluations were performed periodically to determine whether the employee was meeting standards set by the facility. The Health Care Academy (a web-based venue that provides courses for training post-acute care workers) was used to train staff throughout the month.</p> <p>The Facility Assessment did not document the specific staff competencies, education, and/or training, and it did not document how the facility ensured professional standards of practice were met as directed by the facility's Facility Assessment Policy.</p> <p>On 11/7/19 at 9:38 AM, E.D. #2 said she expected the Facility Assessment was reviewed annually and as needed, and it was not reviewed annually. E.D. #2 said the Facility Assessment did not meet her expectations, and it could be expanded and improved.</p> <p>2. Please refer to F725 as it related to lack of sufficient staff to meet residents' needs, placing residents in immediate jeopardy.</p> <p>3. Please refer to F600 as it related to failure to ensure residents are free from abuse, placing</p>	F 838			

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F 838	Continued From page 243 residents in immediate jeopardy. 4. Please refer to F686 as it related to failure to provide treatment and services to prevent and heal pressure ulcers, placing residents in immediate jeopardy. 5. Please refer to F689 as it related to failure to provide 1:1 supervision, resulting in falls with injury, wandering into other residents' rooms, and elopement, placing residents in immediate jeopardy. 6. Please refer to F677 as it related to failure to provide bathing and showers to meet the residents' needs.	F 838			
F 839 SS=E	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on review of staff schedules, policy review, and staff interview, it was determined the facility failed to ensure nursing staff possessed a license within the state where they provided care. This was true for 1 of 5 nurse licenses reviewed, and had the potential to affect all 97 residents in the facility. This failure created the potential for harm if residents received inappropriate care due	F 839	Individual Residents: No individual residents were identified in this deficiency. Other residents in similar situations: Residents had the potential to be affected by this practice. An audit of current licensed staff was completed to ensure	1/2/20	

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F 839	<p>Continued From page 244</p> <p>to a nurse lacking the required credentials to provide nursing care. Findings include:</p> <p>The facility's policy for Professional Credentials, dated 11/28/16, documented the following:</p> <ul style="list-style-type: none"> * All associates possessed and maintained the required professional credentials needed to comply with applicable laws and regulations. * "If it is determined that the associate does not possess the necessary credentials or the credentials have lapsed, expired, or otherwise prevent the associate/individual from practicing, the associate/individual should not be allowed to deliver care or otherwise function in the capacity requiring the credential." * The Facility Department Director (such as the DON) validated the appropriate credentials of the candidate during the pre-hiring process and before interviewing the candidate. The state license/credential was printed, dated, and initialed and a copy placed in the associate's personnel file. <p>A License Verification Report, dated 10/29/19, documented RN #3 was authorized to practice as an RN in Washington state. There was no documentation she was authorized to practice as an RN in Idaho.</p> <p>Review of the facility's staff schedules and employee time punches documented the following:</p> <ul style="list-style-type: none"> * On 10/11/19, RN #3 clocked in from 6:00 PM to 6:00 AM on 10/12/19. * On 10/15/19, RN #3 clocked in from 5:57 PM to 6:30 AM on 10/16/19. 	F 839	<p>that there was no further non-compliance and none were noted.</p> <p>Measures to prevent reoccurrence: Director of nursing, Staffing coordinator and AP/Payroll were educated on license verification process to ensure that licensed staff had accurate and State specific licensure prior to working.</p> <p>Ongoing monitoring: The AP/Payroll manager will verify licenses monthly x3 and submit findings to the Executive Director for review. Licenses will also be audited upon hire to ensure that no associate is scheduled to work without proper licensure. Findings of these audits will be reviewed through QAPI monthly x3 months.</p> <p>Individual to ensure compliance: The Executive Director will ensure ongoing compliance.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 839	<p>Continued From page 245</p> <ul style="list-style-type: none"> * On 10/17/19, RN #3 clocked in from 5:52 PM to 6:20 AM on 10/18/19. * On 10/19/19, RN #3 clocked in from 5:42 PM to 7:35 AM. * On 10/23/19, RN #3 clocked in from 5:40 PM to 6:30 AM. * On 10/24/19, RN #3 clocked in from 5:49 PM to 8:25 AM. <p>No other RNs were scheduled or clocked in for night shift on 10/18, 10/23, or 10/24/19.</p> <p>On 10/29/19 at 11:06 AM, the DON said it was discovered on 10/25/19 that RN #3 was not licensed in Idaho, and she had been removed from the schedule. The DON said there was a delay between the date RN #3 was originally hired and when she actually started working due to an injury, and Human Resources was responsible for verifying her licensure. The Regional Director of Clinic Services said RN #3 worked one day by herself on 10/24/19 on night shift. The Regional Director of Clinic Services said the scheduler thought RN #3 had a Washington State compact license, which she did not think existed, and RN #3 was in the process of obtaining an Idaho license when she was put on the schedule.</p> <p>On 10/30/19 at 3:50 PM, E.D. #1 said he was aware of an RN working in the facility who was not licensed in Idaho, and she was kept from working on the floor until her license was "good" but the decision was made outside of his knowledge to let her work on the floor one shift without an appropriate license.</p> <p>On 11/1/19 at 2:58 PM, LPN #4 said RN #3</p>	F 839			

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F 839	Continued From page 246 worked in the facility for approximately 2 weeks, she provided resident care, and the last few shifts she worked unsupervised.	F 839			
F 865 SS=I	<p>QAPI Prgm/Plan, Disclosure/Good Faith Atmpt CFR(s): 483.75(a)(2)(h)(i)</p> <p>§483.75(a) Quality assurance and performance improvement (QAPI) program.</p> <p>§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;</p> <p>§483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>§483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, review of grievances, review of I&A Reports, review of staffing schedules, review of Quality Assessment and Performance Improvement (QAPI) meeting minutes, and interviews with residents and staff, it was determined the facility failed to ensure the QAPI program was effectively implemented. This failure directly impacted 40 out of 40 residents (#4, #7, #8, #13, #14, #17, #18, #19, #20, #23, #24, #25, #28, #31, #32, #35, #36, #38, #46, #49, #53, #54, #57, #59, #61, #62, #65, #72, #75, #130,</p>	F 865	<p>Individual Residents: Residents #4, 7, 8, 13, 14, 17, 18, 19, 20, 23, 24, 25, 28, 35, 38, 46, 53, 54, 57, 59, 61, 62, 65, 72 and 131 were interviewed to identify any new concerns related to care and services and grievances were initiated per policy. Residents # 36, 49, 75, 130, 180, 231, 333, 380, 40, 431, 480 and 481 no longer reside in the facility.</p> <p>Other residents in similar situations:</p>	1/2/20	

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F 865	<p>Continued From page 247</p> <p>#131, #134, #180, #231, #333, #380, #430, #4311, #480, and #481) who were reviewed, and affected the other 57 residents in the facility. As a result, the facility failed to implement improvement actions to resolve identified patient care concerns necessary to ensure each resident's well-being and safety were maintained. Findings include:</p> <p>The facility's QAPI Plan, dated 11/15/17, stated "The decision making within the facility will be driven by quality assurance performance improvement principles. These decisions will assist in promoting quality of care and quality of life of residents." The QAPI Plan was signed by a previous E.D.</p> <p>The facility's QAPI Meeting Minutes from 2/21/19 through 10/4/19 were reviewed. The meeting minutes identified concerns with an increase in grievances, call light issues, skin assessments, increase in incident reports, and facility staffing, without documented corrective action being taken to resolve the issues, as follows:</p> <p>1. The facility's QAPI Plan, dated 11/15/17, stated "The QAPI program focuses on safety while striving to achieve successful clinical interventions and outcomes."</p> <p>The QAPI Meeting Minutes, dated 2/21/19, documented an increase in reportable incidents. There was no action plan to address the reportable incidents.</p> <p>The QAPI Meeting Minutes, dated 3/13/19, documented there was a significant increase in incident reports and state reportable incidents. It</p>	F 865	<p>Residents had the potential to be affected by this practice. A review of the last 30 days of grievances and manager rounds was completed to identify trends with facility practices, staffing, grievance process and general care.</p> <p>Measures to prevent reoccurrence: Facility leadership was educated by the Executive Director of the QAPI program and practices. Monthly QAPI meetings were initiated to ensure that appropriate tracking and trending was implemented and action is taken by committee.</p> <p>Ongoing monitoring: The QAA committee will review the results of the monthly QAPI meeting to ensure compliance with program standards and progress towards identification and trending of resident concerns and facility practices.</p> <p>Individual to ensure compliance: The Executive Director will ensure ongoing compliance.</p>		

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F 865	<p>Continued From page 248</p> <p>was documented the facility received previous citations related to abuse/neglect and thorough investigations. There was no action plan to address the increase in incident reports and state reportable incidents</p> <p>The QAPI Meeting Minutes, dated 7/9/19 and 10/4/19 did not include information related to resident abuse, neglect or reportable incidents.</p> <p>Please refer to F600 where an Immediate Jeopardy was identified as it relates to the facility's failure to ensure 8 residents (Residents #4, #7, #32, #35, #61, #62, #333 and #480) were free from verbal abuse and staff intimidation when reporting verbal abuse.</p> <p>2. The facility's QAPI Plan, dated 11/15/17, documented the QAPI committee had the responsibility of planning, designing, implementing, and coordinating care and services for residents.</p> <p>The QAPI Meeting Minutes, dated 2/21/19, documented an increase in skin issues. There was no action plan to address the increase in skin issues.</p> <p>The QAPI Meeting Minutes, dated 3/13/19, documented it continued to be necessary to provide frequent reminders to perform skin assessments. There was no action plan to address the need to remind staff to perform skin assessments.</p> <p>The QAPI Meeting Minutes, dated 7/9/19 and 10/4/19, did not include information related to skin issues.</p>	F 865			

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F 865	Continued From page 249 Please refer to F686 where an Immediate Jeopardy was identified as it relates to the facility's failure to ensure 4 residents (#13, #36, #131, and #134) received treatment and services to prevent and heal pressure ulcers. 3. The facility's QAPI Plan, dated 11/15/17, documented the QAPI committee chose associates to "...participate in performance improvement projects. The committee will follow the progress, provide any necessary input and will ensure that the staff members have the appropriate resources." The QAPI Meeting Minutes, dated 2/21/19, documented the facility continued to struggle with 24-hour RN coverage for night shift. Agency staff were utilized due to the facility's difficulty in meeting staffing needs. There was an increase in grievances, and call lights were noted as an issue. The facility continued to rely on agency staff in an attempt to meet staffing needs. There was no documented action plan to address the facility's staffing needs, the residents' grievances, and concerns regarding call lights. The QAPI Meeting Minutes, dated 3/13/19, documented there were 24 grievances for the month, and the greatest trend was care complaints related to call light response times. It was documented the facility received a previous citation related to RN coverage, and state requirements included 24-hour RN coverage for a census of 90 or greater. There was no action plan to address the residents' complaints, call light response times, or the facility's staffing needs.	F 865			

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F 865	<p>Continued From page 250</p> <p>The QAPI Meeting Minutes, dated 7/9/19, documented Resident Council trends/needs included call lights. There was no action plan to address the Resident Council issues regarding call light response times or staffing needs.</p> <p>The QAPI Meeting Minutes, dated 10/4/19, documented staff missed lunches, causing overtime. There was no action plan to address the facility's staffing needs.</p> <p>Please refer to F725 where an Immediate Jeopardy was identified as it relates to the facility's failure to ensure there was sufficient staff to prevent adverse outcomes including supervision, ADL needs, medication administration, and answer call lights in a timely manner for residents, for 26 residents (#4, #7, #13, #14, #17, #19, #20, #23, #24, #25, #32, #35, #46, #49, #53, #59, #61, #62, #65, #72, #130, #131, #180, #333, #380, and #480).</p> <p>4. The facility's QAPI Plan, dated 11/15/17, documented the QAPI program focused on safety while aiming to achieve successful clinical interventions and outcomes.</p> <p>The QAPI Meeting Minutes from 2/21/19 to 10/4/19 did not document discussion of 1:1 supervision, falls, wandering, or elopement. There was no action plan to address resident safety.</p> <p>Please refer to F689 where an Immediate Jeopardy was identified as it relates to the facility's failure to provide 1:1 supervision, resulting in falls with injury, wandering into other</p>	F 865			

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F 865	<p>Continued From page 251 residents' rooms, and elopement, for 5 residents (#8, #36, #130, #172, and #231).</p> <p>On 10/30/19 at 3:50 PM, E.D. #1 said the facility was facing a "staffing crunch." E.D. #1 said at times a shower aide was pulled from giving showers to work on the floor, but now they were "catching up on showers." E.D. #1 said the facility needed CNAs and had not been successful in finding more CNAs. E.D. #1 said evening shift was difficult to cover, so they used agency staff. He said there were issues with the facility's staffing coordinator, so a new staffing coordinator was being brought on. E.D. #1 said overall the care needed to be better, and other issues he was aware of included falls and wounds. E.D. #1 said the facility did not have a wound team or wound nurse at that time. E.D. #1 said call light response times and showers were also a concern, but the facility was not able to get more help due to a nationwide shortage of medical staff. He said when he received grievance cards, he gave a copy to the department head and they were to address the grievance and return the grievance back to him. E.D. #1 said the RCMs were to come up with effective interventions regarding falls and accidents. He said he was aware of an RN who did not have a license for Idaho, and she was kept from working on the floor until her license was "good," but the decision was made outside of his knowledge to let her work on the floor one shift without an appropriate license.</p> <p>On 11/8/19 at 9:13 AM, E.D. #2 said the latest QAPI meeting was in October, and she was guessing there were previous issues that were not worked through QAPI because there were</p>	F 865			

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F 865	Continued From page 252 still problems identified during the current survey. E.D. #2 said the facility was aware of areas that needed improvement, including accidents, medications, skin issues, comments and concerns, abuse, and grievances. E.D. #2 said the QAPI meeting notes documented staffing was addressed in October, and there were activities addressing resident council concerns, psychotropic medication management, and infection control. On 11/14/19 at 2:30 PM, E.D. #2 said there was no additional information for the QAPI Meeting Minutes from 2/21/19 through 10/4/19. The facility failed to ensure an effective QAPI program was implemented and maintained to address identified priorities. The facility failed to identify issues and concerns which were likely to cause serious harm, impairment, or death through its QAPI program.	F 865			
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:	F 880		1/2/20	

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F 880	<p>Continued From page 253</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</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>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2019
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854		
(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	Continued From page 254 §483.80(a)(4) A system for recording incidents 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, staff interview, and policy review, it was determined the facility failed to ensure staff performed hand hygiene and follow professional standards of practice during medication pass and dressing changes. This was true for 4 of 11 residents (Resident #18, #19, #61, and #131) who were observed for infection control. These failures placed residents at risk for infection due to cross contamination and exposure. Findings include: The facility's Hand Hygiene policy, revised 7/25/19, stated hand hygiene was the single most important procedure in preventing infection. The policy referred to the Lippincott Procedures online manual for further guidance. The Lippincott Procedures stated hand hygiene was performed before direct patient contact, before putting on gloves, after contact with a patient, when moving from a contaminated body site to a clean body site during patient care, after contact with body fluids, nonintact skin, or wound dressings, and after removing gloves.	F 880	Individual Residents: Residents #18, 19, 61 and 131 were reviewed through the infection control line listing tracking to identify any potential negative outcomes secondary to hand washing and none were noted. Other residents in similar situations: A review of the last month's line listing was completed to determine if there were any negative trends related to hand washing and none were noted. Measures to prevent reoccurrence: LNs were educated by the Director of Nursing on proper hand washing techniques with treatments and medication administration. Competencies were completed in these areas and hand washing observations to ensure compliance. Ongoing monitoring:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2019
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F 880	<p>Continued From page 255</p> <p>This policy was not followed.</p> <p>1. On 10/27/19 at 4:14 PM, RN #1 was observed performing a wound dressing change for Resident #131's sacral wound (buttock area). RN #1 washed her hands and put on gloves then removed Resident #131's incontinent brief. The incontinent brief was saturated with a large amount of serous (yellowish tan in color) drainage and there was no dressing on Resident #131's sacral wound. RN #1 tucked the saturated incontinent brief under Resident #131's buttocks with her gloved hands. RN #1 did not remove her gloves or perform hand hygiene after she tucked the dirty incontinent brief under Resident #131. She then cleansed the sacral wound with normal saline, sprinkled collagen powder onto the unchanged glove of her left hand and sprinkled it over the wound bed. RN #1 removed her gloves and replaced them with a clean pair of gloves without washing her hands. She then packed three 4 x 5 inch Aquacel AG dressings (moisture-retention dressing that has antimicrobial properties) into the wound bed, applied skin prep (a liquid barrier) to the skin around the wound, and secured with two Alleevyn (an adhesive foam dressing) dressings. RN #1 removed her gloves and washed her hands.</p> <p>On 10/27/19 at 4:50 PM, RN #1 stated she should have removed her gloves, washed her hands, and applied a clean pair of gloves after she tucked Resident #131's saturated incontinent brief under his buttocks, after she cleansed his wound with normal saline, and after she applied the collagen powder to Resident #131's wound bed.</p>	F 880	<p>LN's will have competencies completed on medication pass and treatments to include hand washing upon hire, annually and as needed. Additionally, 5 LN's will have competencies completed for the next 3 months. Infection control trends will be reviewed monthly through QAPI to identify trends and additional education.</p> <p>Individual to ensure compliance: The Director of Nursing will ensure ongoing compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2019
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F 880	Continued From page 256 2. On 10/28/19 at 10:03 AM, RN #1 was observed changing the dressing to the bottom of Resident #61's right foot. RN #1 washed her hands and applied clean gloves to provide wound care to Resident #61. She cleansed the wound with normal saline, then packed Aquacel AG into the wound bed, then wrapped Resident #61's right foot and leg with an UNNA boot (compression dressing). RN #1 removed her gloves and washed her hands. RN #1 stated she should have washed her hands and applied clean gloves after she cleansed Resident #61's right foot. 3. On 11/1/19 at 10:15 AM, RN #3 was observed outside of Resident #18's room in the hallway, at the medicine cart. RN #1 approached the medicine cart and stated she was going to administer the medications for RN #3. RN #3 left the area and RN #1 began dispensing the remainder of Resident #18's medication into the plastic medication cup which contained eight medications. RN #1 did not wash her hands before dispensing the medications and did not wash her hands before giving the medications to Resident #18. At the conclusion of the administration of the medications RN #1 confirmed she did not wash her hands prior to administering the medications to Resident #18. 4. On 11/1/19 at 11:40 AM, RN #1 was observed while administering medications to Resident #19. RN #1 put on gloves, without washing her hands, then administered Resident #19's eye drops. RN #1 administered 1 drop of Systane Ultra to both	F 880			

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

PRINTED: 12/31/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2019
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F 880	Continued From page 257 eyes, then with the same gloves on, she administered fluorometholone (FML) 0.1% 1 drop in the right eye of Resident #19. RN #1 then administered 1 drop of Restasis 0.05% to both eyes. On 11/1/19 at 12:05 PM, RN #1 confirmed she did not wash hands or change gloves between giving the eye drops.	F 880			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2019
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854
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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiency was cited during the state licensure survey conducted at the facility from October 27, 2019 through November 8, 2019.</p> <p>The surveyors conducting the survey were:</p> <p>Cecilia Stockdill, RN, Team Coordinator Jenny Walker, RN Sallie Schwartzkopf, LCSW Michael Brunson, RN</p>	C 000		
C 763	<p>02.200,02,c,iii When Average Census 90 or More</p> <p>iii. In SNFs with an average occupancy rate of ninety (90) or more patients/residents a registered professional nurse shall be on duty at all times.</p> <p>This Rule is not met as evidenced by: Based on the Three-Week Nursing Schedule and review of employee time punches, it was determined the facility failed to ensure a Registered Nurse (RN) was staffed on all shifts when the resident census was 90 and greater. This was true for 1 out of 21 days of daily staffing reviewed from 10/6/19 through 10/26/19. Findings include:</p> <p>The Three-Week Nursing Schedule completed by the facility documented there was no RN scheduled on night shift on 10/22/19, and the resident census was 97. Review of employee time punches did not document an RN clocked in during the night shift on 10/22/19.</p> <p>The facility did not provide documentation an RN was scheduled during the night shift on 10/22/19.</p>	C 763	<p>Individual Residents: No individual residents identified in these deficiencies.</p> <p>Other residents in similar situations: Residents had the potential to be affected by this practice. A review of the last 30 days of grievances was conducted to identify trends related to staffing and follow up was initiated as needed.</p> <p>Measures to prevent reoccurrence: The staffing coordinator and director of nursing were educated on the Idaho requirements related to RN coverage. The facility evaluated the staffing pattern and RN availability and adjusted as needed. Recruitment efforts were</p>	1/2/20

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
12/12/19

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2019
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF POST FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854
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C 763	<p>Continued From page 1</p> <p>On 10/28/19, the scheduler said she was aware of the requirement to have an RN for all shifts when the resident census was 90 or greater. The scheduler said it was possible there were some shifts where an RN was not scheduled, and she would have to review the employee time punches to be sure.</p> <p>On 10/29/19 at 10:10 AM, the DON said the required RN coverage for the facility's population was 24 hours a day. On 10/29/19 at 4:52 PM, the DON said it was possible there was no RN coverage for night shift on 10/22/19, and the facility had struggles with staffing. On 10/30/19 at 11:44 AM, the DON said there was no RN coverage for night shift on 10/22/19.</p> <p>On 10/30/19 at 3:50 PM, E.D. #1 said the facility had a "staffing crunch." E.D. #1 said the facility was required to have an RN 24 hours per day when the resident census was above 90, and the facility did not have that consistently.</p>	C 763	<p>re-initiated with sign on bonuses and additional advertising.</p> <p>Ongoing monitoring: The Executive Director will monitor compliance with this requirement when applicable through the daily staffing meeting and stand up meeting. Recruitment and retention efforts will be reviewed monthly through QAPI to identify trends and needed actions. Findings will be reviewed through QAPI x3 months.</p> <p>Individual to ensure compliance: The Executive Director will ensure ongoing compliance.</p>	



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
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FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

January 16, 2020

Stephanie Bonanzino, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Bonanzino:

On **October 27, 2019** through **November 8, 2019**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The survey was investigated in conjunction with an annual recertification survey. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00008116

ALLEGATION #1:

The facility failed to ensure residents were free from abuse.

FINDINGS #1:

Grievances and Incident and Accident Reports were reviewed for the past 6 months. The records of 9 residents were reviewed. Interviews were conducted with 5 residents and 2 resident representatives. A resident council interview was conducted with 14 residents in attendance. Six staff members were interviewed. Staff interactions with residents were observed throughout the facility during the survey.

Stephanie Bonanzino, Administrator
January 16, 2020
Page 2 of 2

A grievance from May 2019 documented a resident had concerns regarding his care in the facility, including being hurt. It was documented the concerned party's response to the facility's action plan was "hesitant and concerned." During record review, resident interviews, and resident representative interviews, it was six residents had concerns regarding staff abuse and/or voicing concerns regarding staff interactions due to fear of retaliation. During the resident council interview, 3 residents voiced concerns regarding how they were treated by staff.

One resident's record documented he had a hip fracture and was recovering from surgery related to the fracture. He was protective of his leg, and did not want to turn or be repositioned due to pain when he was turned. There was no documentation of resident/resident representative concerns regarding specific staff interactions or behaviors causing him pain. The resident's representative stated his family member was unable to provide staff names, dates, or times when staff handled him roughly. When asked to describe the staff member who caused the resident's pain, the resident's representative stated one staff member was very large and was mean, and another staff member was very thin.

Based on the investigative findings, the allegation was substantiated due to allegations of verbal abuse and residents being fearful to report verbal abuse found during the survey. Please refer to F600 as it relates to abuse and placing residents in immediate jeopardy.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj

Stephanie Bonanzino, Administrator
January 16, 2020
Page 3 of 2



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
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E-mail: fsb@dhw.idaho.gov

March 24, 2020

Stephanie Bonanzino, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Bonanzino:

On **November 8, 2019**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008210

ALLEGATION:

The facility failed to ensure sufficient numbers of staff were present to meet residents' needs.

FINDINGS:

During the survey, observations were conducted, resident records were reviewed, policies were reviewed, facility grievances were reviewed, Incident and Accident reports were reviewed, staffing schedules were reviewed, residents and family were interviewed, and staff were interviewed.

The facility's policy for Staffing, dated 4/24/19, stated the facility maintained adequate staff on each shift to meet residents' needs and utilized the Facility Assessment to determine staffing levels needed to ensure residents' needs were met. This policy was not followed.

Eleven residents and one family member were interviewed, 11 staff were interviewed, a Resident Council interview was conducted with 14 residents in attendance. The Resident Council expressed concerns regarding lengthy call light response times and assistance with meals which were not addressed by the facility. Several residents stated the facility was short staffed and they had to wait for a long time to get assistance. Residents also stated they were afraid to say anything to staff for fear of retaliation, they often felt rushed by staff, and they felt threatened by staff 's communication with them.

Several staff stated the facility was short staffed and when it was discussed or brought forward to administration they did not listen to the staff 's concerns. On 10/30/19 at 3:50 PM, the Executive Director said the facility was facing a "staffing crunch." He said at times a shower aide was pulled from giving showers to work on the floor, but now they were "catching up on showers." The Executive Director said the facility needed CNAs and had not been successful in finding more CNAs. He said evening shift was difficult to cover, so they used agency staff.

Grievances and Incident and Accident Reports were reviewed for the previous 6 months. The daily staffing scheduled was reviewed for the previous 3 weeks. Observations were conducted of resident care and staff present throughout the facility during the survey.

Upon record review, observations, and resident and staff interviews, six residents experienced adverse outcomes related to inadequate staffing to meet resident's needs. Residents experienced falls, aggressive behaviors, elopement, incontinence, lack of assistance with activities of daily living, and lack of receiving wound treatment and medications timely. Seven residents did not receive a bath or shower consistent with their needs.

Based on the investigative findings, the allegation was substantiated, and federal citations were issued at F725 related to the facility's failure to ensure there were sufficient numbers of competent staff to meet the needs of the residents which resulted in the identification of immediate jeopardy of serious harm, impairment or death. The facility was cited at F686 related to its failure to ensure the prevention, development, and worsening of pressure ulcers which resulted in the identification of immediate jeopardy of serious harm, impairment, or death. The facility was cited at F684 as it related to their failure to ensure residents were provided care and services in a manner which enhanced and promoted each resident's highest practicable physical, mental, and psychosocial health and well-being. The facility was also cited at F755 related to the facility's failure to ensure residents' medications were filled and delivered as ordered to meet the needs of each resident and F759 related to the facility's failure to ensure medications were given as ordered.

Stephanie Bonanzino, Administrator
March 24, 2020
Page 3 of 3

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,

A handwritten signature in cursive script, appearing to read "Belinda Day".

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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E-mail: fsb@dhw.idaho.gov

March 24, 2020

Stephanie Bonanzino, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Bonanzino:

On **November 8, 2019**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008223

ALLEGATION #1:

The facility failed to ensure sufficient numbers of staff were present to meet residents' needs.

FINDINGS #1:

During the survey, observations were conducted, resident records were reviewed, policies were reviewed, facility grievances were reviewed, Incident and Accident reports were reviewed, staffing schedules were reviewed, residents and family were interviewed, and staff were interviewed.

The facility's policy for Staffing, dated 4/24/19, stated the facility maintained adequate staff on each shift to meet residents' needs and utilized the Facility Assessment to determine staffing levels needed to ensure residents' needs were met. This policy was not followed.

Eleven residents and one family member were interviewed, 11 staff were interviewed, a Resident Council interview was conducted with 14 residents in attendance. The Resident Council expressed concerns regarding lengthy call light response times and assistance with meals which were not addressed by the facility. Several residents stated the facility was short staffed and they had to wait for a long time to get assistance. Residents also stated they were afraid to say anything to staff for fear of retaliation, they often felt rushed by staff, and they felt threatened by staff 's communication with them.

Several staff stated the facility was short staffed and when it was discussed or brought forward to administration they did not listen to the staff 's concerns. On 10/30/19 at 3:50 PM, the Executive Director said the facility was facing a "staffing crunch." He said at times a shower aide was pulled from giving showers to work on the floor, but now they were "catching up on showers." The Executive Director said the facility needed CNAs and had not been successful in finding more CNAs. He said evening shift was difficult to cover, so they used agency staff.

Grievances and Incident and Accident Reports were reviewed for the previous 6 months. The daily staffing scheduled was reviewed for the previous 3 weeks. Observations were conducted of resident care and staff present throughout the facility during the survey.

Upon record review, observations, and resident and staff interviews, six residents experienced adverse outcomes related to inadequate staffing to meet resident's needs. Residents experienced falls, aggressive behaviors, elopement, incontinence, lack of assistance with activities of daily living, and lack of receiving wound treatment and medications timely. Seven residents did not receive a bath or shower consistent with their needs.

Based on the investigative findings, the allegation was substantiated, and federal citations were issued at F725 related to the facility's failure to ensure there were sufficient numbers of competent staff to meet the needs of the residents which resulted in the identification of immediate jeopardy of serious harm, impairment or death. The facility was also cited at F684 as it related to their failure to ensure residents were provided care and services in a manner which enhanced and promoted each resident's highest practicable physical, mental, and psychosocial health and well-being and F689 as it related to the facility's failure to provide adequate supervision.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

Stephanie Bonanzino, Administrator
March 24, 2020
Page 3

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

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day". The signature is written in dark ink and is positioned above the typed name.

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
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March 24, 2020

Stephanie Bonanzino, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Bonanzino:

On **November 8, 2019**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008266

ALLEGATION:

Residents were not notified of receiving a roommate or of a room change.

FINDINGS:

The records of two residents were reviewed, including a closed record (meaning the resident had been discharged from the facility). Grievances were reviewed for the previous six months. A resident and a family representative were interviewed. A resident council interview was conducted with 14 residents in attendance.

There were no documented concerns regarding residents receiving a roommate or a room change without notification. There were no concerns expressed by residents or their representative regarding notification of receiving a roommate or a room change. One resident's record documented he was notified of receiving a roommate and he did not want a roommate. The facility offered him a private room on another hallway and the resident approved of the move rather than having a roommate.

Stephanie Bonanzino, Administrator
March 24, 2020
Page 2 of 4

The licensed social worker (LSW) stated residents were informed prior to receiving a new roommate. The LSW stated when the resident does not want a roommate other options are offered to accommodate current residents.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 24, 2020

Stephanie Bonanzino, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Bonanzino:

On **October 27, 2019** through **November 8, 2019**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008285

ALLEGATION #1:

The facility failed to provide adequate supervision and staffing to ensure residents' needs were met.

FINDINGS #1:

During the survey, resident records were reviewed, observations were conducted, facility policies were reviewed, grievances were reviewed, staffing schedules were reviewed, and interviews were conducted with residents, family, and staff.

The facility's policy for Staffing, dated 4/24/19, stated the facility maintained adequate staff on each shift to meet residents' needs and utilized the Facility Assessment to determine staffing levels needed to ensure residents' needs were met.

The records of 32 residents were reviewed. One resident's record included a progress note which stated she had exited the facility and set off a door alarm.

The resident was followed out to the parking lot by a Certified Nursing Assistant (CNA) and the resident told the CNA her son was waiting for her in the car, which he was not. The CNA used a cell phone to contact other staff for assistance. The resident's record included documentation of an Elopement Risk Evaluation which stated she was at risk for elopement due to dementia and hallucinations, dated the same day as the above incident. The resident's care plan identified her exit seeking, or elopement, and included interventions to redirect her if she was heading towards the doors and if wearing a coat or jacket to reassure her she was in the right place, allow her to express her desire to go home, and assist with calling her son if that was she was exit seeking.

On 10/30/19 at 2:25 AM, a Licensed Practical Nurse (LPN) stated the resident was outside of the facility after dark. The LPN stated she saw the resident walk by the nurses' station about 8:15 PM with her coat on. The LPN said she was unaware the resident left the facility. At about 8:45 PM, a staff person returned with the resident stating she was found knocking on the side door. The weather was cold, and it was dark outside. The LPN stated there was one LPN and one CNA on the unit to care for 42 residents.

On 10/30/19 at 2:00 AM, there was one CNA and one LPN on the 200 hall to care for 42 residents. One LPN and two CNAs were on the 100 hall to care for 43 residents. An Executive Director (ED) was in the facility standing outside of a resident's room providing 1:1 supervision. At 2:42 AM, a CNA said she had not yet seen all of her assigned residents. At 2:55 AM, another CNA said a resident door was to be checked every 15 minutes. She said the checks were not being done because the corporate person who was doing the checks left.

Eleven residents and one family member were interviewed. One resident stated staff made her feel degraded and had "made me cry" in the last month, the last time was about two weeks ago. She said staff talked down to her and acted like she was "out of bounds" with them. Another resident stated resident stated that meals were not always served on time, her pain medication and other medications were not administered on time, and that scheduled showers were not routinely provided.

Twelve staff were interviewed. The first ED said the facility was facing a "staffing crunch." He said at times a shower aide was pulled from giving showers to work on the floor, but now they were "catching up on showers." The ED said the facility needed CNAs and had not been successful in finding more CNAs. He said evening shift was difficult to cover, so they used agency staff.

During review of facility grievances one resident wrote, "I have never been treated so poorly. The last two nights I had my call light on for more than two hours without any assistance. I went out to the 200 Hall nurse's station and no one could be found.

Is anyone even working here anymore? I even called the facility and the phone rang 25 times and no answer." She wrote on the blue card that she reported the concerns to two nurses on the 200 Hall.

The 200 Hall Daily Assignment Schedule for October 2019 included a section for the shower aide which was left blank on 10/1/19, 10/3/19, 10/5/19, 10/6/19, 10/9/19, 10/12/19, 10/13/19, 10/14/19, 10/17/19, 10/20/19, 10/21/19, 10/26/19, 10/27/19, and 10/30/19. On 11/4/19 at 1:40 PM, a Resident Care Manager (RCM) stated the nursing scheduler was responsible to schedule the shower aides for each hall. He stated he was unaware the residents on the 200 Hall were not receiving their showers twice a week when the shower aide was on light duty and was unable to perform the task as a shower aide.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F725 as it related to the facility's failure to ensure there were sufficient numbers of competent staff to meet supervision, ADL needs, medication administration, and answer call lights in a timely manner for residents.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility did not provide 1:1 supervision as ordered for residents.

FINDINGS #2:

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

The records of 32 residents were reviewed, two of the records documented the residents required 1:1 supervision by staff.

One resident's record, who required 1:1 supervision, documented he had a history of falls and a fracture related to a fall. A fax, documented the resident was found sitting on the floor, with no clothes on, after sitting on the garbage can to have a bowel movement. It indicated the resident was to be monitored per protocol. The form dated 10/17/19 indicated the resident was to receive 1:1 observation as needed.

On 10/27/19 starting at 11:30 AM and continuing until 12:10 PM the resident was observed in a tilt back wheelchair in the dayroom on the 200 unit without any 1:1 observation by staff. The resident was observed repositioning the leg rests and moving his legs over the side of the wheelchair.

During interviews with an LPN at 11:20 AM and an RN at 11:30 AM the nurses stated the resident was supposed to have 1:1 observation. They verified no one staff member was assigned to do 1:1 observation as evidenced by the assignment sheet. The RN stated the facility used the tilt back wheelchair to either prevent the resident from falls or at least give the staff enough time to get to the resident before he falls. The nurses verified the resident's order for "1:1 as needed" had no parameters. The interviews confirmed there was not enough staff to provide 1:1.

In an interview with a CNA on 10/27/19 at 3:30 PM, the CNA stated there was not enough staff to do 1:1 observation. During interviews with two other CNAs on 10/27/19 at 3:50 PM and 3:40 PM, both CNAs said there was not enough staff to do 1:1 observations for the resident.

A progress note, dated 10/27/19, documented the resident self-propelled to the 100 unit via his manual wheelchair where he attempted to self-transfer while in the private room of another resident. He ended up falling out of his chair due to his inability to bear weight properly. No injuries were noted in the post-fall assessment and the resident denied any increased pain.

On 10/28/19 at 3:16 PM, the resident's wife stated the resident has two "false hips". She stated he fell at day care and fractured the right hip at the end of September 2019. She stated she was taking care of him at home, but he started having too many falls. The resident was now sleeping in the wheelchair in the sitting room on the 200 unit. The resident's wife stated the facility kept him up most of the day because if he was in bed he would fall. She stated she was not notified of any falls last night or today.

In an interview with the Medical Director, on 10/30/19 at 3:14 PM, he said the order for the "1:1 as needed" was not a definitive order. He stated he was not notified of the recent two falls on 10/27/19 and 10/28/19.

An interview with the Physician's Assistant, on 10/30/19 at 3:35 PM, verified she had written an order for 1:1 observation of the resident due to the high risk for falls. She stated she was instructed by the first ED he would not pay for two residents on the same unit to have 1:1 observation therefore it had to be written as "as needed". She stated staff had not been notifying her or documenting all the falls for the resident so she was not able to justify the 1:1 observations for the resident.

Stephanie Bonanzino, Administrator
March 24, 2020
Page 5 of 5

Based on the investigative findings, the allegation was substantiated and the facility was cited at F725 as it related to the failure of the facility to ensure residents received adequate supervision to prevent hazards, risks, accidents, and injuries to residents.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



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March 24, 2020

Stephanie Bonanzino, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Bonanzino:

On **November 8, 2019**, an unannounced on-site complaint survey was conducted at Life Care Center Of Post Falls. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008287

ALLEGATION #1:

The facility failed to ensure sufficient numbers of staff were present to meet residents' needs.

FINDINGS #1:

During the survey, observations were conducted, resident records were reviewed, policies were reviewed, facility grievances were reviewed, Incident and Accident reports were reviewed, staffing schedules were reviewed, residents and family were interviewed, and staff were interviewed.

The facility's policy for Staffing, dated 4/24/19, stated the facility maintained adequate staff on each shift to meet residents' needs and utilized the Facility Assessment to determine staffing levels needed to ensure residents' needs were met. This policy was not followed.

Eleven residents and one family member were interviewed, 11 staff were interviewed, a Resident Council interview was conducted with 14 residents in attendance. The Resident Council expressed concerns regarding lengthy call light response times and assistance with meals which were not addressed by the facility. Several residents stated the facility was short staffed and they had to wait for a long time to get assistance. Residents also stated they were afraid to say anything to staff for fear of retaliation, they often felt rushed by staff, and they felt threatened by staff 's communication with them.

Several staff stated the facility was short staffed and when it was discussed or brought forward to administration they did not listen to the staff 's concerns. On 10/30/19 at 3:50 PM, the Executive Director said the facility was facing a "staffing crunch." He said at times a shower aide was pulled from giving showers to work on the floor, but now they were "catching up on showers." The Executive Director said the facility needed CNAs and had not been successful in finding more CNAs. He said evening shift was difficult to cover, so they used agency staff.

Grievances and Incident and Accident Reports were reviewed for the previous 6 months. The daily staffing scheduled was reviewed for the previous 3 weeks. Observations were conducted of resident care and staff present throughout the facility during the survey.

Upon record review, observations, and resident and staff interviews, six residents experienced adverse outcomes related to inadequate staffing to meet resident's needs. Residents experienced falls, aggressive behaviors, elopement, incontinence, lack of assistance with activities of daily living, and lack of receiving wound treatment and medications timely. Seven residents did not receive a bath or shower consistent with their needs.

Based on the investigative findings, the allegation was substantiated, and federal citations were issued at F725 related to the facility's failure to ensure there were sufficient numbers of competent staff to meet the needs of the residents which resulted in the identification of immediate jeopardy of serious harm, impairment or death. The facility was cited at F684 as it related to their failure to ensure residents were provided care and services in a manner which enhanced and promoted each resident's highest practicable physical, mental, and psychosocial health and well-being. The facility was also cited at F689 as it related to the facility's failure to provide adequate supervision and F677 as it related to the facility's failure to ensure residents were provided with bathing consistent with their needs.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Stephanie Bonanzino, Administrator
March 24, 2020
Page 3 of 3

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

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

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day". The signature is written in dark ink and is positioned above the typed name of the sender.

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj



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April 7, 2020

Stephanie Bonanzino, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Bonanzino:

On **November 8, 2019**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008071

ALLEGATION #1:

The facility failed to ensure sufficient numbers of staff were present to meet residents' needs.

FINDINGS #1:

During the survey, observations were conducted, resident records were reviewed, policies were reviewed, facility grievances were reviewed, Incident and Accident reports were reviewed, staffing schedules were reviewed, residents and family were interviewed, and staff were interviewed.

The facility's policy for Staffing, dated 4/24/19, stated the facility maintained adequate staff on each shift to meet residents' needs and utilized the Facility Assessment to determine staffing levels needed to ensure residents' needs were met. This policy was not followed.

Eleven residents and one family member were interviewed, 11 staff were interviewed, a Resident Council interview was conducted with 14 residents in attendance. The Resident Council expressed concerns regarding lengthy call light response times and assistance with meals which were not addressed by the facility. Several residents stated the facility was short staffed and they had to wait for a long time to get assistance. Residents also stated they were afraid to say anything to staff for fear of retaliation, they often felt rushed by staff, and they felt threatened by staff 's communication with them.

Several staff stated the facility was short staffed and when it was discussed or brought forward to administration they did not listen to the staff 's concerns. On 10/30/19 at 3:50 PM, the Executive Director said the facility was facing a "staffing crunch." He said at times a shower aide was pulled from giving showers to work on the floor, but now they were "catching up on showers." The Executive Director said the facility needed CNAs and had not been successful in finding more CNAs. He said evening shift was difficult to cover, so they used agency staff.

Grievances and Incident and Accident Reports were reviewed for the previous 6 months. The daily staffing scheduled was reviewed for the previous 3 weeks. Observations were conducted of resident care and staff present throughout the facility during the survey.

Upon record review, observations, and resident and staff interviews, six residents experienced adverse outcomes related to inadequate staffing to meet resident's needs. Residents experienced falls, aggressive behaviors, elopement, incontinence, lack of assistance with activities of daily living, and lack of receiving wound treatment and medications timely. Seven residents did not receive a bath or shower consistent with their needs.

Based on the investigative findings, the allegation was substantiated, and federal citations were issued at F725 related to the facility's failure to ensure there were sufficient numbers of competent staff to meet the needs of the residents which resulted in the identification of immediate jeopardy of serious harm, impairment or death. The facility was cited at F686 related to its failure to ensure the prevention, development, and worsening of pressure ulcers which resulted in the identification of immediate jeopardy of serious harm, impairment, or death and the facility was cited at F684 as it related to their failure to ensure residents were provided care and services in a manner which enhanced and promoted each resident's highest practicable physical, mental, and psychosocial health and well-being.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Stephanie Bonanzino, Administrator
April 7, 2020
Page 3

ALLEGATION #2:

Facility failed to adequately investigate an injury of unknown origin.

FINDINGS #2:

The investigation revealed the resident #481 was prescribed prednisone, 10 milligrams (mg) one time a day related to Crohn's disease. According to the American Osteopathic College of Dermatology, <https://www.aocd.org/page/SteroidsOral> , Steroids may cause the skin to become more fragile, which leads to easy bruising.

According to Physician's Orders dated 8/27/19, the staff was instructed to monitor the resident's bruising every shift. Review of the Treatment Administration Record showed the staff had been monitoring several different areas of bruising on the resident's extremities.

Review of the facility's grievance and incident reports did not show any allegation made by the resident and/or the resident's responsible party of rough handling by the staff.

An interview was conducted with Resident #481's Nurse Practitioner (NP) 11/05/19 at 11:10. The NP stated the resident had been prone to bruising.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj

Stephanie Bonanzino, Administrator
April 7, 2020
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April 7, 2020

Stephanie Bonanzino, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Bonanzino:

On **October 27, 2019** through **November 8, 2019**, an unannounced on-site complaint survey in conjunction with the annual recertification survey was conducted at Life Care Center of Post Falls. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008074

Allegation #1: The facility failed to ensure therapeutic diets were provided as ordered.

Findings #1: During the recertification initial pool process, multiple interviews were conducted with current residents and family members. There were 97 residents included in the recertification and complaint survey process. Multiple alert and oriented residents, and resident representatives were interviewed as part of this investigative process.

One resident's record reviewed documented she was admitted on 3/16/19, with a diagnoses of vascular disorder of intestine. The Registered Dietician's initial review for this resident, documented she was alert and able to communicate her needs. The resident was independent with meals and fluids and was on a self-imposed diet restriction due to concerns about tearing her esophagus. The resident's current oral intake was adequate to meet 90% of her estimated needs. There were no changes to the nutrition plan of care. The resident's daughters provided the kitchen with a list of foods the resident could eat. This was followed by the kitchen as well as nursing staff, however, the resident's requests were honored. The resident's average daily percentage consumption of meals documented breakfast was 75%, lunch was 50%, and dinner was 61%.

Review of the resident's diet order and care conference dated 3/19/19, documented her diet was low salt, no spicy or acidic food, no fresh salad, no fresh veggies, no fresh fruit, and she was to have easy to swallow, soft foods only. The resident's record documented she was gaining weight.

The resident's record documented dietary guidelines were provided by the family at the initial care conference. Interventions included dietary guidelines to follow: no highly salted food, spicy food, fresh salad (any type of lettuce), fresh fruit (including bananas), fresh vegetables (including tomatoes and onions), sausage or bacon, hamburger or roast beef, pasta or rice, french fries or fried potatoes, cookies or lemon bars, chocolate. Breakfast- scrambled eggs, muffins, pancakes, cottage cheese with or without canned fruit, yogurt, lunch/Dinner- very soft cooked vegetables including squash, beets, baked sweet potatoes, peas and carrots ...

Based on investigative findings, the allegation of the facility failing to provide and monitor therapeutic diets could not be substantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility failed to ensure medications were provided as ordered and on time.

Findings #2: During the survey, observations were conducted, resident records were reviewed, and staff were interviewed.

The records of 32 residents were reviewed. Twenty six of the records included documentation of medications being administered as ordered. For example, 1 resident's record documented Lasix one tablet daily had been ordered and was administered as ordered. Six of the resident records documented the residents did not receive care, including medications, as ordered by the physician. For example, a resident's record, documented a physician order for Ampicillin-Sulbactam antibiotic to be given IV every six hours. The August 2019 medication administration record documented the times for the IV antibiotics were scheduled for as 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. The resident was to receive the first dose of the Ampicillin IV at 6:00 PM. The August medication administration record documented the resident did not receive doses from 8/1/19 at 6:00 PM to 8/6/19 at 12:00 PM.

A physician's progress note written by the infectious disease physician documented the resident did not receive the IV antibiotic for 72 hours due to a shortage of the Ampicillin-Sulbactam.

The Medical Director stated he was not notified the pharmacy was unable to provide the IV Ampicillin-Sulbactam due to a shortage of the antibiotics until 4 days later. The Medical Director stated he was on-call 24/7 or one of his colleagues and the pharmacy was on-call 24/7 to notify them of the shortage of the Ampicillin-Sulbactam. The Medical Director stated the antibiotic could have been changed to a different one. The Medical Director stated there should not have been a delay in treatment.

During observations of medication administration, it was determined the facility failed to ensure medications were administered as ordered and at the appropriate time for 3 residents. Examples included:

- A resident's physician orders included 7 units of Novolog Insulin before meals and a sliding scale for additional Novolog Insulin to be given before meals and at bedtime based on his blood sugar results when checked at the bedside.

A Registered Nurse (RN) was observed providing insulin to the resident. The resident was eating lunch when the RN checked his blood sugar with a glucose meter and his blood sugar was 291. The RN then administered 11 units of Novolog via an injection. The resident should have received 7 units of Novolog and an additional 6 units, per the sliding scale with his blood sugar reading, per his physician's orders.

After the RN left the resident's room she stated the insulin and blood sugar reading were late and should have been done prior to lunch.

- A resident's physician orders included Lacosamide 100 mg to be given twice a day for seizures, Keppra 1000 mg to be given twice a day for seizures, Brilinta 90 mg to be given twice a day for coronary artery disease, and Coreg 6.25 mg to be given twice a day for ischemic heart disease (less blood and oxygen to the heart from narrowed arteries).

On 10/27/19 at 12:40 PM, an RN was observed administering the above medications to the resident. The RN was interviewed after administering the medications and stated the above medications were scheduled for administration at 8:00 AM. She stated there were only two nurses on the unit for 43 residents, which was not enough to get medications to the residents on time. She stated physicians were not notified of medications being given late.

- A resident's physician orders included Lamotrigine 200 mg two times a day for seizures, Lacosamide 20 ml two times a day for seizures, Metoprolol 25 mg two times a day for tachycardia (fast heart rate), and Lantus insulin 40 units via injection two times a day. Lantus insulin is a long-acting insulin which is to be given at the same time every day according to Drugs.com, accessed on 12/2/19. Lantus is intended to have a long duration of action over a 24-hour period of time to control blood sugar levels.

On 11/1/19 at 11:40 AM, an RN was observed administering Lamotrigine, Lacosamide, and Metoprolol to the resident. After administering the medications the RN stated the medications were scheduled to be given at 8:00 AM.

At 12:30 PM, the RN was observed administering Lantus insulin 40 units via injection to the resident. After administering the insulin the RN stated the insulin was scheduled to be given at 8:00 AM.

Based on the investigative findings, the allegation was substantiated, and deficient practice was cited at F759 related to the facility's failure to ensure medications were given as ordered.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #3: The facility failed to provide quality care and treatment to prevent injuries to residents.

Findings #3: Incident and Accident Reports and investigations were reviewed for the previous 6 months. The records documented various resident injuries from accidents. For example, an investigation documented on 3/17/19 at 3:00 AM a resident sustained a skin tear to her left middle finger. The resident reported that when the staff lifted the foot rest, her hand fell down and she was injured. The resident stated it did not feel like it was intentional, she was just fearful it may need stitches. The resident was seen at the urgent care center per family request for evaluation of injury, which required sutures.

The Incident and Accident Reports also documented various resident injuries which were due to a lack of adequate supervision. For example, an Incident and Accident Report, dated 9/23/19, documented a resident was found on the floor at 12:40 PM and was responsive only to vigorous stimulation. His eyes were open, but he was not responding to questions. The facility did not provide supervision and interventions to prevent the resident from having an unwitnessed fall with injury.

A total of 5 residents were identified as being placed at risk serious impairment, harm or death due to the facility's failure to ensure the residents received adequate supervision to prevent hazards, risks, accidents, and injuries to residents.

Based on the investigative findings, the allegation was substantiated and deficient practice was cited at F689 related to the facility's failure to provide adequate supervision necessary to prevent hazards, risks, accidents, and injuries to residents.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

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

Stephanie Bonanzino, Administrator
April 7, 2020
Page 5 of 5

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

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

BELINDA DAY, RN, Supervisor
Long Term Care Program

BD/ac



IDAHO DEPARTMENT OF
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April 7, 2020

Stephanie Bonanzino, Administrator
Life Care Center of Post Falls
460 North Garden Plaza Court
Post Falls, ID 83854-6437

Provider #: 135135

Dear Ms. Bonanzino:

On **November 8, 2019**, an unannounced on-site complaint survey was conducted at Life Care Center of Post Falls. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008284

ALLEGATION #1:

The facility failed to ensure sufficient staffing was provided to meet the residents' needs.

FINDINGS #1:

During the survey, observations were conducted, resident records were reviewed, policies were reviewed, facility grievances were reviewed, Incident and Accident reports were reviewed, staffing schedules were reviewed, residents and family were interviewed, and staff were interviewed.

The facility's policy for Staffing, dated 4/24/19, stated the facility maintained adequate staff on each shift to meet residents' needs and utilized the Facility Assessment to determine staffing levels needed to ensure residents' needs were met. This policy was not followed.

Eleven residents and one family member were interviewed, 11 staff were interviewed, a Resident Council interview was conducted with 14 residents in attendance. The Resident Council expressed concerns regarding lengthy call light response times and assistance with meals which were not addressed by the facility. Several residents stated the facility was short staffed and they had to wait for a long time to get assistance. Residents also stated they were afraid to say anything to staff for fear of retaliation, they often felt rushed by staff, and they felt threatened by staff 's communication with them.

Several staff stated the facility was short staffed and when it was discussed or brought forward to administration they did not listen to the staff 's concerns. On 10/30/19 at 3:50 PM, the Executive Director said the facility was facing a "staffing crunch." He said at times a shower aide was pulled from giving showers to work on the floor, but now they were "catching up on showers." The Executive Director said the facility needed CNAs and had not been successful in finding more CNAs. He said evening shift was difficult to cover, so they used agency staff.

Grievances and Incident and Accident Reports were reviewed for the previous 6 months. The daily staffing scheduled was reviewed for the previous 3 weeks. Observations were conducted of resident care and staff present throughout the facility during the survey.

Upon record review, observations, and resident and staff interviews, six residents experienced adverse outcomes related to inadequate staffing to meet resident's needs. Residents experienced falls, aggressive behaviors, elopement, incontinence, lack of assistance with activities of daily living, and lack of receiving wound treatment and medications timely. Seven residents did not receive a bath or shower consistent with their needs.

Based on the investigative findings, the allegation was substantiated, and federal citations were issued at F725 related to the facility's failure to ensure there were sufficient numbers of competent staff to meet the needs of the residents which resulted in the identification of immediate jeopardy of serious harm, impairment or death. The facility was cited at F684 related to its failure to ensure residents were provided care and services in a manner which enhanced and promoted each resident's highest practicable physical, mental, and psychosocial health and well-being. The facility was also cited at F677 related to the facility's failure to ensure residents were provided with bathing consistent with their needs and F759 related to the facility's failure to ensure medications were given as ordered.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Stephanie Bonanzino, Administrator
April 7, 2020
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ALLEGATION #2:

The facility does not have appropriate supplies to meet the residents' needs.

FINDINGS #2:

The complainant alleges the facility did not have briefs in the resident's size for a weekend. The resident listed in the complaint, interviewed on 10/28/19 at 1:30 PM confirmed the facility did not have the size of her preference. Interview with the Central Supply Director on 10/31/19 at 2:45 PM was unaware Resident #28 lacked adequate briefs available and stated Resident #28 preferred the larger briefs. The Central Supply Director also stated Resident #28 prefers a size of brief different for the brief to fit her measurements. The allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj