IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN– Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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November 29, 2019

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211-0420

Provider #: 135066

Dear Mr. Clinger:

On **November 19, 2019**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **October 30, 2019**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **F0657 -- S/S: D -- 483.21(b)(2)(i)-(iii) -- Care Plan Timing And Revision**
- **F0686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer**
- **F0880 -- S/S: D -- 483.80(a)(1)(2)(4)(e)(f) -- Infection Prevention & Control**
- **F0637 -- S/S: D -- 483.20(b)(2)(ii) -- Comprehensive Assessment After Signifcant Chg**
- **F0684 -- S/S: E -- 483.25 -- Quality Of Care**

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.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 9, 2019**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;

- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.

- Include dates when corrective action will be completed in column (X5).

  If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

As noted in the Bureau of Facility Standards' letter of **September 20, 2019**, following the survey of **September 6, 2019**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions effective **December 6, 2019** and termination of the provider agreement on **March 6, 2020**, if substantial compliance is not achieved by that time. The findings of non-compliance on **November 19, 2019**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **November 21, 2019**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after **December 6, 2019**
- **Termination of the provider agreement March 6, 2020**

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

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

This request must be received by **December 9, 2019**. If your request for informal dispute resolution is received after **December 9, 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 please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, at (208) 334-6626, option #2.

Sincerely,

Belinda Day, RN, Supervisor
Long Term Care Program

bd/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135066		R **11/19/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWER COUNTY NURSING HOME	**510 ROOSEVELT STREET (83211-1362)** **AMERICAN FALLS, ID 83211**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The following deficiencies were cited during the onsite revisit survey conducted from 11/18/19 - 11/19/19. The survey was conducted by: Monica Meister, QIDP, Team Coordinator Karen George, RN Abbreviations used in this report: AROM = Active Range of Motion CNA = Certified Nursing Assistant DON = Director of Nursing MDS = Minimum Data Set PROM = Passive Range of Motion ROM = Range of Motion	{F 000}		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a	F 637	F637 SS=D CFR(s) 483.20 (b)(2)(ii) Comprehensive Assessment After	12/31/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/09/2019

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 637	Continued From page 1 significant change comprehensive assessment was conducted for 1 of 3 residents (Resident #1) whose minimum data sets were reviewed. This resulted in the potential to adversely affect a resident's care. The findings include: 1. Resident #1 was admitted to the facility on 06/21/13, with diagnoses including diabetes mellitus type 2, gastroesophageal reflux disease, hypothyroidism, hypertension, chronic kidney disease, and Alzheimer's dementia. Resident #1's quarterly MDS, dated 03/25/19, and Resident #1's annual MDS, dated 06/23/19, both stated Resident #1 required extensive assistance of 2+ persons for bed mobility, walking in room, locomotion on the unit, locomotion off the unit, dressing, eating, and personal hygiene. However, Resident #1's quarterly MDS, dated 09/23/19, stated Resident #1 was totally dependent on 2+ persons for bed mobility, walking in room, locomotion on the unit, locomotion off the unit, dressing, eating, and personal hygiene. Residents #1's 09/23/19 quarterly MDS documented a decline in seven areas of activities of daily living since her 06/23/19 annual MDS was conducted. During an interview on 11/18/19 at 2:35 PM, the DON stated, "[Resident #1] has been slowly declining. She no longer walks. I don't know why we didn't do a significant change assessment for her after the quarterly [referring to the 09/23/19 quarterly MDS]." The DON stated Resident #1	F 637	Significant Change What corrective actions will be accomplished for residents found to be affected by the deficient practice. Resident #1 is totally dependent on staff for all of her cares and has been for the entire time described in these 3 MDS date ranges. The DON/MDS Coordinator has reviewed documentation from the last year and she has not had a significant change. This is a documentation error and the DON/MDS Coordinator will do modifications of the MDS dated 3/25/19 and 6/23/19 so that they reflect that the resident is totally dependent on staff for all cares. DON/MDS Coordinator will also do staff teaching in the next staff meeting (December) to ensure aide staff understand how to chart correctly the difference between 2+ extensive assist and 2+ dependent for cares. The aide staffs use 2+ persons for this resident, except for eating. I believe this is what caused the confusion. How will you identify other resident(s) with potential to be affected and what corrective action(s) will be taken. All residents receiving total care and also needing 2+ assist will be identified and MDS for those residents will be reviewed for documentation errors. The DON/MDS Coordinator will complete a modification of any MDS that are found to be incorrect. What measures will be put in place to	

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F 637	Continued From page 2 had always been dependent for most activities of daily living. The facility failed to conduct a significant change comprehensive assessment for Resident #1.	F 637	ensure the deficient practice does not recur. Staff training and practice charting with similar residents to Resident #1 will be provided by the DON/MDS Coordinator at the next LTC staff meeting (December). How the corrective action(s) will be monitored to ensure the deficient practice will not recur. DON/MDS Coordinator will monitor CNA charting of 2+ assist residents for errors. This will be done every week for 4 weeks; then monthly for 4 months; and quarterly thereafter. If errors are found the DON/MDS Coordinator will do additional staff training in monthly staff meetings or individually as needed. This monitoring will be kept in the DON Survey binder for tracking.	
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	{F 657}		12/31/19

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{F 657}	Continued From page 3 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, and staff interviews, it was determined the facility failed to ensure a resident's Care Plan was updated for 1 of 8 residents (Resident #1) whose care plans were reviewed. This resulted the potential to adversely affect a resident's care. The findings include: 1. Resident #1 was admitted to the facility on 06/21/13, with diagnoses including diabetes mellitus type 2, gastroesophageal reflux disease, hypothyroidism, hypertension, chronic kidney disease, and Alzheimer's dementia. a. Resident #1's Skin Assessment, dated 10/25/19, documented a stage two pressure ulcer on Resident #1's buttocks was healed and "Pt [patient] with clean, dry, intact, and pink skin. Skin to buttocks remains blanchable and intact." However, Resident #1's Care Plan, updated 09/25/19, stated "Focus: I have altered skin integrity...skin breakdown on buttocks, Goal: Open area on inner R buttock will resolve by	{F 657}	F657 SS=D CFR(s): 483.21 (b)(2)(i)(iii) Care Plan Timing and Revision What corrective actions will be accomplished for residents found to be affected by the deficient practice. Resident #1 care plan will be updated to reflect that her skin breakdown is resolved and that she is now using compression stockings rather than wraps. How will you identify other resident(s) with potential to be affected and what corrective action(s) will be taken. Any resident with a change or new order is at risk to be affected. The DON or RN designee updating the recaps with new orders will also make sure that the care plans are updated at the same time. This will be done monthly and periodically as new orders arrive. What measures will be put in place to ensure the deficient practice does not	

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{F 657}	Continued From page 4 10/6/19...Interventions...[skin care dressing] or [skin care dressing] to buttocks. Change every 3 days and prn [as needed] when soiled. Revision on 09/25/19." Resident #1's Care Plan was not updated to reflect the pressure ulcer on Resident #1's buttocks had been resolved as of 10/25/19. b. During an observation of Resident #1 on 11/18/19 at 3:43 PM, Resident #1 was wearing compression stockings. Resident #1's Physician Order, dated 10/30/19, stated, "Ok to use compression stockings instead of compression wraps." Additionally, Resident #1's Physician Order, dated 11/18/19, stated, "Compression stocking to lower legs daily off at night." However, Resident #1's Care Plan, revised 09/25/19, stated "Focus: I have altered skin integrity...Interventions: skin nurse to remove wraps to check legs weekly...Wrap and treat my lower legs as ordered to protect them from scratching..." Resident #1's Care Plan was not updated to reflect the use of compression stockings. During an interview on 11/18/19 at 3:43 PM, CNA #1 stated, "She used to wear wraps on her legs, but they got discontinued and now she wears compression stockings. This happened about two weeks ago." During an interview on 11/18/19 at 4:05 PM, the DON stated Resident #1's leg wraps had been	{F 657}	recur. DON will review all care plans and document in the resident nurse notes that the care plan was reviewed and is current at this time. This will be accomplished by 12/31/19. DON or RN designee will review care plans when skin issues resolve or occur to make sure they are current. This will be done weekly by the skin nurse. The DON will review skin reports weekly and make sure the care plans are updated and complete if necessary. DON will also train all nursing staff to remove and add orders and check the alert charting and update resident care plans as needed. This training will take place at the December LTC staff meeting and individually with those not at the meeting. The DON receives copies of all new orders and will review them weekly to ensure staff compliance to update care plans. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. DON or RN designee will do chart checks monthly to see that all new orders are on the recaps and to ensure all care plans are updated to reflect changes. The DON will add review findings to pharmacy review meeting minutes and track compliance and deficiencies on the monthly QAPI tracking and reporting.	

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{F 657}	Continued From page 5 changed to compression stockings on 11/03/19 and the Care Plan had not been updated. The facility failed to update Resident #1's Care Plan.	{F 657}		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure residents received restorative nursing treatment and care in accordance with their care plans for 7 of 8 residents (Residents #1 - #7) whose care plans were reviewed. This resulted in residents receiving restorative exercises that were not consistent with their care plans. The findings include: 1. The facility's Restorative Care - Range of Motion policy, dated 10/1/19, stated a resident's need for a restorative range of motion program was identified in various ways including the resident's Care Plan. Residents #1 - #7's Care Plans documented they were to receive specific restorative exercises. However, the facility's restorative aids were not	F 684	F684 SS=E CFR(s) 483.25 Quality of Care What corrective actions will be accomplished for residents found to be affected by the deficient practice. DON will review all resident current exercise plans with all restorative aides and restorative nurse and update the care plans as follows: Residents #1-7 care plans will be updated stating exactly what exercises they are to be doing with restorative aides. These restorative care plans will be copied directly from the EMR care plan and put in the restorative book for restorative aides to refer to. How will you identify other resident(s) with	12/31/19

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F 684	Continued From page 6 following residents' Care Plans; rather the aides were following an outdated list of exercises, as follows: a. Resident #1's Care Plan, initiated on 10/8/19, stated she was to ambulate with a Barney walker 1 time daily, 5 - 7 days a week for 20 feet and she was to receive PROM to all extremities 15 minutes a day. However, the Restorative Care exercises list, undated, stated Resident #1 was to receive massages, stretches, and 5 - 10 repetitions of PROM. b. Resident #2's Care Plan, initiated on 9/5/19, stated she was to receive AROM, leg kicks, arm pullies and transfer training 5 - 7 days a week. However, Resident #2 was not identified or included on the Restorative Care exercise list. c. Resident #3's Care Plan, initiated on 9/14/19, stated he was to maintain his ability to walk, transfer, and maintain full ROM. His Care Plan, initiated 10/8/19, stated he was to receive 20 repetitions of AROM, 20 arm pullies, and 20 kicks. However, Resident #3 was not identified or included on the Restorative Care exercise list. d. Resident #4's Care Plan, initiated on 10/8/19, stated she was to receive AROM and PROM to all extremities. However, the Restorative Care exercises list, undated, stated Resident #4 was to receive	F 684	potential to be affected and what corrective action(s) will be taken. All residents on restorative care have potential to be affected. The DON will review all other residents receiving restorative care to update their care plans and add their specific care plans from the EMR to the restorative book for reference and use by staff. All restorative staff will receive individual training on all updated care plans by DON or Designee so that all restorative aides are aware of the care plan updates and are all doing consistent exercises for each resident receiving restorative care. What measures will be put in place to ensure the deficient practice does not recur. DON will train restorative nurse to update care plans when needed and how to print out new updated care plans when resident needs change. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. DON or designee will meet with restorative nurse monthly and review any changes made and ensure they are on the care plans to help update as needed. If any changes are made, DON or restorative RN will do individual in-service with all restorative aides to ensure their compliance. Deficiencies will be reported on the monthly QAPI tracking and reporting. LTC Staff meeting notes will be kept in the DON Survey binder for	

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F 684	Continued From page 7 AROM, arm pullies, bicycling, and wall stretches. e. Resident #5's Care Plan, initiated on 10/8/19, stated he was to receive arm pullies, PROM to his right side, AROM to his left side, and ambulate 200 feet twice a day, 5 days a week. However, the Restorative Care exercises list, undated, stated Resident #5 was to receive 40 arm pullies, 20 kicks, and ambulate. f. Resident #6's Care Plan, initiated on 10/28/19, stated he was to perform squats to strengthen his legs, and maintain walking and balance activities 5 - 7 days a week. However, the Restorative Care exercises list, undated, stated Resident #6 was to receive AROM, arm pullies, and bicycling. g. Resident #7's Care Plan, initiated on 9/14/19, stated she was to exercise at least 5 - 7 days a week to maintain her ability to move her right arm and right leg. However, the Restorative Care exercises list, undated, stated Resident #7 was to receive massages, stretches, PROM to her left arm and AROM to the rest of her body, arm pullies, and bicycling. During an interview on 11/18/19 at 11:30 AM, Restorative Aid (RA) #1 stated she used the Restorative Care exercise list to guide the work she did with the residents. RA #1 stated, "I usually don't look at the Care Plan, I just have it in my mind."	F 684	tracking. DON or designee will choose a resident and review their restorative plan of care and observe restorative aides doing exercises with the resident to ensure they are being done according to the updated plan of care. This monitoring will be conducted 3 days per week for 3 months, then 3x per month thereafter and results will be kept in the DON survey binder for tracking.	

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F 684	Continued From page 8 During an interview on 11/19/19 from 9:02 - 9:30 AM, the DON and RA #2 provided the survey team with an updated Restorative Care exercises list that was dated 11/18/19. When asked, both the DON and RA #2 stated the list of exercises were not taken from residents' Care Plans. The DON and RA #2 both stated the list of exercises were based on working with the residents. The facility failed to ensure Residents #1 - #7 received restorative services in accordance with their care plans.	F 684		
{F 686} SS=D	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, record review, and staff interviews, it was determined the facility failed to implement interventions to ensure a resident at high risk for pressure related injuries received appropriate preventive care. The facility failed to: 1.) implement an individualized turning and positioning Care Plan; and 2.) remove a transfer	{F 686}	F686 SS=D CFR(s) 483.25 (b)(1)(ii) Treatments/Svcs to Prevent/Heal Pressure Ulcer What corrective actions will be accomplished for residents found to be affected by the deficient practice.	12/31/19

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{F 686}	Continued From page 9 sling from under the resident when in bed for 1 of 2 residents (Resident #1) reviewed for pressure ulcers. This resulted in the potential to increase the risk of new or worsening pressure ulcers for any resident with compromised skin integrity. The findings include: 1. Resident #1 was admitted to the facility on 06/21/13, with diagnoses including diabetes mellitus type 2, gastroesophageal reflux disease, hypothyroidism, hypertension, chronic kidney disease, and Alzheimer's dementia. Resident #1's Braden Scale for Predicting Pressure Sore Risk, dated 04/02/19, documented Resident #1 had an overall score of "14," or a moderate risk for the development of pressure sores. Resident #1's Braden Scale for Predicting Pressure Sore Risk, dated 07/09/19, documented Resident #1 had an overall score of "10," or a high risk for the development of pressure sores. Resident #1's quarterly Minimum Data Set (MDS), dated 09/23/19, documented Resident #1 had a stage two pressure ulcer and was dependent on staff for bed mobility, walking, personal hygiene, and bathing transfers and toilet use. Resident #1's Skin Assessment data, dated 10/04/19 - 11/15/19, documented that on 10/25/19, the stage two pressure ulcer on Resident #1's buttocks was healed and "Pt [patient] with clean, dry, intact, and pink skin. Skin to buttocks remains blanchable and intact."	{F 686}	Resident #1 care plan will be updated by DON to reflect turning/repositioning schedule which does not allow her to spend long (>2hours) periods on her buttocks. Instructions will be added to be last up, first down for lunch and dinner meals. After breakfast she will be up for restorative care except on Thursday to get her hair done. The care plan will also reflect her individual sleeping schedule and night shift will be interviewed and assist the DON in setting this up. Consideration will be taken to allow the resident to sleep if staffs enter and she is asleep at night. DON contacted PointClickCare EMR vendor and received instructions on how to set up more detailed aide charting on when a resident is turned and what position the resident is in specifically. Staff will be given a written in-service and additional training at the December LTC staff meeting to understand and be aware of how to chart the repositioning and all changes to resident care plan. Resident #1 care plan will also be updated to state that the hoyer sling will not be left under her at any time. Staff will use turning/repositioning bed pad with handles to turn the Resident rather than leaving the sling under the resident. How will you identify other resident(s) with potential to be affected and what corrective action(s) will be taken. DON will identify other residents with potential to be affected according to their ability to turn and reposition	

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{F 686}	Continued From page 10 During an observation of peri-care for Resident #1 on 11/18/19 at 3:43 PM, Resident #1's stage two ulcer appeared healed, with no open area, exudate, or redness. Resident #1's Care Plan, revised 10/10/19, documented the following: "Focus: I am dependent on staff for my adl's [activities of daily living]; Goal: I will be clean and odor free through the next review date; Interventions: ...Turn/reposition and change me at night every 2-3 hours and as needed, do not leave me on my bottom for > 2 hours." However, Resident #1's Care Plan intervention did not contain an individualized Turning and Positioning (T & P) intervention that reflected Resident #1's preference, or a plan related to documenting Resident #1's positioning every 2 hours, in order to ensure the plan was appropriately implemented. Resident #1's Plan of Care Response History, dated 11/04/19 - 11/18/19, did not contain consistent documentation and did not provide any information regarding positioning of Resident #1. Examples included, but were not limited to, the following: - On 11/04/19 from 4:10 - 8:31 PM, there was no documentation of T & P, and from 8:31 - 11:14 PM, Resident #1 was not turned at all. - On 11/05/19 from 4:38 AM to 2:02 PM and from 4:19 - 8:44 PM, there was no documentation of T & P. - On 11/06/19 from 5:33 AM to 2:43 PM, there	{F 686}	independently as well as their braden scale scores. Any residents unable to reposition themselves independently or who have a history of having breakdown will be considered high risk and care plans will be updated as well as turning/repositioning schedules set up and individualized according to their own schedules as much as possible. EMR charting will be set up to show repositioning details for residents. What measures will be put in place to ensure the deficient practice does not recur. DON will add turning/repositioning to admission checklist so that on admission a resident who is not independent will have a repositioning schedule assessed and set up. DON will add turning/ repositioning to MDS checklist so that it can be assessed and documented with each resident quarterly and annual change of status MDS reporting. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. DON or designee will do monitoring of staff repositioning 3x weekly for 3 months, then weekly for 3 months, and monthly thereafter. This will be accomplished by choosing a random sample of 3 high risk residents monthly. The DON or designee will then monitor the staff with residents by visualizing appropriate repositioning is occurring according to the selected resident care	

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{F 686}	Continued From page 11 was no documentation of T & P. - On 11/07/19 from 4:00 - 8:30 PM, there was no documentation of T & P. Resident #1's data from 11/08/19 - 11/18/19 showed a lack of consistent documentation related to T & P. Additionally, Resident #1's data, dated 11/04/19 - 11/18/19, did not contain any information related to specific positioning (i.e., right side, left side, back, front) of Resident #1. During an interview on 11/18/19 at 3:24 PM, the DON stated, "If there is a span of time on the T & P documentation, it is because someone forgot to document," and "I will need to do some more training." When asked about specific positioning during an interview on 11/18/19 at 5:11 PM, the DON stated, "I don't have a good way to monitor what position the resident was placed in, or anyway to say what the position of the resident was during periods of time when T & P was not being documented," and "I don't believe there is a policy and procedure for a turning and positioning program." During an interview on 11/19/19 at 10:25 AM, the DON stated, "I don't have an actual guideline for T & P, I just added it to the Care Plan and put it under tasks to remind the CNAs to T & P her [Resident #1]." The DON stated, "If they [the CNAs] chart, I assumed they have done the T & P. As long as they move her, I am not too concerned what position they put her in. I have been taught that even a quarter of a turn is enough to offload and relieve pressure," and "We	{F 686}	plan and subsequent documentation. ie: if the care plan states resident is repositioned at 0930 and staff documented it was done and resident is on their right side, DON or designee will visualize resident on their right side and will recheck at next repositioning interval for repositioning and documentation. This will occur at least 2x on days of audits.	

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{F 686}	Continued From page 12 have trained the staff not to wake the residents up at night, so that is why I went with two to three hours. Her [Resident #1's] Care Plan does not address letting her sleep. I don't know where I got that standard of practice. It's just standard to turn every two hours. The three hours was just to let her sleep, but I didn't put that on the Care Plan." b. During an observation of Resident #1 on 11/18/19 at 10:46 AM, Resident #1 was lying in bed on her back, tipped to the right side and a transfer sling (used to lift and transport her in the lift) was under her body, on the bed. During an observation of Resident #1 on 11/18/19 at 1:54 PM, Resident #1 was lying in bed on her back, tilted to her right side and a transfer sling was under her body. During an observation of peri-care for Resident #1 on 11/18/19 at 3:43 PM, a transfer sling was under Resident #1 as she lay in bed. During an interview on 11/18/19 at 3:55 PM, CNA #1 stated, "We used a [lift] on her [Resident #1] to change the pillows. Once she is done at night, we will remove the sling. CNA #1 stated they did that because Resident #1 was so "stiff and heavy." CNA #1 stated the sling was left under Resident #1 throughout the day. During an interview on 11/18/19 at 4:05 PM, the DON stated, "The sling should be removed after she is in bed, and the sling should probably not be under her now. The DON stated she did not think there was a policy that addressed leaving a sling under a resident while they were lying in	{F 686}		

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{F 686}	Continued From page 13 bed." At 4:15 PM, the DON stated she had told the CNAs they could leave the sling under Resident #1 because she was so hard to move. Review of the product information sheet "[The sling]" provided by the DON on 11/19/19 at 1:45 PM, did not address leaving a sling under a resident. During an interview on 11/19/19 at 1:45 PM, the DON stated she did not think the facility had a policy and procedure for the use of the sling. The facility failed to implement interventions to ensure Resident #1 who was at high risk for pressure related injuries, received appropriate preventive care.	{F 686}		
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers,	{F 880}		12/31/19

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{F 880}	Continued From page 14 visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	{F 880}		

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{F 880}	Continued From page 15 §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, record review, and staff interviews, it was determined the facility failed to implement proper infection prevention interventions when providing peri-care to 1 of 1 residents (Resident #1) observed for peri-care. This resulted in the increased potential for infection due to cross-contamination. The findings include: 1. The facility's "Hand Washing" policy, updated 04/05/15, stated, "...It is recommended that hospital personnel wash their hands often...After touching anything that may possibly be contaminated or anyone whom may be infected," and "When working on the same patient but moving to a different body site." a. During an observation of peri-care for Resident #1 on 11/18/19 at 3:43 PM, CNA #2 cleaned feces from Resident #1's backside. When she completed the task, she did not remove her gloves or sanitize her hands before applying a barrier cream to Resident #1's backside. CNA #2 then removed and changed her gloves but did not sanitize her hands. CNA #2 placed an incontinence brief and a panty liner pad under Resident #1. CNA #1 and CNA # 2 rolled	{F 880}	F880 SS=D CFR(s) 483.80 (a)(1)(2)(4)(e)(f) Infection Prevention and Control What corrective actions will be accomplished for residents found to be affected by the deficient practice. All staff will have training for donning, doffing, proper hand washing, changing gloves and disinfecting after cleaning a resident and before applying barrier ointment/cream. A bottle of pump hand sanitizer was placed in Resident #1 room for use with peri-care. Staff can then more quickly and easily sanitize and reapply new gloves before applying barrier ointment. Staff will receive in-service on this procedure in writing as well as a demonstration and practice on the procedure at the December LTC staff meeting. How will you identify other resident(s) with potential to be affected and what corrective action(s) will be taken. Any resident needing staff assistance for peri-care is at risk for hand hygiene	

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{F 880}	Continued From page 16 Resident #1 onto her back. CNA #1 then wiped under Resident #1's pannus and in her groin area. Without changing gloves, CNA #1 applied barrier cream to the area under the pannus and the groin area. She then removed her gloves and donned a new pair of gloves without sanitizing her hands. CNA #1 and CNA #2 applied the incontinence brief and adjusted Resident #1's clothing and cleaned the area. CNA #1 and CNA #2 washed their hands after all cares had been completed. During an interview on 11/18/19 at 3:55 PM, CNA #1 stated, "We washed our hands before we came down and we will wash them again when we leave. We do not sanitize in between." During an interview on 11/18/19 at 4:14 PM, the Infection Control Officer stated the expectation for changing gloves and sanitizing hands was, "The policy says when moving from one site to another they [the care giver] should change their gloves." The facility failed to implement proper infection prevention interventions when providing peri-care to Resident #1.	{F 880}	issues. Residents identified to need staff perio-care will also receive a sanitizer pump placed in their room for staff use between wiping/removing gloves and reapplying gloves for barrier ointment/cream application. Staff written in-service instructions on the procedure will also include a list of all residents needing staff peri-care as a reminder. What measures will be put in place to ensure the deficient practice does not recur. DON or RN designee will monitor and watch aides change an incontinent resident 2x weekly for 2 months, then weekly for 4 months, and monthly thereafter for 1 year. The DON or designee will do individual training as needed with staff found to be deficient in hand hygiene practices for peri-care. The training will also be added to the new aide training checklist along with donning, doffing, and hand hygiene to review and demonstrate knowledge and compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur DON or designee will monitor staff and do a hand hygiene audit to witness and notate on the form any training or teaching done. The audit notes will be kept in the DON Survey binder for tracking. Peri-care disinfecting between wiping and applying barrier ointment/cream compliance will be tracked separately	

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{F 880}	Continued From page 17	{F 880}	from handwashing audits in monthly QAPI tracking and reporting.	