IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE– Governor
DAVE JEPPESEN– Director

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LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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January 8, 2020

Royal Jensen, Administrator
Cascadia of Boise
6000 W. Denton St.
Boise, ID 83704

Provider #: 135146

Dear Mr. Jensen:

On **December 13, 2019**, a survey was conducted at Cascadia of Boise 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 an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **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 **January 21, 2020**. Failure to submit an acceptable PoC by **January 21, 2020**, may result in the imposition of civil monetary penalties by **February 9, 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; and

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

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

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

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

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

- Denial of payment for new admissions effective March 13, 2020

- Civil money penalty

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 13, 2020**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors of LTC, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **January 21, 2020**. If your request for informal dispute resolution is received after **January 21, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

Belinda Day, RN, Supervisor
Long Term Care Program

bd/lj

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	135146		12/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADIA OF BOISE	6000 W DENTON ST BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from December 8, 2019 to December 13, 2019. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Jenny Walker, RN Presie Billington, RN Cecilia Stockdill, RN Sallie Schwartzkopf, LCSW Michael Brunson, RN Kim Saccomando, RN Susan Gosney, RN Karen George, RN Roxie Lacey, RN Gay Thomas, RN Survey Abbreviations: ADL = Activities of Daily Living BG = blood glucose BP = blood pressure CDM = Certified Dietary Manager cm = Centimeters CNA = Certified Nursing Assistant DON = Director of Nursing ED = Emergency Department EMR = Electronic Medical Record EMT = Emergency Medical Technician LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment mg = milligrams ml = milliliters NP = Nurse Practitioner O2 = oxygen	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/18/2020

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 PLOF = Prior Level of Function PRN = As Necessary pt = patient PTA = Physical Therapy Aide RD = Registered Dietician RN = Registered Nurse SDC = Staff Development Coordinator STS = Sit to Stand TAR = Treatment Administration Record UM = Unit Manager vs = vital signs WCC= Wound Care Certified	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		2/4/20

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F 550	Continued From page 2 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. 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 respect and maintain each residents' dignity. This was true for 6 of 21 residents (#6, #13, #24, #55, #66, and #420) who were reviewed for dignity. Resident #66 was harmed when he experienced emotional distress when he was incontinent of stool and was unable to use his call light to request assistance. These deficient practices also created the potential for residents to experience embarrassment and decreased sense of self-worth. Findings include: 1. Resident #66 was admitted to the facility on 10/11/19, with multiple diagnoses including stroke, muscle weakness, transient paralysis (unable to move intermittently), and diabetes. Resident #66's Physical Therapy Evaluation,	F 550	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cascadia of Boise does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. F550G Resident Specific Resident #66 had a skin evaluation	

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F 550	Continued From page 3 dated 10/11/19, documented severe weakness of the left and right hands. Resident #66's admission MDS assessment, dated 10/21/19, documented upper extremity impairment (shoulder, elbow, wrist, and hand) on both sides of the body. The assessment also documented Resident #66 required extensive assistance by two or more staff for physical assistance with dressing, bathing, and personal hygiene. The admission assessment documented Resident #66 was always incontinent and required extensive assistance with two staff for toileting. Resident #66's care plan documented he had limited physical mobility related to physical weakness and stroke. There were no interventions included in the care plan for Resident #66's incontinence. A Physical Therapy Progress report, dated 12/1/19 to 12/7/19, documented Resident #66's remaining impairments included body awareness deficits, decreased functional capacity, gross motor coordination deficits, motor control deficits, and sensation and strength impairments. On 12/8/19 at 1:01 PM, Resident #66 shook his head side to side indicating "no" when asked if he was cleaned up quickly when soiled (incontinent of stool). On 12/10/19 at 9:08 AM, Resident #66 was in his room lying on his back in bed and there was a strong odor of stool. The following was observed: * At 9:08 AM, Activities Assistant #1 went into	F 550	completed with no adverse effects noted related to cited event. The Interdisciplinary Team (IDT) reviewed resident #66 related to impairments and current needs. Resident #66 care plan was revised to include but not limited to interventions for incontinence care and an adaptive call light was implemented. Resident #66 was able to return demonstrate use of adaptive call light and is satisfied with updates. Resident #24 was evaluated by Physical Therapy and Occupational Therapy. Conference with Resident #24□s family was conducted with care plan revisions made to reflect needs while maintaining resident dignity. Resident #24 small decorative clothing protectors were taken home by family and replaced by standard facility provided clothing protector per family request. Resident #6, #13, #24, #55 were reviewed by the licensed nurse with no adverse effect noted from cited event Resident #420 no longer resides at the facility Other Residents The IDT reviewed current residents with physical impairments to address if adaptive call lights were needed, updates to incontinence plan of care, and adaptive equipment that is age appropriate.	

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F 550	Continued From page 4 Resident #66's room and delivered a paper for his roommate to read then left the room. * At 9:14 AM, CNA #9 walked by Resident #66's room, looked in the room then walked away. * At 9:18 AM, CNA#9 again walked by Resident #66's room, looked in the room then walked away. There was a distinct odor of stool in the hallway outside Resident #66's room. CNA #9, RN #5, and RN #8 walked by Resident #66's room without entering from 9:21 AM to 9:37 AM. An alarm sounded from Resident #66's room for his roommate's ventilator. At 9:40 AM, RN #5 entered the room, the alarm was then quiet, and RN #5 exited the room. The odor was still present upon her exit. There continued to be the odor of stool in the hallway outside Resident #66's room. CNA #15 and RN #5 walked by the room without entering from 9:46 AM to 9:56 AM. At 10:24 AM, Resident #66 was observed crying while lying in his bed in his room. When asked if he had a soiled brief he nodded his head up and down indicating "yes." When asked if he could reach his call light on his chest he shook his head side to side indicating "no." At 11:11 AM, CNA #9 stated incontinent residents were checked every 2 hours. CNA #9 stated she checked Resident #66 one hour ago. At 11:21 AM, Physical Therapist #1 entered Resident #66's room to perform bedside therapy. Physical Therapist #1 attempted to sit Resident	F 550	Findings were addressed. Rounds were made by IDT during meals to validate residents were served meals at the same time as their table mates with no other findings noted. Facility Systems Facility staff were educated by CNO and/or designee on resident rights to include but not limited to, the need to ensure if odors are detected during rounds that a CNA or nurse be notified to address care needs, and CNA and/or nurse promptly assist resident with care needs, ensure call lights are within reach and that the resident is able to use the call light with notification to nurse with any concerns, adaptive equipment is age appropriate, need to ensure meals are served to residents sitting at a table at the same time. MDS Coordinator and Unit Managers educated by CNO and/or designee on needs to ensure interventions are included in plan of care for identified items. The system is amended to include admitting nurse validate ability to use call light and document or change call light type as needed. IDT discussion on admission, change of condition to include need for adaptive call lights, adaptive equipment that is age appropriate, and incontinent care plans. IDT to round daily at various times to note if any odors in hallways, follow up on any findings to ensure resident care needs are met. Rounds during meals by IDT and/or licensed	

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F 550	Continued From page 5 #66 up at the side of the bed and Resident #66 was observed shaking his head side to side indicating "no." Physical Therapist #1 then laid him back down into bed and left the room. At 11:26 AM, CNA #15 went into the room and performed incontinence care for Resident #66. On 12/10/19, Resident #66 experienced emotional distress when he was incontinent of stool and unable to use his call light, and remained in an adult brief soiled with stool for 2 hours and 18 minutes (9:08 AM to 11:26 AM). On 12/12/19 at 1:46 PM, Resident #66 was in bed with his call light on his chest. The call light was a hard sided, push button type of call light. When asked if he could use his call light, Resident #66 shook his head side to side indicating "no." When asked if he could reach his call light, Resident #66 tried to move his left arm to his chest, but his arm could not move off of the bed. When asked if he had ever had a different type of call light, Resident #66 shook his head side to side indicating "no." On 12/11/19 at 8:33 AM, Charge Nurse #1 stated they kept "a close eye" on residents who required incontinence care. He stated residents were to be checked at a minimum of every two hours. 2. Resident #24, whose age was in the mid-30's, was admitted to the facility on 11/3/18, with multiple diagnoses including cerebral palsy (brain injury which most often happens before or during a baby's birth, or during the first 3-5 years of a child's life, that affects muscle tone, movement, and motor skills, and may also cause sight,	F 550	nurses to ensure meals served at the same time to table mates. Monitor The Social Worker and/or designee will audit for odors in hallways and adaptive call lights that can be activated by the resident 3 times a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. The Social Worker and/or designee will audit for meals being served timely to residents sitting at the same table at the same time, residents using age appropriate adaptive equipment for 5 meals a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 550	Continued From page 6 hearing, and learning problems) and intellectual disability. Resident #24's care plan, dated 8/6/19 and 11/21/19 respectively, documented she used a mitt for her right hand for skin protection, used a bottle with a nipple with all liquids, and wore a clothing protector to protect clothing and skin from moisture. On 12/8/19 at 11:52 AM, Resident #24 was in the day room in her wheelchair with a baby bottle and an oven mitt in her lap. She had on a small clothing protector with M&M caricatures on it. On 12/8/19 at 12:47 AM, Resident #24 was at the dining room table with a baby bottle with milk in it and her diet meal ticket at the table documented, "Baby bottles for beverages." On 12/9/19 at 9:46 AM, Resident #24 was in the day room in her wheelchair with an oven mitt on her right hand with a detachable strap holding the oven mitt in place around her elbow. She had on a small clothing protector with M&M caricatures on it. On 12/10/19 at 8:50 AM, Resident #24 was at the dining room table drinking juice from a baby bottle. She again had on a small clothing protector with M&M caricatures on it and an oven mitt in her lap. On 12/8/19 at 11:59 AM, RN #8 said Resident #24's oven mitt was used to protect her hand from skin breakdown because she chewed and sucked on her hand. RN #8 said the clothing protector was to protect her skin from breakdown	F 550		

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F 550	Continued From page 7 due to oral secretions. On 12/11/19 at 3:15 PM, the Director of Therapy said the facility had not been successful in finding a more appropriate adult-like glove or other option for Resident #24 who chewed on her hand. She said the baby bottle had not been assessed for appropriateness. On 12/11/19 at 3:53 PM and 4:19 PM, the Clinical Resource nurse, with the DON present, said Resident #24's family was providing the baby bottles, the clothing protectors, and the oven mitts. She said she could see how the baby bottles and clothing protectors could be viewed as "babyish." The DON said she did not expect Resident #24's meal tray ticket to document the use of a baby bottle. 3. Residents were not served their meals at the same time as their tablemates. a. On 12/8/19 from 12:24 PM to 12:33 PM, Residents #6, #13, #24, and #55 were seated at the same dining room table in the Alpine unit. Resident #13 was assisted with his lunch meal by CNA #9. Residents #6, #24, and #55 had not received their meals. At 12:33 PM, Resident #13 was finished with his meal and CNA #9 assisted him from the dining room. At 12:40 PM, Residents #6, #24, and #55 received their meals and were then individually assisted by three CNAs. At 12:50 PM, CNA #9 said there were not enough staff to assist the residents with their meals. On 12/10/19 at 1:28 PM, UM #2 said residents at the assistance table had not received their meals	F 550		

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F 550	Continued From page 8 at the same time because the CNAs were not available to assist them at that time. On 12/11/19 at 4:19 PM, the DON said she expected all of the residents at the same table to be served at the same time with staff there to assist them. b. On 12/8/19 at 12:26 PM, Resident #420 and one other resident were sitting at a table in the dining room. At another table, next to them, there were three residents sitting at the table waiting to be served lunch. The four other residents were served lunch and began eating, while Resident #420 was waiting to be served. On 12/8/19 at 12:33 PM, Resident #420 stated he did not know why he did not receive his meal with the other four residents. At 12:44 PM, LPN #2 observed Resident #420 without a plate in front of him and she notified the kitchen server. At 12:47 PM, Resident #420 was served his meal and he began to eat. The four other residents stayed and visited with each other, while Resident #420 ate his meal. On 12/8/19 at 12:52 PM, LPN #2 stated all the residents at a table should be served their meal at the same time. On 12/8/19 at 1:10 PM, UM #2 stated all the residents should have been served at the same time.	F 550		
F 552 SS=G	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care.	F 552		2/4/20

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F 552	Continued From page 9 The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, resident and family interview, and policy review, it was determined the facility failed to ensure appropriate consent was obtained from a resident's Co-Guardians for a laboratory test when the resident did not have the capacity to make their own medical decisions. This was true for 1 of 26 residents (Resident #69) reviewed for resident rights. This deficient practice caused psychosocial harm by causing emotional distress to Resident #69 after he refused to provide urine for a laboratory test which was later obtained by straight catheter after four staff approached him and stated it was physician ordered. Findings include: The facility's policy Resident Rights, with a release date of 11/28/2017, stated "Each resident	F 552	F552G Resident Specific Resident #69 no longer resides at the facility Other Residents IDT reviewed current residents with guardians and/or conservators to validate that notification/consent was obtained and documented for procedures ordered within the last 30 days. Appropriate notifications were made for any findings. Facility Systems	

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F 552	Continued From page 10 has the right to exercise their rights as a resident of the Facility and as a citizen or resident of the United States without interference, coercion, discrimination, and reprisal and be supported by the facility in the exercise of those rights ... Throughout the Resident Rights policies, the term resident also applies to resident or resident and/or a surrogate decision-maker (any person who may, under state law, act on the resident's behalf when the resident is unable to act for himself or herself). Resident Rights include the resident's right to exercise his or her rights ... and participate in decisions ...To request, refuse, and/or discontinue treatment ...In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law ..." This policy was not followed. Resident #69 was admitted to the facility on 10/4/18, with multiple diagnoses including a stroke affecting his left non-dominant side, bipolar disorder (unusual shifts in mood and activity levels), and schizoaffective disorder (symptoms of hallucinations or delusions, mania, and depression). Resident #69's record included a "Letter of Co-Guarding" which documented two people were duly appointed and qualified as Co-Guardians for Resident #69 on 6/14/18. The letter documented Resident #69 was an incapacitated and protected person. A quarterly MDS assessment, dated 7/19/19,	F 552	Licensed staff was educated by CNO and/or designee regarding resident rights to include but not limited to the need to contacting co-guardians for consent and to document conclusions of the conversation. The system is amended to validate consent/notification was obtained and documented for new orders/procedures during clinical meeting. Monitoring The CNO and/or designee will audit 3 resident charts with guardians/conservators for documentation of notification of new orders weekly for 4 weeks, then one resident weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 552	Continued From page 11 documented Resident #69 was cognitively intact but he had unclear speech. The assessment documented he required two or more staff for bed mobility, transfers, personal hygiene, toilet use, and dressing. The assessment also documented Resident #69 had impairment on one side of his upper and lower extremities. A Care Plan, revised on 8/5/19, identified Resident #69 had impaired cognitive function with impaired thought processes related to impaired decision making due to traumatic brain injury. The goals included communicating with family regrading his capabilities and needs. The care plan interventions included for Resident #69 to be able to communicate his basic needs, to remain oriented to person, place, situation, and time, and to maintain his current level of cognitive function. A behavior progress note by the IDT, dated 7/31/19 at 10:40 AM, stated on 7/29/19 Resident #69 was observed acting out of the ordinary from his base line. A CNA asked Resident #69 what was wrong, and he informed the CNA his caregiver, hired by his family for socialization, had given him a marijuana brownie. The physician was informed, and an order was written for a urine drug screen. The note documented Resident #69's family was informed of the situation also. A physician's order, dated 7/31/19 at 4:30 PM, documented "Urine drug/tox [toxicity] screen. One time only for Urine lab for 1 Day." A progress note, dated 8/2/19 at 8:26 PM, documented urine needed to be collected for a	F 552		

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F 552	Continued From page 12 drug/toxicity screen on 7/31/19 for Resident #69. The note stated Resident #69 was refusing to use his urinal and was incontinent of urine and this was reported to the nurse practitioner on call and an order was received to use a straight catheter to obtain the urine sample if Resident #69 allowed. The note documented Resident #69 refused the straight catheter and the nurse practitioner was informed. A nurse's progress note, dated 8/3/19 at 5:56 AM, documented two nurses and a CNA approached Resident #69 and asked him if he would consent to a urine laboratory test ordered by a physician. They told him they would obtain the urine by a straight catheter. Resident #69 agreed to obtaining the urine for the laboratory test. Two nurses and two CNAs obtained the urine sample using a straight catheter. On 12/10/19 at 9:50 AM, Co-Guardian #1 stated after telling the facility not to do a laboratory test for Resident #69, the facility went ahead and did the laboratory test anyway without permission from the guardian. The family member stated there was no need for the test and he had told them that. On 12/12/19 at 3:21 PM, the DON was interviewed regarding the urinalysis obtained without the guardian's permission. The DON said the one guardian had returned after the other guardian had left and said it was okay to do the urinalysis. The DON was asked where it was documented the one guardian had given permission. The DON looked in the notes and stated, "I guess no one documented it."	F 552		

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F 552	Continued From page 13 On 12/12/19 at 3:25 PM, the Administrator was interviewed regarding the court appointed Co-Guardians of the resident. The Administrator was asked if the Co-Guardians were to decide on Resident #69's medical care and treatments. The Administrator said the guardians had been appointed by the court to oversee Resident #69 in everything but his housing. The housing where Resident #69 was placed was the only thing they both had to agree upon.	F 552		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, resident interview, and staff interview, it was determined the facility failed to ensure residents needs were accommodated when a resident's call light was out of reach and was inadequate for the resident's physical limitations, the double doors leading to the Activity Room were difficult to open and keep open, and a resident's urinal was out of reach. This was true for 4 of 8 residents (#4, #9, #27, and #30) in the Resident Group interview and 2 of 21 residents (#15 and #66) reviewed for accommodation of needs. This failure created the potential for harm if residents fell trying to open and keep open doors and when reaching for urinals, and if residents needs were not met when call lights	F 558	F558E Resident Specific Resident #66 had a skin evaluation completed with no adverse effects noted related to cited event. The IDT reviewed resident #66 related to impairments and current needs. Resident #66 care plan was revised to include but not limited to interventions for incontinence care and an adaptive call light was implemented. Resident #66 was able to return demonstrate use of adaptive call light and is satisfied with updates.	2/4/20

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F 558	Continued From page 14 were inappropriate or unavailable. Findings include: The facility's Resident's Environment policy, dated 11/28/19, documented the facility was to provide residents with reasonable accommodation of needs and preferences, including common areas frequented by residents, and call lights that are adapted to meet the needs of the residents. This policy was not followed. 1. Resident #66 was admitted to the facility on 10/11/19, with multiple diagnoses including stroke, muscle weakness, transient paralysis (unable to move intermittently), and diabetes. Resident #66's Physical Therapy Evaluation, dated 10/11/19, documented he had severe weakness of the left and right hands. An Occupational Therapy note, dated 10/14/19, documented Resident #66 had impaired range of motion, and impaired fine and gross motor coordination in both hands. An admission MDS assessment, dated 10/21/19, documented Resident #66 had upper extremity impairment (shoulder, elbow, wrist, and hand) on both sides of his body. Resident #66's care plan documented he had limited physical mobility related to physical weakness and stroke. A Physical Therapy summary, dated 12/1/19 to 12/7/19, documented Resident #66 had	F 558	Resident #4, #9, #27 and #30 were reviewed by the Social Worker for adverse effects related to the cited event with no adverse findings. They were informed that the facility has a work order in progress with a construction group to install magnetic door holders on resident access doors that may be difficult to navigate in a wheelchair. Resident #15 was evaluated by licensed nurse with no adverse effect noted. Rounds made by IDT with both urinals noted empty and within residents reach. Other Residents IDT reviewed current residents that use urinals, have adaptive call lights for resident ability to activate, and rounds were made to validate that urinals and call lights were within reach for residents as indicated with no further findings. CEO, plant services, and the resident council president made rounds to determine which resident access doors could benefit from magnetic door holders.	

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F 558	Continued From page 15 impairments which included body awareness deficits, decreased functional capacity, gross motor coordination deficits, motor control deficits, and sensation and strength impairments. On 12/8/19 at 12:02 PM, CNA #10 was asked how Resident #66 called for assistance and CNA #10 stated Resident #66 could use the call light provided by pushing the button on the call light with his thumb. CNA #10 stated Resident #66 could answer yes and no questions with head movement. CNA #10 stated there was a need for better communication with Resident #66. On 12/10/19 at 9:08 AM, Resident #66 was lying on his back in bed and a strong odor of stool was present. The call light was on Resident #66's chest. At 10:24 AM, CNA #15 looked into Resident #66's room and stated she was doing rounds. Resident #66's call light remained on his chest. When Resident #66 was asked if he could reach his call light, he shook his head "no". At 11:01 AM, RN #5 entered and exited the room. The call light remained on Resident #66's chest. On 12/11/19 at 2:58PM, Resident #66's call light was on the floor by the left side of his bed. On 12/12/19 at 8:56 AM, CNA #10 stated Resident #66 did not use his call light "even though we put it in his hand" and staff had to check on him. On 12/12/19 at 9:17 AM, RN #4 stated Resident #66 had a squeeze type of call light that RN #4 had checked to make sure Resident #66 could use. When asked if Resident #66 had a push button call light, RN #4 stated he thought	F 558	Facility Systems Nursing staff was educated by CNO and/or designee on the accommodation of need for residents, to include but not limited to urinals placed within reach, adaptive call lights that can be activated by the resident, resident access areas to have ease of entry, and other items that would accommodate resident needs as indicated per plan of care. The system is amended to include IDT rounds validating that urinals are within reach and adaptive call lights can be activated by the resident for residents in bed. Activity room doors will be maintained in an open state by magnetic door holders that are tied into the facility fire system to accommodate resident needs. Magnets are anticipated to be installed on February 4, 2020. Monitoring The Department Managers and/or designee will complete rounds to determine urinals, adaptive call lights, access doors, etc can be activated by residents 3 times weekly for 4 weeks, then once weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any	

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F 558	Continued From page 16 Resident #66 had a squeeze type of call light. On 12/12/19 at 1:46 PM, Resident #66 was in bed with his call light on his chest. The call light was a hard sided, push button type of call light. When asked if he could use his call light, Resident #66 shook his head side to side indicating "no." When asked if he could reach his call light, Resident #66 tried to move his left arm to his chest, but he was unable to move his arm off of the bed. When asked if he had ever had a different type of call light, Resident #66 shook his head side to side indicating "no." When asked if he would like another type of call light, Resident #66 shook his head up and down indicating "yes." On 12/12/19 at 1:50 PM, UM #1 was asked about Resident #66's call light use and if he had ever witnessed him use it. UM #1 answered he had to check. UM #1 did not provide additional information. 2. On 12/10/19 at 2:35 PM, during the Resident Group interview in the Activity Room, Resident #30 said the Activity Room doors were hard to open, especially for those with wheelchairs. He said he had told various staff members, including the Maintenance Director. He said all the staff knew about the door because they had to hold them open so residents could come and go from the room. At 3:15 PM, Resident #4 joined the group interview in the Activity Room and a staff member assisted to open the door, so he could navigate his wheelchair into the room. Residents #4, #9, #27, and #30 said they had trouble opening the	F 558	concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 558	Continued From page 17 doors and keeping them open to get in and out of the room. On 12/10/19 at 3:40 PM, the double doors to the Activity Room had straight handles on the hallway side of the doors with a latch at the top of the doors. The other side of the Activity Room doors had a push bar function. When opened, the doors closed on their own. On 12/11/19 at 9:33 AM, the Activity Director said residents had difficulty coming into the Activity Room because she was told by the Maintenance Director the doors had to be kept closed and they closed automatically. On 12/11/19 at 9:54 AM, the Maintenance Director said he was aware the Activity Room doors were a concern for residents and Resident #30 had spoken to him about his concern. The Maintenance Director said the door closed automatically because it was a fire safety feature. He said he had thought of keeping the doors opened with magnets and they would close if the fire alarm went off. He said he had not placed magnets on the Activity Room doors. 3. Resident #15 was readmitted to the facility on 9/6/19, with multiple diagnoses including morbid (severe) obesity and rectal fistula (an abnormal connection between the end of the bowel and the skin). An admission MDS, dated 10/11/19, documented Resident #15 required extensive assistance of two staff members for most of his ADLs except for eating.	F 558		

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F 558	Continued From page 18 Resident #15's ADL care plan, revised on 9/19/19, documented Resident #15 had two urinals at his bedside. On 12/13/19 at 11:08 AM, Resident #15 was observed in bed. Resident #15 said he needed to use his urinal but he could not reach it. Resident #15's two empty urinal containers were observed on top of his overbed table located at the foot of his bed and was out of his reach. On 12/13/19 at 11:11 AM, CNA #7 entered Resident #15's room and assisted Resident #15 to use his urinal. CNA #7 said the urinals should be within reach of Resident #10.	F 558		
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 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.	F 565		2/4/20

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F 565	Continued From page 19 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §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. This REQUIREMENT is not met as evidenced by: Based on Resident Council meeting minutes, Resident Group interview, policy review, and staff interview, it was determined the facility failed to ensure Resident Council concerns were addressed. This was true for 3 of 8 residents (#9, #30, and #44) who participated in the Resident Group interview. This deficient practice had the potential to cause psychosocial harm for residents frustrated by the perception their concerns were not valued or addressed by the facility. Findings include: The facility's Grievance policy, dated 11/28/17, documented the facility would make prompt efforts to resolve grievances, including Resident Council concerns, and to keep residents notified of progress toward resolution. Resident Council Meeting minutes, dated 9/4/19, documented concerns with call light response times up to 30 minutes and very slow response times during meals. Resident Council Meeting	F 565	F565E Resident Specific Resident Council minutes from 9/19-12/19 were reviewed by the IDT. Concerns regarding call light response times, food temps and room tray delivery, staffing and resident showers were reviewed and addressed to include documentation of interventions and resident response. Resolution was reviewed with Resident #9, Resident #30, Resident #44 and will also be reviewed at the next resident council meeting by CEO. Residents expressed they were appreciative of	

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F 565	Continued From page 20 minutes, dated 10/2/19, documented concerns with call light response times up to one and a half hours, not enough staff, staff saying they would come back to help residents and did not, and breakfast served in resident rooms were late. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19 meeting. Resident Council Meeting minutes, dated 11/6/19, documented concerns with call light response times up to two hours, long response times during shift change, staff saying they would come back to help residents and did not come back, and room trays were late due to not enough staff to pass out trays. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19 or 10/2/19 meetings. Resident Council Meeting minutes, dated 12/4/19, documented concerns with not enough staff on the weekends and not all the residents were getting showers as scheduled. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19, 10/2/19, and 11/6/19 meetings. On 12/10/19 at 2:35 PM, during the Resident Group interview, Residents #9, #30, and #44 said there were still issues with slow call light response times, not enough staff, low food temperatures, and late delivery of trays. They stated these concerns were not addressed by the facility. On 12/11/19 at 9:36 AM, the Activity Director said she emailed the Resident Council meeting notes	F 565	progress made in these areas, are willing to be part of the solution, and will continue to provide feedback to the CEO as part of the solution. Other Residents Resident Council minutes from 9/19-12/19 were reviewed by the IDT to validate concerns addressed with follow up to include documentation with findings. Resident Council was held with meeting minutes reviewed to validate that concerns are addressed and follow up conducted with resident(s) and documented. Facility Systems Activity Director, Social Workers, CEO, and CNO were educated by Clinical Resource RN and/or designee regarding the need to review previous resident council meeting concerns to validate residents are aware of resolution as indicated and are satisfied with outcome. Grievance forms will be written for concerns brought up during resident council for documentation of follow up and outcome. CEO will validate that concerns are managed and resident response is documented. The system is amended to include, CEO and leadership holding a snack and chat community	

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F 565	Continued From page 21 to the department heads. She said she had not been given direction to readdress the old complaints during the Resident Council meetings. The Activity Director said the Administrator met individually with the Resident Council President to address the Resident Council concerns. On 12/11/19 at 1:10 PM, the Administrator said he met with the Resident Council President and relied on the council's President to report back to the Resident Council. The Administrator provided minutes for meetings with the council's President for 11/11/19 and 11/27/19. The minutes did not document a discussion of not enough staff, staff saying they will come back to help residents and then not coming back, and late meal trays. The Administrator said he did not see where concerns were readdressed in the Resident Council minutes. The Administrator said he expected Resident Council concerns to be addressed.	F 565	meeting as an opportunity for residents to bring up concerns and have open discussion directly with management regarding follow up to concerns. Monitoring The CEO and/or designee will audit grievances and resident council minutes for documentation to resolution weekly for 4 weeks, then every other week for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary	F 578		2/4/20

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F 578	Continued From page 22 or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents' advance directive information was reviewed quarterly with the resident and/or their representative. This was true for 1 of 9 residents (Resident #19) whose advanced	F 578	F578D Resident Specific	

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F 578	Continued From page 23 directives were reviewed. This failed practice created the potential for harm if the resident's documented wishes were not accurate and up-to-date regarding their advance directive information. Findings include: The facility's policy regarding Advanced Directives/Health Care Decisions, dated 10/1/17, documented the following: * The facility determined upon a resident's admission whether the resident had executed an advanced directive or other instructions to indicate their care preferences in the event the resident became incapacitated. * If the resident or their representative had executed an advance directive, a copy was obtained and maintained in the resident's record. * If the resident had not executed an advance directive, the facility informed the resident and their family of their right to establish an advance directive. * The facility documented discussion about advance directives and any healthcare decisions in the resident's record. * If the resident wanted to formulate an advance directive, a nurse or social worker provided written information regarding the right to make decisions regarding medical care. * The facility established processes for documenting and communicating the resident's choices to the interdisciplinary team. * The facility "identifies, clarifies, and periodically reviews at least quarterly, after a life altering event... and after return from a hospitalization, as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these	F 578	Resident #19 advance directive information was reviewed with the resident and responsible party to validate there were no changes or additional education resources needed. No further information or requests made at this time. Other Residents Current residents were reviewed for date of last advance directive review conducted with resident and/or family to validate compliance. Findings were addressed as indicated. Facility Systems Social Services and Unit Managers were re-educated by the CNO and/or designee on the facility advance directives to include but not limited the need to review advance directive information at least quarterly and with change of condition and document review. The system is amended to include weekly review of residents who have had care plan conferences and/or change of condition to validate advanced directives were discussed. Monitoring	

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F 578	Continued From page 24 instructions." This policy was not followed. Resident #19 was admitted to the facility on 2/7/19, with multiple diagnoses including stroke, hemiplegia and hemiparesis (weakness and paralysis on one side), and aphasia (loss of ability to understand or express speech). A Multidisciplinary Care conference note, dated 2/18/19 at 9:14 AM, documented a care conference meeting was held with Resident #19 and her son in attendance. The note documented advance directive information was offered and it was declined at that time. A Multidisciplinary Care conference note, dated 5/22/19 at 8:42 AM, documented a care conference meeting was held with Resident #19, and her son did not attend. The note documented advance directive information was offered. There was no documentation in Resident #19's record the advanced directive information was reviewed or offered to Resident #19 and/or her representative after 5/22/19. Resident #19's significant change MDS assessment, dated 10/16/19, documented she was moderately cognitively impaired. On 12/10/19 at 11:50 AM, the DON said there was only a POST form in Resident #19's record, but her care plan was updated to say she was not cognitively able to make the decision regarding advance directives. On 12/11/19 at 3:06 PM, the DON said the	F 578	The Director of Medical Records and/or designee will audit 5 residents with change of condition and/or care conferences in the last week for documentation that advanced directives were reviewed weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 578	Continued From page 25 Resident Services Manager (RSM) discussed advanced directive information with residents at their care conferences. On 12/11/19 at 3:15 PM, the RSM said she asked residents at their care conferences if they had an advanced directive, and she asked for a copy if they had one. The RSM said if the resident did not have an advance directive, she asked if they would like one and the Social Worker helped them fill it out if they wanted to complete it. The RSM said an advance directive or Living Will was offered at every care conference meeting. The RSM said a care conference meeting was held with Resident #19's son. The RSM said Resident #19's son was asked if he wanted information regarding advance directives, he said yes, and the facility informed him Resident #19 did not have the cognitive ability to make that decision so she could not complete the advance directive. The RSM said at the care conference on 2/21/19, Resident #19's son did not want information regarding advance directives. The RSM said there was no advance directive or Living Will completed for Resident #19 prior to her admission to the facility or change in condition. The RSM said the last time Resident #19's advance directive information was reviewed was in May 2019, and it should be reviewed quarterly. The RCM said Resident #19 had a change in condition, and she should have had another care conference since then but she did not.	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,	F 580		2/4/20

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F 580	Continued From page 26 consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (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. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in	F 580		

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F 580	Continued From page 27 §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure the guardian was notified of a significant medication error. This was true for 1 of 26 residents (Resident #70) whose records were reviewed for notification of changes. This deficient practice placed Resident #70 at risk due to lack of information sharing and residents right to be informed. Findings include: The facility's Resident Change of Condition policy, dated 11/28/17, documented the facility was to immediately inform the resident, the physician, and the resident representative when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention; 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); or a need to alter treatment significantly. This policy was not followed. Resident #70 was admitted to the facility on 3/14/19, with multiple diagnoses including atrial fibrillation (irregular heart rhythm), diabetes, and hypertension (high blood pressure).	F 580	F580D Resident Specific Resident #70 no longer resides at the facility. Other Residents Nursing Administration reviewed medication errors that occurred in the last 90 days to validate physician and Responsible Party notification were made and documented and any findings corrected. Facility Systems Licensed Nurses were educated on the facility Change of Condition Policy to include but not limited to, timely responsible party notification of medication errors. The system is amended to include review of medication	

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F 580	Continued From page 28 A quarterly MDS assessment, dated 6/24/19, documented Resident #70 was moderately cognitively impaired. A Nurse's Progress Note, dated 7/10/19 at 5:28 AM, documented the wrong medications were administered to Resident #70 on 7/9/19. The note documented Resident #70 received eight medications in error at 7:00 PM on 7/9/19. The medications he received were as follows: - Ranitidine (used to decrease stomach acid production) - Lithium (used to treat psychiatric disorders) - Morphine IR (an opioid pain medication with an immediate release) - Soma (a muscle relaxer) - Lyrica (used to treat seizures, nerve pain, and fibromyalgia) - Gabapentin (used to treat nerve pain) - Simvastatin (used to treat high cholesterol) - Trazodone (used to treat depression and insomnia) The progress note did not include documentation the guardian was notified. A Medication/Treatment/Lab Error Report, dated 7/9/19 at 7:15 PM, documented Resident #70 received the wrong medications. The report documented Resident #70 was notified of receiving the wrong medications on 7/10/19. The report documented the physician was notified and received orders to monitor Resident #70's pulse and oxygen saturations. The report documented Resident #70 was lethargic and vital signs were stable.	F 580	errors during clinical meeting to validate responsible party notification occurred and is documented. Monitoring The CNO and/or designee will audit each medication error incidents for documentation that resident advocate is notified weekly for 4 weeks, then every other week for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 580	Continued From page 29 On 12/10/19 at 3:02 PM, Resident #70's guardian said neither of Resident #70's guardians were notified of the medication error that occurred on 7/9/19. On 12/12/19 at 1:12 PM, the DON said Resident #70's record did not include documentation the guardians were notified of the medication error on 7/09/19. Resident #70's guardians were not notified when he received the wrong medications.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		2/4/20

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F 583	Continued From page 30 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to ensure a resident's private health information was protected when an arm bracelet displayed private health information. This was true for 1 of 21 residents (Resident #6) reviewed for privacy. This failure created the potential for residents to experience a decreased sense of self-worth when their confidential health information was displayed to the public. Findings include: The facility's quality of life policy, dated 11/28/17, directed staff not to display confidential clinical or personal information. This policy was not followed. Resident #6 was readmitted to the facility on 9/17/19, with multiple diagnoses including osteoarthritis. Resident #6's care plan, dated 9/17/19, documented she was at risk for falls. On 12/8/19 at 12:35 PM and on 12/10/19 at 8:33 AM, Resident #6 was in the dining room in her	F 583	F583D Resident Specific Resident #6 hospital fall bracelet was removed. No s/s of adverse effect noted upon evaluation by licensed nurse. Other Residents IDT completed rounds with no other residents noted with fall bracelets from the hospital noted. Facility System Nursing staff was educated by CNO and/or designee regarding privacy and confidentiality to include residents not	

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F 583	Continued From page 31 wheelchair and had a yellow bracelet on her right wrist which had the words "FALL RISK" imprinted on it. On 12/10/19 at 9:39 AM, Resident #6 said she did not know why she had the "FALL RISK" bracelet on. On 12/10/19 at 1:39 PM, LPN #2 said Resident #6 had a history of falling and said she had the bracelet on her wrist for at least three or four weeks. She said she was not sure where the bracelet came from since the facility did not use them. On 12/11/19 at 3:35 PM, Resident #6 was in her bed with the yellow bracelet on her wrist. On 12/11/19 at 3:39 PM, Hospice RN #1 said Resident #6 was at risk for falling. She said the hospice provider did not use fall risk bracelets and said she thought the facility had placed the bracelet on her wrist. On 12/11/19 at 3:42 PM, the DON said the facility did not use fall risk bracelets and expected staff to remove them if residents had them on.	F 583	wearing bracelets that were initiated in the hospital that identify private health information. Admission checklist was modified to include to review for any hospital bracelets in place and to remove upon admit. Monitoring The CNO and/or designee will audit residents for bracelets or other private health information visible weekly for 4 weeks, then monthly for 2 months. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Completion February 4, 2020	
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		2/4/20

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F 585	Continued From page 32 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. §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. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §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: (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;	F 585		

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F 585	Continued From page 33 (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	Continued From page 34 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. 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 grievances were responded to and investigated, and prompt corrective action was taken to resolve the grievances. This was true for 2 of 26 residents (#30 and #56) reviewed for grievances. This failure created the potential for harm if residents' verbal grievances were not acted upon and residents were not provided appropriate care to meet their care and needs. Findings include: The facility's Complaints and Grievances Policy and Procedure, dated 11/28/17, documented: * Residents had the right to voice grievances verbally or in writing. * The facility should make prompt efforts to resolve grievances the resident may have. * Complaints/grievances may be brought by any individual or group. * Complaints/grievances were acknowledged, investigated, and the complainant was apprised of progress toward a resolution and took appropriate corrective action if the alleged violation was confirmed by the facility. This policy was not followed. 1. Resident #56 was admitted to the facility on	F 585	F585 Resident Specific Resident #56 had personal shampoo, face wash, leggings and concert T-shirt replaced. Resident #56 expressed satisfaction. Resident #30 was reviewed by the Social Worker for adverse effects related to the cited event with no adverse findings. They were informed that the facility has a work order in progress with a construction group to install magnetic door holders on resident access doors that may be difficult to navigate in a wheelchair. Other Residents IDT reviewed current residents for grievances that had not been addressed and CEO, plant services, and the resident council president made rounds to determine which resident access doors	

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F 585	Continued From page 35 5/16/19, with multiple diagnoses including hemiplegia and hemiparesis affecting the left side (paralysis or weakness on one side of the body) following a stroke and seizure disorder. Resident #56's quarterly MDS assessment, dated 11/18/19, documented she was cognitively intact. On 12/8/19 at 11:48 AM, Resident #56 said she had no shampoo or face wash due to her prior roommate using it and then her roommate took some with her. She said they were expensive products. Resident #56 said she told staff and they told her the items would not be replaced because they were not on her inventory, and the staff had thrown the remaining bottles away. Her roommate was discharged prior to 11/29/19. On 12/9/19 at 10:40 AM, Resident #56 said she was missing leggings and a concert T-shirt and she had reported it to facility staff. Resident #56 stated she was told laundry service looked for the clothing items but did not find them. She stated nothing happened after that. The facility's grievance file did not include a grievance for Resident #56. On 12/11/19 at 10:34 AM, the RSM said a resident would let her know their grievance and she wrote the grievance, checked the laundry, and if a missing item was not found it was replaced. The RSM said Resident #56 had not reported her missing clothes, and she knew about Resident #56's missing face wash and hair products. The RSM said she had suggested to Resident #56 it would be better to get a physician order for the scalp shampoo. The RSM said they	F 585	could benefit from magnetic door holders. Facility Systems Staff educated to complete grievance forms for concerns brought up by residents and/or resident advocates. CEO will validate that concerns are managed and resident response is documented. The system is amended to include, IDT rounds to include asking residents if they have any concerns and completing grievance forms as indicated. Monitoring The CEO and/or designee will audit grievances for documentation to resolution weekly for 4 weeks, then every other week for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 585	Continued From page 36 offered to get an order and purchase scalp shampoo and Resident #56 said that would be okay. Resident #56's record did not include documentation of a physician order for special scalp shampoo. On 12/13/19 at 9:44 AM, the RSM reviewed Resident #56's record and said she did not see an order for shampoo. She said if a written grievance for Resident #56's missing property was not found in the grievance file then she had not written a grievance on Resident #56's behalf. The facility failed to ensure Resident #56's grievances were documented, investigated, and acted upon. 2. On 12/10/19 at 2:35 PM, during the Resident Group interview, Resident #30 said the Activity Room door was hard to open, especially for those with wheelchairs. He said he had told various staff members, including the Maintenance Director. He said all the staff knew about the door because they had to hold them opened so residents could come and go from the room. On 12/11/19 at 9:54 AM, the Maintenance Director said he was aware the Activity Room door was a concern for residents and Resident #30 had spoken to him about his concern. The Maintenance Director said he had not filed a grievance regarding the concern. On 12/11/19 at 10:43 AM, the RSM said she was the grievance coordinator. She said there was	F 585		

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F 585	Continued From page 37 not a grievance for Resident #30 regarding the Activity Room door. She said she expected staff to help residents file grievances when concerns were brought to them. The facility did not ensure Resident #30's grievance was documented and acted upon.	F 585		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on employee record review and staff interview, it was determined the facility failed to ensure employee reference checks were completed prior to potential employees starting work in the facility. This was true 4 of 5 (Staff A, C, D and E) staff whose personnel files were reviewed for pre-employment background checks. This had the potential to place each of the 74 residents residing in the facility at increased risk of adverse events. Findings include: The facility's Preventing Abuse policy, revised 7/13/18, directed the facility to complete at least	F 607	F607E Resident Specific No specific resident(s) identified. Reference checks were completed for staff A, C, D and E unless they no longer	2/4/20

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F 607	Continued From page 38 two reference checks for employees upon hire. This was not followed. On 12/10/19 at 4:32 PM, five employees' personal files were reviewed for reference checks as follows: *Staff A was hired on 1/20/19 *Staff C was hired on 10/1/19 *Staff D was hired on 11/5/19 *Staff E was hired on 12/3/19 Staff A, C, D, and E's files did not contain reference checks at the time of review. HR/Payroll Staff #1 said she was not working in the facility when Staff A was hired, and she did not know why Staff A did not have reference checks completed. HR/Payroll Staff #1 said they had 30 days to complete the employees' personnel files and due to lots of paper work it might have slipped her mind that Staff C, Staff D, and Staff E did not have a reference checks.	F 607	work at the facility. Other Residents Current employee files reviewed by HR representative to validate reference checks were completed. Any items were corrected. Facility Systems HR representative was educated by CEO and/or designee regarding the Preventing Abuse policy including but not limited to the need for at least 2 reference checks to be completed for employees upon hire. The system is amended to include that prior to hire, reference checks are completed and verified as completed by HR and/or designee. Monitoring The CEO and/or designee will audit new employee files for reference checks weekly for 4 weeks, then monthly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12	

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F 607	Continued From page 39	F 607	weeks, as it deems appropriate. Date of Completion February 4, 2020	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, facility policy review, and review of Incident and Accident (I&A) reports, it was determined the facility failed to ensure an alleged perpetrator was not allowed to report for work while an investigation of alleged abuse was being conducted. This was true for 1 of 5 residents (Resident #10) reviewed for abuse and neglect.	F 610	F610D Resident Specific Resident #10 was evaluated with no further skin impairment or signs of injury	2/4/20

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F 610	Continued From page 40 The deficient practice placed residents at risk of ongoing abuse. Findings include: The facility's Abuse policy, revised 7/23/19, documented staff implicated in an abuse/neglect situation would be suspended pending investigation results, and interview notes should contain the full name of the person interviewed, time and date. This policy was not followed. Resident #10 was admitted to the facility on 9/24/18, with multiple diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following cerebral infarction (stroke) and anxiety. Resident #10 annual MDS assessment, dated 10/1/19, documented she was severely cognitively impaired and required extensive assistance of 1 - 2 staff members for her ADLs. Resident #10's physician's orders included Aspirin (may interfere with blood clotting at low doses) 81 mg one tablet one time a day for cardiac (heart) precautions, ordered on 12/4/18. A Nursing Note, dated 1/27/19 at 5:30 PM, documented the nurse was called by a CNA to check on the bruise found on Resident #10's arm. The bruise measured 11 cm x 9 cm extending down to her right breast measuring 8 cm x 5 cm. Resident #10 denied pain and did not know how it happened. An I&A report documented Resident #10's bruise	F 610	noted. Resident #10 transfer technique was reviewed by physical therapy and verified as appropriate. Staff F no longer works at the facility Other Residents Review of abuse allegation in the last 30 days was completed by CEO to validate that if a staff member was identified or suspended for potential abuses that they remained on suspension until the investigation is cleared with no further findings noted at this time. Facility Systems CEO, CNO, and DOR were re-educated on facility abuse policy which incudes but is not limited to, if a staff member is suspected or accused of potential abuse they are to be immediately suspended pending investigation and not returned to work until investigation is completed and abuse is ruled out. The system is amended to include team review prior to suspended employee return to work. Monitoring	

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F 610	Continued From page 41 was found on 1/27/19. The I&A report documented during witness statement collection Staff A went and looked at Resident #10's bruise and reported to the nurse she thought her bruise could have happened during her therapy session with Staff F on 1/26/19 with the STS lift. The I&A report documented the Administrator and DON were notified and Staff F was put on suspension pending investigation. The I&A report also documented Staff F was interviewed by the Director of Therapy on 1/28/19 and two more staff were interviewed on the same day. The I&A report also documented five residents who were under the care of Staff F were interviewed on 1/30/19 and there were no concerns noted. On 12/11/19 at 8:46 AM, HR/Payroll Staff #1 provided the 1/25/19 through 1/30/19 Time Card Report of Staff F. Staff F's Time Card Report documented the following: *1/27/19 - In at 9:59 PM and Out at 10:10 PM *1/28/19 - In at 8:00 AM and Out at 4:00 PM *1/29/19, In at 9:15 AM and Out at 6:50 PM *1/30/19, In at 9:00 AM and Out at 5:49 PM On 12/11/19 at 10:25 AM, the Administrator said he was the Abuse Coordinator and he enlisted the assistance of the DON, LSW and other departmental Supervisors in investigating an abuse incident. The Administrator said the alleged perpetrator would be suspended immediately until the abuse was ruled out which could be from an hour to 24 hours or more and they could return to work after it was determined it was not abuse. The Administrator reviewed	F 610	The CEO and/or designee will audit abuse investigations to validate alleged perpetrators are not allowed to report for work while investigation is on-going weekly for 4 weeks, then monthly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 610	Continued From page 42 Staff F's Time Card Report and said PT staff could check in remotely to finish their documentation. The Administrator said Staff F was informed of the incident on Sunday, 1/27/19 and could have written her statement on 1/27/19 between 9:59 PM and 10:10 PM as shown on her Time Card Report. When asked why Staff F was allowed to come back to work on 1/28/19 through 1/30/19 while the investigation was still in progress, the Administrator said he had a conference call with DON, LSW and the Director of Therapy on the night of 1/27/19 and they determined abuse did not occur to Resident #10 based on Staff A, Staff F, and Resident #10's interviews, and her bruise was caused by the sling from the STS lift. The facility failed to ensure the alleged perpetrator was not allowed to report for work while the alleged abuse was being investigated as documented in its Abuse Policy.	F 610		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral	F 622		2/4/20

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F 622	Continued From page 43 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 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:	F 622		

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F 622	Continued From page 44 (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. (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 staff interview, policy review, and record review, it was determined the facility failed to ensure required information was provided to the receiving facility when a resident was transferred to the hospital. This was true for 4 of 5 residents (#15, #36, #39 and #62) reviewed for	F 622	F622E Resident Specific	

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F 622	Continued From page 45 transfers. This deficient practice had the potential to cause harm if the residents were not treated in a timely manner due to lack of information. Findings include: The facility's Transfer & Discharge policy, dated 11/28/17, documented when the discharge or transfer of a resident was necessary, the following information should be provided to the receiving provider: *Contact information of the practitioner responsible to the care of the resident. *Resident representative information including contact information. *Advance Directive information. *Special instructions and/or precautions for ongoing care such as need for oxygen use, isolation precautions, and other risk factors such as risk for falls, bleeding, aspiration precautions and pressure ulcer injury. *The resident's comprehensive care plan. *List of medications, relevant laboratory and diagnostic test, diagnoses and allergies. This policy was not followed. Examples include: 1. Resident #15 was readmitted to the facility on 12/13/18, and again readmitted on 9/6/19, with multiple diagnoses including acute respiratory failure with hypoxia (decreased oxygen supply to the body tissues) and hypercapnia (excessive carbon dioxide in the bloodstream caused by inadequate respiration) and rectal fistula (an abnormal connection between the end of the bowel and the skin). A Nurse's Progress Note, dated 9/1/19,	F 622	Resident #15, Resident #36 and Resident #39 have been re-admitted to the facility and were reviewed by a licensed nurse. Documented plan of care per physician□s order in place with no adverse effects related to cited event noted at this time. Resident #62 no longer resides at the facility. Other Residents Residents discharged in the last 30 days were reviewed by the IDT to validate transfer/discharge policy was followed with no further findings. Facility Systems Licensed Nurses were educated on the facility transfer/discharge policy to include but not limited to, validation that required information was provided to the receiving facility when a resident is transferred to the hospital. The system is amended to include review of residents who are transferred/discharged in clinical meeting to validate the required information was provided to the receiving facility and the discharge documentation is complete.	

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	135146		12/13/2019

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F 622	Continued From page 46 documented Resident #15 told a CNA he was not feeling well. Resident #15 was observed to stutter "I need a" repeatedly. The physician was notified and ordered Resident #15 be transferred to the hospital due to altered mental status. The Nurse's note documented Resident #15 left the facility at 10:40 PM via gurney accompanied by paramedics and two copies of discharge paperwork was sent to the hospital. Resident #15's medical record did not include what discharge paperwork was sent with him to the hospital. On 12/10/19 at 11:12 AM, UM #1 said the facility had a Discharge/Transfer Checklist which directed the staff what documents were required to be sent with the resident when they transferred to the hospital. UM #1 said Resident #15's medical record did not include what discharge paper work was sent to the hospital with Resident #15. On 12/10/19 at 1:00 PM, the DON said she did not find the discharge paper/documents for Resident #15. 2. Resident #39 was admitted to the facility on 5/13/19, and was readmitted on 11/27/19, with multiple diagnoses including congestive heart failure and respiratory failure. A Nurse's Progress Note, dated 11/17/19 at 10:27 PM, documented Resident #39's behavior and mood were outside of his baseline. He was confused and did not eat his breakfast and lunch. The Nurse's Note documented he was sent to the hospital and his family representative was notified of his transfer.	F 622	Monitoring The CNO and/or designee will audit discharges/transfers to validate required documentation was provided 5 times a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 622	Continued From page 47 Resident #39's record did not include documentation information was provided to the hospital to ensure safe and effective transition of care. On 12/10/19 at 11:12 AM, UM #1 said Resident #39's record did not include what discharge paper work was sent to the hospital with Resident #39. On 12/10/19 at 1:00 PM, the DON said she did not find the discharge paper/documents for Resident #39. 3. Resident #62 was readmitted from the hospital to the facility on 11/12/19, with multiple diagnoses including quadriplegia, dependence on a ventilator (a machine that helps a person breathe), and a colostomy (a surgical opening in the abdominal wall to bypass a damaged colon). Resident #62's discharge MDS assessment, dated 11/2/19, documented he had an unanticipated discharge to the hospital. Resident #62's Nurse's Progress Note, dated 11/2/19 at 7:08 PM, documented he was feeling unwell with a temperature of 102.4 Fahrenheit. His abdomen was large, round, firm, and tender. Resident #62's family decided they wanted him sent to the emergency department, and the physician was notified. Resident #62's record did not include documentation what information had been provided to the receiving hospital or provider. On 12/12/19 at 10:57 AM, the DON stated there	F 622		

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F 622	Continued From page 48 was no additional information in the in Resident #62's record other than the Progress Note from 11/2/19 at 7:08 PM. The DON stated she would look in the medical records department to see if there was additional documentation. On 12/12/19 at 4:30 PM, the DON stated she did not find additional documentation regarding Resident #62's transfer to the hospital. 4. Resident #36 was admitted to the facility on 10/28/19, with multiple diagnoses including a traumatic brain injury. A discharge MDS assessment, dated 12/9/19, documented Resident #36 was discharged to a hospital. A Nurse's Progress Note, dated 12/9/19 at 6:41 PM, documented Resident #36 had a fall with a change in his neurological status. The note documented Resident #36 had increased confusion, was unable to hold a conversation, and his eyes were heavy. Resident #36's physician was notified and a non-emergent transport was called. The note documented Resident #36 was sent to a local hospital for further evaluation. Resident #36's record did not document information regarding what time the non-emergent transport arrived and left the facility, his condition when leaving the facility, or who transported him to the hospital. Resident #36's record did not include documentation that information was provided to the non-emergent transport staff members, the emergency room, and the hospital to ensure a safe and effective	F 622		

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F 622	Continued From page 49 transition of care. On 12/11/19 at 3:31 PM, LPN #2 stated after assessing Resident #36 she notified non-emergent transport. LPN #2 stated she did not provide documentation to the non-emergent transport staff members of Resident #36's change of condition. The DON stated Resident #36's record did not include documentation the Transfer/Discharge Form and paperwork were provided to the non-emergent transport staff members, a physician's order to transport him, and the reason for admission to the hospital. The DON stated the documentation should have included when non-emergent transport arrived and left the facility.	F 622		
F 623 SS=E	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	F 623		2/4/20

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F 623	Continued From page 50 (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 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (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 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (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; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

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F 623	Continued From page 51 (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 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. §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. §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 staff interview, policy review, and record review, it was determined the facility failed	F 623	F623E	

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F 623	Continued From page 52 to ensure written notice was provided to the resident and the resident's representative prior to transfer to the hospital and that a copy of the written transfer/discharge notice was sent to the State Ombudsman. This was true for 4 of 5 residents (#15, #36, #39, and #62) reviewed for transfer/discharge to the hospital. This created the potential for harm if residents were not made aware of or able to exercise their rights related to transfers. Findings include: The facility's Transfer and Discharge policy, dated 11/28/17, stated "If the facility determines a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility complies with the requirements: ...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 the [sic] understand..." This policy was not followed. 1. Resident #36 was admitted to the facility on 10/28/19, with multiple diagnoses including a traumatic brain injury. A discharge MDS assessment, dated 12/9/19, documented Resident #36 was discharged to a hospital. A Nurse's Progress Note, dated 12/9/19 at 6:41 PM, documented Resident #36 had a fall with a change in his neurological status and was transported to the hospital for further evaluation. On 12/11/19 at 3:31 PM, LPN #2 stated she did	F 623	Resident Specific Resident #15, Resident #36 and Resident #39 have been re- admitted to the facility and were reviewed by a licensed nurse. Documented plan of care per physician□s order in place with no adverse effects related to cited event noted at this time. Resident #62 no longer resides at the facility Other Residents Resident discharged in the last 30 days were reviewed by the IDT to validate transfer/ discharge policy was followed to include providing a written notice of transfer/discharge to resident or resident responsible party prior to transfer in order for resident to have an opportunity to exercise their rights and that a copy/listing was provided to the state ombudsman. No further findings were noted. Facility Systems Licensed Nurses were educated on the facility transfer/discharge policy to include providing a written notice of transfer/discharge to resident or resident responsible party prior to transfer in order	

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F 623	Continued From page 53 not notify the resident or his family representative in writing. The DON stated Resident #36's record did not include documentation a written notice was provided to Resident #36 and his family representative at the time of his transfer to the hospital. 2. Resident #62 was readmitted from the hospital to the facility on 11/12/19, with multiple diagnoses including quadriplegia, dependence on a ventilator (a machine that helps a person breathe), and a colostomy (a surgical opening in the abdominal wall to bypass a damaged colon). Resident #62's discharge MDS assessment, dated 11/2/19, documented he had an unanticipated discharge to the hospital. Resident #62's Nurse's Progress Note, dated 11/2/19 at 7:08 PM, documented he was feeling unwell with a temperature of 102.4 Fahrenheit. His abdomen was large, round, firm, and tender. Resident #62's family decided they wanted him sent to the emergency department, and the physician was notified. On 12/12/19 at 10:57 AM, the DON stated there was no additional information in Resident #62's medical record, other than the Nurse's Progress Note from 11/2/19 at 7:08 PM about a notification of transfer to the resident and the resident representative. The DON stated she would look in the medical records department to see if there was additional documentation. On 12/12/19 at 4:30 PM, the DON stated she could not find additional documentation regarding Resident #62's notification of transfer to the	F 623	for resident to have an opportunity to exercise their rights. The system is amended to include review of residents who are transferred/discharged in clinical meeting to validate the required information was provided to the receiving facility and the discharge documentation is complete. Medical Records reviews monthly that transfer/discharge listing was provided to the state ombudsman. Monitoring The CNO and/or designee will audit discharges/transfers to validate written notice of transfer/discharge was provided 5 times a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. The CNO and/or designee will audit discharges/transfers to validate transfer/discharge listing was provided to the state ombudsman monthly for 3 months. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed	

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F 623	Continued From page 54 hospital. 3. The facility's Transfer and Discharge policy, dated 11/28/17, stated a copy of written transfer/discharge notices were to be sent to a representative of the Office of the State Long-Term Care Ombudsman. This policy was not followed. a. Resident #15 was readmitted to the facility on 12/13/18, and again readmitted on 9/6/19, with multiple diagnoses including acute respiratory failure with hypoxia (decreasesd oxygen supply to the body tissues) and hypercapnia (excessive carbon dioxide in the bloodstream caused by inadequate respiration) and rectal fistula (an abnormal connection between the end of the bowel and the skin). A Nurse's Progress Note, dated 9/1/19, documented Resident #15 told a CNA he was not feeling well. Resident #15 was observed to stutter "I need a" repeatedly. The physician was notified and ordered Resident #15 be transferred to the hospital due to altered mental status. The Nurse's note documented Resident #15 left the facility at 10:40 PM via gurney accompanied by paramedics and two copies of discharge paperwork was sent to the hospital. Resident #15's medical record did not include what discharge paperwork was sent with him to the hospital. Resident #15's record did not include documentation a written transfer/discharge notice was sent to the Ombudsman.	F 623	with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 623	Continued From page 55 b. Resident #39 was admitted to the facility on 5/13/19, and was readmitted on 11/27/17, with multiple diagnoses including congestive heart failure and respiratory failure. A Nursing Progress Note, dated 11/17/19 at 10:27 PM, documented Resident #39's behavior and mood were outside of his baseline. He was confused and did not eat his breakfast and lunch. The Nursing Note documented he was sent to the hospital and his family representative was notified of his transfer. Resident #39's record did not include documentation a written transfer/discharge notice was sent to the Ombudsman. On 12/13/19 at 9:46 AM, the Admission/Discharge Nurse said she was made aware she needed to send a list of their discharges to the Ombudsman about two days ago.	F 623		
F 625 SS=E	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	F 625		2/4/20

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F 625	Continued From page 56 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 (iv) The information specified in paragraph (e)(1) of this section. §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: Based on staff and resident interview, policy review, and record review, it was determined the facility failed to ensure a bed hold notice was provided to residents or their representatives upon transfer to the hospital. This was true for 3 of 5 residents (#10, #15 and #62) reviewed for transfers. This deficient practice created the potential for harm if residents were not informed of their right to return to their former bed/room at the facility within a specified time. Findings include: The facility's Bed Hold Readmission policy, dated 11/28/19, stated the policy applied to all residents, regardless of payment source. The policy stated the notice of a bed hold was provided to the resident and if applicable their representative, at the time of transfer, or in cases of emergency transfer, within 24 hours of the transfer.	F 625	F625E Resident Specific Resident #10, Resident #15 have been re-admitted to the facility and were reviewed by a licensed nurse. Documented plan of care per physician□s order in place with no adverse effects related to cited event noted at this time Resident #62 no longer resides at the facility Other Residents Resident discharged in the last 30 days	

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F 625	Continued From page 57 This policy was not followed. Examples include: 1. Resident #15 was readmitted to the facility on 12/13/18, and again readmitted on 9/6/19, with multiple diagnoses including acute respiratory failure with hypoxia (decreased oxygen supply to the body tissues) and hypercapnia (excessive carbon dioxide in the bloodstream caused by inadequate respiration) and rectal fistula (an abnormal connection between the end of the bowel and the skin). A Nurse's Progress Note, dated 9/1/19, documented Resident #15 told a CNA he was not feeling well. Resident #15 was observed to stutter "I need a" repeatedly. The physician was notified and ordered Resident #15 be transferred to the hospital due to altered mental status. The Nurse's note documented Resident #15 left the facility at 10:40 PM via gurney accompanied by paramedics. Resident #15's record did not include documentation that a bed hold notice was provided to him or to his representative when he was transferred to the hospital. On 12/8/19 at 3:00 PM, Resident #15 said he was hospitalized due to an infection. Resident #15 could not remember if he was given a bed hold notice. On 12/10/19 at 11:17 AM. UM #1 said he was unable to find the bed hold notice for Resident #15. On 12/10/19 at 1:00 PM, the DON said a bed hold notice should have been provided to	F 625	were reviewed by the IDT to validate Bed-hold/readmission policy was followed to include providing a written notice of the bed-hold policy and their right to return to their former bed/room at the facility. No further findings were noted. Facility Systems Licensed Nurses were educated on the facility Bed-Hold /Readmission policy to include providing a written notice of bed-hold to resident or resident responsible party prior to transfer in order for resident to have an opportunity to exercise their rights to return to their former bed/room at the facility. The system is amended to include review of residents who are transferred/discharged in clinical meeting to validate notice of bed-hold and discharge documentation is provided. Monitoring The CNO and/or designee will audit discharge/transfers 5 days a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it	

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F 625	Continued From page 58 Resident #15 when he was sent to the hospital. The DON said she did not find documentation that a bed hold notice was provided to Resident #15. 2. Resident #39 was admitted to the facility on 5/13/19, and was readmitted on 11/27/19, with multiple diagnoses including congestive heart failure and respiratory failure. A Nurse's Progress Note, dated 11/17/19 at 10:27 PM, documented Resident #39's behavior and mood were outside of his baseline. He was confused and did not eat his breakfast and lunch. The Nurse's Note documented he was sent to the hospital and his family representative was notified of his transfer. Resident #39's record did not include documentation that a bed hold notice was provided to him or to his representative when he was transferred to the hospital. On 12/10/19 at 11:17 AM. UM #1 said he was unable to find the bed hold notice for Resident #39. On 12/10/19 at 1:00 PM, the DON said a bed hold notice should have been provided to Resident #39 when he was sent to the hospital. The DON said she did not find documentation a bed hold notice was provided to Resident #39. 3. Resident #62 was readmitted from the hospital to the facility on 11/12/19, with multiple diagnoses including quadriplegia, dependence on a ventilator (a machine that helps a person breathe), and a colostomy (a surgical opening in	F 625	deems appropriate. Date of Completion February 4, 2020	

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F 625	Continued From page 59 the abdominal wall to bypass a damaged colon). Resident #62's discharge MDS assessment, dated 11/2/19, documented he had an unanticipated discharge to the hospital. Resident #62's Nurse's Progress Note, dated 11/2/19 at 7:08 PM, documented he was feeling unwell with a temperature of 102.4 Fahrenheit. His abdomen was large, round, firm, and tender. Resident #62's family decided they wanted him sent to the emergency department, and the physician was notified. Resident #62's record did not include documentation a bed hold notice was provided to him or to his representative when he was transferred to the hospital. On 12/12/19 at 10:57 AM, the DON was interviewed regarding Resident #62's transfer to the hospital. The DON stated there was no additional information in Resident #62's record regarding a bed hold notice. The DON stated she would look in the medical records department to see if there was additional documentation. On 12/12/19 at 4:30 PM, the DON stated she could not find any documentation regarding a bed hold notice for Resident #62.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		2/4/20

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F 636	Continued From page 60 §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this	F 636		

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F 636	Continued From page 61 chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure residents were accurately assessed. This was true for 2 of 21 residents (Resident #24 and #55) reviewed for assessments. This resulted in a lack of adequate information being available on which to make intervention decisions necessary to ensure each resident's highest practicable physical, mental, and psychosocial well-being was achieved. Findings include: 1. Resident #24, whose age was in the mid-30s, was admitted to the facility on 11/3/18, with multiple diagnoses including cerebral palsy (brain injury which most often happens before or during a baby's birth, or during the first 3-5 years of a child's life, that affects muscle tone, movement, and motor skills, and may also cause sight, hearing, and learning problems) and intellectual disability.	F 636	F636D Resident Specific Resident #24 was evaluated by Physical Therapy and Occupational therapy. Conference with Resident #24 family was conducted with care plan revisions made to reflect needs while maintaining residents□ dignity. Resident #24 small decorative clothing protectors were taken home by family and replaced by age appropriate protector. Resident #24 was evaluated for use of the oven mitt and it was determined to meet the definition of a restraint however, medically justified to protect her hand from constant chewing on her right hand. Resident #55 was evaluated for the use	

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F 636	Continued From page 62 a. Resident #24 was noted to have and use a baby bottle during the following observations: - On 12/8/19 at 11:52 AM, Resident #24 was in the day room in her wheelchair with a baby bottle. - On 12/8/19 at 12:47 AM, Resident #24 was at the dining room table with a baby bottle with milk in it. - On 12/10/19 at 8:50 AM, Resident #24 was at the dining room table drinking juice from a baby bottle. Resident #24's care plan, dated 11/21/19, documented Occupational and Speech Therapy was to screen and provide adaptive equipment for feeding as needed. The care plan directed staff to use a bottle with a nipple for all liquids. The care plan documented Resident #24's family had attempted numerous types of cups and Resident #24 would only drink fluids with a nipple. Resident #24's record did not include an evaluation regarding the need for a baby bottle or documentation of the other types of cups which had been tried and found to be ineffective prior to the use of the baby bottle. On 12/11/19 at 3:15 PM, the Director of Therapy said Resident #24's baby bottle had not been assessed. b. Resident #24's record included a physical restraint assessment, dated 7/24/19, which documented she wore a glove on her right hand	F 636	of tilt back wheelchair and self-release seat belt and determined not to be restrictive and in use per his preference. Other Residents IDT reviewed current resident with no other resident noted to use oven mitts, baby bottle or small decorative clothing protector. IDT review current residents using tilt back wheelchairs and self-release seats belts. Identified residents were reviewed to validate assessments completed and findings were addressed. Facility Systems Licensed nursing staff educated by the CNO and/or designee on assessment of resident adaptive equipment needs, to include but not limited to, potential restrictive devices, tilt back wheelchairs, self-release seatbelts, and other age appropriate adaptive devices in order to make intervention decisions necessary to ensure each resident□s highest practicable physical, mental, and psychosocial well-being is achieved. The system is amended to include review of admissions, change of conditions, and	

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F 636	Continued From page 63 to protect her skin due to chewing on her fingers. However, the assessment did not include information related to why Resident #24 was chewing on her fingers (e.g. oral stimulation, tactile stimulation, etc.) or documentation of less restrictive interventions which had been tried and found to be ineffective prior to the use of the oven mitt. Resident #24 was noted to have an oven mitt during the following observations: - On 12/8/19 at 11:52 AM, Resident #24 was in the day room in her wheelchair with an oven mitt in her lap. - On 12/9/19 at 9:46 AM, Resident #24 was in the day room in her wheelchair with an oven mitt on her right hand with a detachable strap holding the oven mitt in place around her elbow. - On 12/10/19 at 8:50 AM, Resident #24 was at the dining room table. She had an oven mitt in her lap. On 12/11/19 at 3:15 PM, the Director of Therapy said therapy staff had tried several other gloves and mittens to prevent skin breakdown for Resident #24. She said the oven mitt helped to prevent skin breakdown because the material was thicker. On 12/11/19 at 3:53 PM, the Clinical Resource nurse said she expected therapy staff to evaluate for Resident #24's needs. 2. Resident #55 was admitted to the facility on 11/1/19, with multiple diagnoses which included	F 636	new orders in clinical meeting to validate that assessment is completed and devices are utilized as appropriate. Monitoring The CNO and/or designee will audit for tilt back w/c□s, seat belts, and age appropriate device use weekly for 12 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 636	Continued From page 64 Parkinson's Disease and Lewy Body Dementia (a progressive brain disorder marked by abnormal deposits of protein in the brain). A quarterly MDS assessment, dated 11/11/19, documented Resident # 55 was cognitively intact and was totally dependent on two staff members with bathing, bed transfers, and bed mobility. On 12/8/19 at 10:34 AM, Resident #55 was observed reclining in a tilt-back wheelchair with a seat belt fastened across his waist. On 12/9/19 at 11:16 AM, Resident #55 stated his wife said he needed the seat belt so that he would not fall. Resident #55 stated he was able to remove the seat belt. On 12/10/19 at 11:50 AM, Resident #55's wife stated he was admitted to the facility with his tilt-back wheelchair and the seat belt. Resident #55's record did not include an assessment of the tilt-back wheelchair or the use of a seat belt. On 12/9/19 at 11:31 AM, the DON stated there should have been an assessment for the tilt-back wheelchair and the seat belt. On 12/10/19 at 10:58 AM, UM #2 stated he was unable to find a documented assessment for the seat belt or wheelchair. UM #2 stated Resident #55 was able to move his arms and release the seat belt, but he was unable to locate an assessment that stated Resident #55 was able to remove the seat belt.	F 636		

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F 636	Continued From page 65 On 12/10/19 at 4:19 PM, the MDS Coordinator stated she did not document an assessment for the seat belt or specialized wheelchair for Resident #55.	F 636		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and family, resident and staff interview, the facility failed to ensure MDS assessments accurately reflected the resident's status. This was true for 3 of 26 residents (#19, #55, and #66) whose MDS assessments were reviewed for accuracy. This failure created the potential for harm should residents receive inappropriate care related to discrepancies in the MDS assessments. Findings include: 1. Resident #55 was admitted to the facility on 11/1/19, with multiple diagnoses, which included Parkinson's Disease (a progressive disease of the nervous system that affects movement) and Lewy Body Dementia (progressive brain disorder triggered by abnormal deposits of protein in the brain). A quarterly MDS assessment, dated 11/11/19, documented Resident # 55 was cognitively intact and was totally dependent on two staff members with bathing, bed transfers and bed mobility. The MDS did not include documentation Resident #55 used a tilt-back wheelchair with a seat belt strapped across his waist.	F 641	F641E Resident Specific Resident #55 was evaluated for the use of tilt back wheelchair and self-release seat belt and determined not to be restrictive and in use per his preference. Both devices do not meet the RAI guidelines for coding as a restraint on the MDS. Resident #19 MDS and care plan was to validate that it reflects resident□s current status and needs. Resident #19 MDs with the AARD of 8/7/19 was modified for accuracy related functional limitation and range of motion status at that time. Resident #66 MDS and care plan was reviewed to validate that it reflects the resident□s current status and needs.	2/4/20

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F 641	Continued From page 66 On 12/8/19 at 10:34 AM, Resident #55 was observed reclining in a tilt-back wheelchair with a seat belt strapped across his waist. On 12/9/19 at 11:16 AM, Resident #55 stated his wife said he needed the seat belt, so he would not fall. Resident #55 stated he was able to remove the seat belt. On 12/10/19 at 11:50 AM, Resident #55's wife stated he was admitted to the facility with his tilt-back wheelchair and use of a seat belt. On 12/9/19 at 11:31 AM, the DON stated there should have been an assessment for Resident #55's seat belt. On 12/10/19 at 10:58 AM, UM #2 stated he was unable to find a documented assessment for the seat belt or wheelchair. UM #2 stated Resident #55 was able to move his arms and release the seat belt, but he was unable to locate an assessment. On 12/10/19 at 4:19 PM, the MDS Coordinator stated she did not document an assessment for the specialized wheelchair for Resident #55. 2. Resident #19 was admitted to the facility on 2/7/19, with multiple diagnoses including stroke and hemiplegia and hemiparesis (weakness and paralysis on one side) affecting the left side. Resident #19's care plan documented she had a deficit in ADL performance related to hemiplegia on the left side, initiated on 3/11/19. Resident #19's significant change MDS	F 641	Resident #66 MDS with ARD of 10/21/19 was modified for accuracy related to ambulation in his room and hallway at that time. Other Residents IDT reviewed current residents using tilt back wheelchairs and self-release seats belts. Identified residents were reviewed to validate assessments completed. Findings were addressed by licensed nurses. Residents with functional limitations in ROM and ambulation MDS assessments were reviewed for accuracy of coding such limitations and any modifications were completed as needed. Facility Systems MDS Coordinator was educated by CNO/and or designee to facility Resident Assessment Policy to include but not limited to, potentially restrictive device review, ROM/contractures assessment, and accuracy of CNA documentation for ambulation to ensure MDS assessments accurately reflect the resident□s status. The system is amended to include MDS Coordinator to review for potential illogical coding and complete additional assessment/documentation as indicated.	

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F 641	Continued From page 67 assessment, dated 4/9/19, documented she had functional limitations in range of motion with impairment on one side involving the upper and lower extremity. Resident #19's quarterly MDS assessment, dated 8/7/19, documented she had no impairment related to functional limitation in range of motion. Resident #19's significant change MDS assessment, dated 10/16/19, documented she had functional limitations in range of motion with impairment on one side involving the upper and lower extremity. On 12/8/19 at 10:34 AM, Resident #19 was in her room in a wheelchair. She was not observed moving her left arm and left leg. Upon multiple observations throughout the survey, Resident #19 was not observed using her left arm and leg. On 12/10/19 at 11:17 AM, the DON said Resident #19's MDS, dated 8/17/19, was incorrect when it documented she had no impairment, and Resident #19 had hemiparesis. 3. Resident #66 was admitted to the facility on 10/11/19, with multiple diagnoses including stroke, muscle weakness, and transient paralysis (unable to move intermittently). The admission MDS assessment, dated 10/21/19, documented Resident #66 walked in his room and the corridor once or twice with two or more people giving physical assistance. The MDS assessment documented Resident #66 was totally dependent on two or more for locomotion on the unit, locomotion off the unit, and transfers.	F 641	Monitoring The CNO and/or designee will audit MDS assessments weekly for 4 weeks, then monthly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 641	Continued From page 68 The MDS also documented Resident #66 required extensive assistance with two or more people for bed mobility. Resident #66's care plan, dated 11/21/19, documented the following: * He required 1-2 staff assistance for repositioning in bed. * He required a Hoyer mechanical lift for transfers. * He had limited physical mobility related to contractures, limited range of motion, physical weakness, and stroke. * He was totally dependent on help from others for ambulation and locomotion. Resident #66's Progress note documented, 10/30/19, documented he continued to be a full assist due to reduced function and mobility. Resident #66's Progress note, dated 11/2/19, documented he required assistance with ADL's, and was unable to self-propel. Resident #66's Physical Therapy Progress Report, dated 12/1/19 -12/7/19, documented he attempted to walk on 10/24/10 with total dependence and distance traveled was 0 feet. On 12/7/19 the report documented Resident #66 attempted to walk with maximum assistance, and he walked 0 feet. Resident #66's record documented he did not ambulate in his room or corridor with total assistance as documented by his MDS assessment.	F 641		

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F 641	Continued From page 69 On 12/10/19 at 10:29 AM, Therapist #3 came into Resident #66's room and assisted Resident #66 to sit on the side of his bed. Therapist #3 moved Resident #66's legs to the side of the bed without assistance from Resident #66. He then raised Resident #66's trunk to a sitting position without assistance from Resident #66 and held his shoulders as Therapist #3 squatted beside the bed to provide counterbalance for Resident #66's weight so he would not fall off the bed. Resident #66 sat on the side of his bed for less than 5 seconds, shook his head from left to right to indicate "no." Therapist #3 then laid Resident #66 back down in bed. Resident #66 was not observed to walk with total assistance in his room or corridor as documented in his MDS assessment. On 12/10/19 at 4:40 PM, when asked if Resident #66's MDS assessment was correct, the MDS Coordinator stated Resident #66 was partially paralyzed so he probably could get up with assistance and walk. When the MDS coordinator was asked why Resident #66's care plan stated the resident required total assistance, she stated she would have to look into it because she did not know the answer. On 12/12/19 at 3:21 PM, Therapist #4 stated the only way Resident #66 attempted to walk since admission to the facility was with the neuro walker (an alternative positioning device to help support individuals with disabilities) in the therapy room. The MDs assessment did not document Resident #66 required the neuro walker to ambulate.	F 641		

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F 641	Continued From page 70 On 12/12/19 at 4:00 PM, When the MDS coordinator was asked again about Resident #66's MDS assessment stating he ambulated in his room and the corridor, she stated a CNA charted Resident #66 was walking in room and hallway on the task documentation section of his chart. The MDS Coordinator stated the documentation came from the CNA's daily charting. The MDS Coordinator did not say the documentation came from an assessment.	F 641		
F 656 SS=D	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 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (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	F 656		2/4/20

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F 656	Continued From page 71 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to develop and implement comprehensive resident centered care plans. This was true for 2 of 26 residents (#9 and #120) whose care plans were reviewed. This failure created the potential for residents to receive inappropriate or inadequate care. Findings include: 1. Resident #9 was admitted to the facility on 1/29/19, with multiple diagnoses including end stage renal disease (ESRD - chronic kidney disease where kidneys can no longer meet the body's needs), chronic obstructive pulmonary disease (COPD - a progressive lung disease with increasing breathlessness), diabetes, and gout (a form of inflammatory arthritis). Low Back pain was added to her diagnosis information on 6/27/19.	F 656	F656□D Resident Specific: Resident #9 pain assessment was completed and care plan updated to reflect her current needs regarding her pain management. Resident #120 no longer resides at the facility. Other Residents:	

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F 656	Continued From page 72 Resident #9's record included a pain assessment, dated 4/29/19, which documented her pain was due to gout, renal dialysis, chronic disease, and made worse by overexertion, and routine medication was provided and effective. Resident #9's record included a pain assessment, dated 7/29/19, which documented Resident #9 received scheduled medication for pain. The pain assessment documented her scheduled and PRN medications were effective, her pain was relieved in 30 minutes, and she used medications, relaxation, and frequent position changes for pain relief. A Quarterly MDS Assessment, dated 10/5/19, documented Resident #9 was cognitively intact, on a scheduled pain medication regimen and received pain medications as needed. A common pain scale used was a numerical pain scale from 0 to 10. Zero (0) indicated no pain, 1 to 3 indicated mild pain, 4 to 7 was considered moderate pain, and 8 and above was severe pain. The Assessment documented Resident #9's pain was present frequently at a 5 on the pain scale, making it hard for her to sleep at night and limiting her day-to-day activities. On 12/10/19 at 1:23 PM, Resident #9 said she was on a pain management schedule. Resident #9's Order Summary Report included the following: * Indicate non-pharmacological interventions attempted prior to PRN pain medication administration, ordered on 7/30/19. * Pain monitor: Document pain rating scale at the start of each shift, using verbal/non-verbal 0-10	F 656	IDT reviewed current residents with pain or a diagnosis that could result in pain, and care plan updated as needed. IDT reviewed current residents on therapy caseload and those with specific preferences for times of therapy had care plan updated. Systems: Licensed nursing staff and licensed therapy staff were educated by CNO and/or designee to facility Care Plan Policy and the requirement to develop and implement comprehensive resident centered care plans in order to ensure residents receive appropriate, person-centered, and adequate care to include but not limited to, pain management and scheduling of therapy. The system is amended to include review of new admissions, change of condition, and order changes in clinical meeting to validate care plan is updated. Monitoring: The CNO and/or designee will audit care plans for pain management and if they have a preference for therapy times weekly for 12 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately	

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F 656	Continued From page 73 scale, ordered on 1/28/19. * Aspercreme with Lidocaine Cream 4%, applied to lower back/affected area topically every 6 hours as needed for pain, ordered on 10/15/19. * Gabapentin Capsule 300 mg, 1 capsule given orally 3 times a day for neuropathy (damage to the nerves), ordered on 10/16/19. * Tramadol HCl Tablet 50 mg, 1 tablet given by mouth every 6 hours as needed for pain, ordered on 7/7/19. * Tylenol Extra Strength Tablet 500 mg, 2 tablets given by mouth three times a day for pain, not to exceed 3 grams of Tylenol in 24 hours from all sources, ordered dated on 3/8/19. Resident #9's Care Plan did not include information and interventions related to pain management and pain medications as listed in her orders above. On 12/10/19 at 2:02 PM, UM #2 said he did not see a care plan for pain in Resident #9's record. On 12/10/19 at 2:11 PM, the MDS Coordinator said she did not see a care plan for pain in Resident #9's record, and Resident #9 needed one. 2. Resident #120 was admitted to the facility on 11/26/19, with multiple diagnoses including fracture of the sacrum (tailbone) and dementia with Lewy bodies (progressive brain disorder triggered by abnormal deposits of protein in the brain). Resident #120's physician's order, dated 11/26/19, documented she received occupational therapy.	F 656	and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 656	Continued From page 74 Resident #120's care plan, dated 12/4/19, directed staff to keep her routine consistent to decrease confusion. On 12/10/19 at 9:23 AM, Resident #120 was in her room and said she had therapy scheduled at 10:00 AM every morning. At 9:41 AM, PTA #1 was near the nurses station engaged in a conversation with Resident #120. PTA #1 asked Resident #120 if she was ready for therapy and Resident #120 told PTA #1 that she needed to eat breakfast before therapy. At 9:43 AM, PTA #1 said she had heard from other therapy staff that Resident #120 liked to do therapy in the morning and she would check back with the resident after she ate. On 12/12/19 at 11:14 AM, the DON said Resident #120's preferences regarding her therapy time was not on the care plan. She said she expected her preferences to be on the care plan.	F 656		
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.	F 657		2/4/20

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F 657	Continued From page 75 (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 staff and family interview, it was determined the facility failed to ensure resident's care plans were revised and updated to maintain accuracy. This was true for 1 of 26 residents (Resident #10) whose care plans were reviewed. This failure created the potential for harm if care was based on inaccurate care plan information. Findings include: The facility's policy for Care Plans dated 11/28/19 documented: * The care plan was revised and updated as necessary to reflect the Resident's current status. * The care plan was reviewed and revised based on the resident's changing goals, preferences and needs of the resident in response to current interventions. 1. Resident #10 was admitted to the facility on 9/24/18, with multiple diagnoses including	F 657	F657-D Resident Specific: Resident #10 care plan was updated to reflect her current diet order. Other Residents: IDT reviewed current residents diet orders and compared to care plan. Adjustments made as indicated. Systems: CDM, RD and licensed nursing staff were educated by CNO and/or designee to facility Care Plan Policy and requirement	

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F 657	Continued From page 76 hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke, and dysphagia (difficulty swallowing). A Diet Order and Communication form, dated 11/19/19, and a physician order, dated 11/22/19, directed staff to provide Resident #10 pureed solids and moist mechanical soft oatmeal and cottage cheese. Resident #10's care plan, revised 11/11/19, directed staff to provide and serve Resident #10 a regular diet, mechanical soft textures, and regular consistency. On 12/11/19 at 4:10 PM, the Registered Dietitian said mechanical soft was not the same as a pureed texture. The RD said Resident #10's care plan should have been updated to reflect her current diet.	F 657	to ensure resident□s care plans are revised and updated to maintain accuracy to include but not limited to, diet orders. The system is amended to include review of diet order changes in clinical meeting to validate the care plan is updated to reflect the current order. Monitoring: The CNO and/or designee will audit diet orders and care plans for consistency 3 times a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances	F 676		2/4/20

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F 676	Continued From page 77 of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and family and staff interview, it was determined the facility failed to provide communication assistance as needed to 2 of 3 Residents (Residents #14, and #66). This failure placed the residents at risk for decreased quality of life and	F 676	F676-D Resident specific: Resident #66 evaluated by Speech Therapy for use of a functional	

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F 676	Continued From page 78 psychosocial distress, depression, and negative behaviors related to the inability to communicate effectively. Findings include: The facility's policy for quality of life, dated 11/28/17, documented the facility provided appropriate treatment and services to maintain or improve a resident's ability to carry out daily living activities. The facility's policy for activities of daily living, dated 11/28/17, described the use of a functional communication system as an activity of daily living and stated reasonable accommodations were made for activities of daily living. These policies were not followed. 1. Resident #14 was admitted to the facility on 11/5/18, with multiple diagnoses including chronic respiratory failure (when the airways in the lungs become narrow and damaged), quadriplegia (paralysis of all four limbs), and West Nile virus infection with encephalitis (inflammation of the brain). Resident #14's MDS assessment, dated 10/10/19, documented his functional status was total dependence with two or more persons for physical assistance with all ADLs. The assessment also documented Resident #14 had no difficulty with hearing, but had no speech, and he was rarely or never understood. The assessment also documented Resident #14 could clearly understand others. Resident #14's care plan, dated 9/30/19, documented staff were to monitor his need for a	F 676	communication system. Resident #14 no longer resides at the facility. Other Residents: IDT reviewed current residents who are rarely or never understood to determine if they had an adequate functional communication system in place. Referral to Speech Therapy were received with appropriate communication system identified and implemented as needed. Systems: Speech Therapy staff and licensed nursing staff were educated on facility ADLs Policy and the need to provide care and services based on the comprehensive assessment of a resident and consistent with the residents needs and choices for communication including speech, language and other functional communication systems. The system is amended to include review of new admissions and residents with a change of condition in clinical meeting for a potential Speech Therapy referral for change in communication device/system.	

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F 676	Continued From page 79 speech and language program. On 12/12/19 at 8:54 AM, CNA #10 stated she communicated with Resident #14 by having him stick out his tongue left or right for yes or no. On 12/12/19 at 9:02 AM, RN #4 stated he communicated with Resident #14 by having him blink once for yes and twice for no. RN #4 also stated Resident #14 had a "yes/no" gaze board (a communication board with the words yes and no on it, so people who cannot verbalize can point their eyes in the direction of the word to communicate their needs). From 12/8/19 to 12/13/19, no "yes/no" gaze board was observed out in plain sight or used by Resident #14. The facility did not provide Resident #14 with a functional communication system as directed by their policy. 2. Resident #66 was admitted to the facility on 10/11/19, with multiple diagnoses including stroke, muscle weakness, transient paralysis (unable to move intermittently), respiratory failure, and diabetes. Resident #66 also was admitted with a tracheostomy (a tube placed directly in the windpipe for breathing). Resident #66's admission MDS assessment, dated 10/21/19, documented he had upper extremity impairment (shoulder, elbow, wrist, and hand) on both sides of his body. The assessment documented Resident #66's hearing was adequate, and he usually understood others, but his speech was usually unclear.	F 676	Monitoring: The CNO and/or designee will audit functional communication systems to validate they continue to be effective for each resident weekly for 4 weeks, then monthly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 676	Continued From page 80 Resident #66's physician orders, dated 11/21/19, documented speech therapy was to evaluate and treat as Resident #66 as indicated. Resident #66's fiberoptic endoscopic evaluation of swallowing exam documented a long-term goal was for Resident #66 to demonstrate improved communication by utilizing a picture communication board for improved safety and quality of life. On 12/8/19 at 1:05 PM, Resident #66's wife stated she did not have enough communication with Resident #66 and he needed an adaptive device for communication that he could use. On 12/10/19 at 11:26 AM, Resident #66 was observed lip talking yes/no to get his needs met. Resident #66 was unable to express any other thoughts or ideas not framed as a yes/no question. On 12/11/19 at 2:37 PM, Speech Therapist #1 stated Resident #66 communicated by facial expressions and yes/no lip reading. Speech Therapist #1 stated he was advancing Resident #66 with use of his speaking valve (a one-way air flow valve placed on a tracheostomy that helps with vocalization) and the picture board was ineffective. Speech Therapist #1 stated nothing else was used to advance Resident #66's immediate communication. On 12/11/19 at 2:57 AM, CNA #14 stated Resident #66 nodded yes or no, but did not talk. CNA #14 stated a visual board did not work for him.	F 676		

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F 676	Continued From page 81 On 12/12/19 at 8:56 AM, CNA #10 stated the facility communicated with Resident #66 through lip reading his yes/no answers to questions. CNA #10 stated Resident #66 tried to talk but was not understood. The facility did not provide Resident #66 with a functional communication system as directed by their policy.	F 676		
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, Resident Council minutes, and resident and staff interview, it was determined the facility failed to ensure bathing and/or grooming, incontinence care, and transfers were provided consistent with residents' needs. This was true for 5 of 21 residents (#24, #47, #52, #55, and #120) reviewed for ADL care and 5 of 8 residents (#9, #20, #27, #30 and #44) in the Resident Group interview. This created the potential for residents to experience skin breakdown and a negative effect to their psychosocial well-being when care was not provided as needed. Findings include: The facility's ADLs and Quality of Life policies, dated 11/14/17 and 11/28/19; respectively, directed staff to assist residents with toileting, grooming, and provide bathing as scheduled; and	F 677	F677E Resident Specific: Resident #52 had a skin evaluation completed and no new or worsening skin conditions were identified and was noted to be well groomed and clean shaven. Resident #47 has received showers per his preference and he has voiced satisfaction with his shower schedule. Resident #24 has received showers per schedule, hair shampooed and clean clothes in place. Her shower schedule was assessed and adjustments made as needed.	2/4/20

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F 677	Continued From page 82 to provide treatment and services to maintain or improve residents' ability to carry out ADLs. These policies were not followed. 1. Resident #52 was admitted to the facility on 12/19/18, with multiple diagnoses including a stroke affecting his right dominant side, aphasia (an impairment of language due to brain injury, affecting the production or comprehension of speech and the ability to read or write), dysphagia (difficulty swallowing), and edema (swelling caused by excess fluid trapped in your body's tissues). A significant change MDS assessment, dated 11/15/19, documented Resident #52 was severely cognitively impaired and was totally dependent on staff with all bed mobility, transfers, toileting, grooming, hygiene, eating, and bathing. The assessment documented he had an indwelling catheter and was always incontinent of bowel. The assessment documented Resident #52 was at risk for developing pressure ulcers, had two Stage 3 pressure ulcers, and was on a turning and repositioning program. a. Resident #52's skin impairment care plan, dated 2/6/19, stated Resident #52 was to be repositioned by staff 2 to 3 times per shift and as needed. Resident #52's ADL care plan, revised on 7/23/19, documented he was totally dependent on staff for incontinence care and staff were to apply barrier cream to his scrotum/peri area with incontinence care. The care plan documented Resident #52 required 2-person assistance for all	F 677	Resident #55 has received showers per schedule. Resident #20 and 120 no longer resides at the facility. Residents #9, #27, #30, and #44 were interviewed and expressed satisfaction with plans for ADL cares. Other Residents IDT reviewed current residents to validate they were provided assistance for showers, grooming, incontinence care and transfers consistent with their needs. Facility Systems Nursing staff educated to the facility ADLs and Quality of Life policies and the need to ensure residents receive the assistance with ADLs as they require. The system is amended to include IDT rounds weekly at varying times to monitor residents receiving cares as needed. Shower documentation is reviewed in clinical meeting with alternate shower options provided as indicated. Monitoring	

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F 677	Continued From page 83 mechanical lift transfers. On 12/10/19 at 8:11 AM, Resident #52 was observed in his wheelchair in the dining room for breakfast. At 9:17 AM, he was observed in his wheelchair in the dining room. At 10:03 AM, a CNA asked Resident #52 if he was "doing okay" and then walked away. At 10:27 AM, Resident #52 remained in the dining room and had been sleeping much of the morning since 8:11 AM, when the observations of him were initiated. On 12/10/19 at 10:44 AM, the roommate of Resident #52 stated staff had taken Resident #52 out of his room at approximately 6:30 AM that morning. On 12/10/19 at 10:57 AM, CNA #11 stated residents who were dependent on staff and required incontinent care were to be checked every 2 hours. CNA #11 stated he and CNA #6 got Resident #52 up and ready for breakfast at 7:30 to 7:45 AM and he stated that was 3 hours ago. CNA #11 stated Resident #52 was dependent on staff to provide incontinence care and repositioning. CNA #11 stated Resident #52 had "not yet" received care since before breakfast. On 12/10/19 at 11:01 AM, CNA #6 stated she had not provided any care for Resident #52 that morning except to assist him with his breakfast. CNA #6 stated Resident #52 had been taken to the dining room for breakfast at approximately 7:00 AM. CNA #6 stated Resident #52 needed to be provided care "now." On 12/10/19 at 1:27 PM, the Clinical Resource	F 677	The CNO and/or designee will audit residents to validate cares received as needed 2 times a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 677	Continued From page 84 Nurse stated Resident #52 should have been checked every 2 hours per his care plan. On 12/10/19 at 1:44 PM, CNA #6 and CNA #11 were observed assisting Resident #52 to bed using the mechanical lift. CNA #11 stated this was the first time since about 11:00 AM Resident #52 had been checked for incontinence. CNA #11 stated that was 2 hours and 45 minutes ago. b. Resident #52's ADL care plan, dated 2/6/19, documented he required 1-person assistance for personal hygiene. On 12/8/19 at 11:10 AM, Resident #52 was observed in the hallway outside of his room. He was unshaven and had dried food caked around his mouth. On 12/9/19 at 9:36 AM, 1:03 PM, and 4:58 PM Resident #52 was observed and he was unshaven. On 12/10/19 at 8:11 AM, 9:17 AM, and 10:27 AM Resident #52 was observed and he was unshaven. On 12/10/19 at 1:44 PM, CNA #6 and CNA #11 were asked if Resident #52 had been shaved since before 12/8/19, both CNAs stated they knew he had not been shaved during at least the past 3 days. CNA #6 stated Resident #52 would be shaved during his shower on 12/11/19. 2. Resident #47 was readmitted to the facility on 12/03/19, with multiple diagnoses including amyotrophic lateral sclerosis (a progressive degenerative nervous system disease that	F 677		

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F 677	Continued From page 85 affects nerve cells in the brain and the spinal cord). A quarterly MDS assessment, dated 11/11/19, documented Resident #47 was cognitively intact and required extensive, 2-person assistance for bathing. The ADL Care Plan, undated, documented Resident #47 was dependent on staff for bathing. He was to be assisted with bathing twice per week and PRN. Resident #47's ADL Reports for October, November, and December 2019 documented he did not receive a bath/shower from 10/5/19 to 10/11/19 (6 days), from 10/16/19 to 10/22/19 (6 days), from 10/23/19 to 11/4/19 (11 days), from 11/5/19 to 11/25/19 (20 days), and from 12/7/19 to 12/11/19 (5 days). On 12/8/19 at 10:25 AM, Resident #47 stated the time between showers/baths had gotten longer. On 12/12/19 at 8:57 AM, Resident #47 said his regular scheduled shower days were Wednesdays and Saturdays and he said the facility wanted to change his Saturday schedule to a different day and he told them no. On 12/12/19 at 3:56 PM, the Clinical Resource Nurse said Resident #47's record did not include additional baths/showers received in October, November, and December. 3. Resident #24, whose age was in the mid-30s, was admitted to the facility on 11/3/18, with multiple diagnoses including cerebral palsy (brain	F 677		

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F 677	Continued From page 86 injury which most often happens before or during a baby's birth, or during the first 3-5 years of a child's life, that affects muscle tone, movement, and motor skills, and may also cause sight, hearing, and learning problems) and intellectual disability. Resident #24's annual MDS assessment, dated 10/21/19, documented she required extensive, 2-person assistance with personal hygiene and was totally dependent, requiring 2-person assistance with bathing. Resident #24's care plan, dated 11/21/19, documented she was dependent on staff and directed staff to provide assistance with her bathing and personal hygiene. Resident #24's ADL Reports for November and December 2019, documented her bathing days were Tuesday and Friday and PRN. The reports documented she was not bathed from 11/20/19 to 11/26/19 (7 days) and from 11/27/19 to 12/3/19 (7 days). On 12/8/19 at 11:52 AM, Resident #24 was in her wheelchair in the Alpine unit day room watching TV. Her hair was matted and appeared unkempt. She had a non-stained clothing protector around her neck and chest area. She had on a sweater that was stained with streaks of food and excessive oral secretions underneath the clothing protector. The top left of her pants were soiled with food stains, near her hip. On 12/8/19 at 11:59 AM, RN #8 assisted Resident #24 to her room and changed her sweater with a new shirt and a new clothing	F 677		

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F 677	Continued From page 87 protector. RN #8 said the stain to Resident #24's shirt was probably pudding she had eaten earlier in the day. RN #8 then assisted Resident #24 out of her room. RN #8 did not attempt to change Resident #24's pants or brush her matted hair. On 12/9/19 at 9:56 AM, CNA #2 assisted Resident #24 to her room to change her wet and stained shirt. After placing the new shirt on her, CNA #2 began to take Resident #24 from the room. CNA #2 said Resident #24's chest had been wet from oral secretions and CNA #2 had not attempted to clean Resident #24's chest before placing the new shirt on. On 12/10/19 at 8:13 AM, CNA #12 said Resident #24 received 2 showers a week. She said as long as staff wiped off her excessive oral secretions and groomed her hair, then 2 showers a week was fine for Resident #24. CNA #12 said if showers were not completed during the day shift then the evening shift was to complete them. On 12/11/19 at 3:53 PM and 4:19 PM and on 12/12/19 at 11:09 AM, the DON, with the Clinical Resource Nurse present, said she expected staff to provide Resident #24 with showers as scheduled, to wipe her oral secretions off, provide grooming, and to change her clothes when soiled. The Clinical Resource Nurse said due to Resident #24's age she might need to be reassessed to see if 2 showers a week was adequate. 4. Resident #55 was admitted to the facility on 11/1/19, with multiple diagnoses, which included Parkinson's Disease (a disorder of the central nervous system that affects movement, often	F 677		

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F 677	Continued From page 88 including tremors) and Lewy Body Dementia (progressive brain disorder triggered by abnormal deposits of protein in the brain). A admission MDS assessment, dated 11/11/19, documented Resident #55 was cognitively intact and was totally dependent on two staff members with bathing, bed transfers and bed mobility. The facility's shower schedule documented Resident #55's shower schedule was Mondays and Thursdays in the morning. Resident #55's care plan, revised on 11/18/19, documented he required extensive assistance of 1-2 staff for bathing. Resident #55's ADL report for November 2019 documented there were no showers given or offered from 11/6/19 through 11/10/19 (5 days), and 11/12/19 through 11/17/19 (6 days). Resident #55's ADL report for December 2019 documented there were no showers given or offered from 12/6/19 through 12/10/19 (5 days). On 12/10/19 at 2:15 PM, Resident #55 stated his last shower was on 12/5/19. On 12/10/19 at 2:22 PM, UM #2 stated that Resident #55 refused his shower on 12/9/19, and he was scheduled to receive a makeup shower. UM #2 said hospice services did most of Resident #55's showers. UM #2 was unable to find documentation that Resident #55 refused his shower on 12/9/19. On 12/13/19 at 9:19 AM, UM #2 stated Resident	F 677		

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F 677	Continued From page 89 #55 did not receive showers as scheduled. 5. Resident #120 was admitted to the facility on 11/26/19, with multiple diagnoses including muscle weakness and Parkinson's disease. Resident #120's admission MDS assessment, dated 12/2/19, documented she required 1-person assistance with bathing. Resident #120's care plan, dated 11/26/19, directed staff to provide 1-person assistance with bathing. Resident #120's ADL Reports for November and December 2019, documented her bathing days were Wednesday and Saturday and PRN. The reports documented she was not bathed from 11/28/19 to 12/2/19 (5 days) and from 12/5/19 to 12/9/19 (5 days). On 12/8/19 at 11:33 AM, Resident #120 said since she had been admitted to the facility, she had not received her showers as scheduled. On 12/12/19 at 11:10 AM, the DON said Resident #120's showers were missed on 11/30/19 and 12/7/19. She said if staff did not complete the residents' showers she expected staff to offer the shower the next day. 6. Resident Council minutes, dated 12/4/19, documented residents were not receiving their scheduled showers. On 12/10/19 at 2:35 PM, during the Resident Group interview, Residents #9, #20, #27, #30, and #44 said showers were not being completed,	F 677		

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F 677	Continued From page 90 especially on Saturdays.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, activity calendar review, and family and staff interview, it was determined the facility failed to ensure activities met the needs of the residents and were varied to provide residents mental stimulation. This was true for 3 of 8 residents (#14, #62, and #66) reviewed for activities and had the potential to affect all other 71 residents in the facility. This failure created the potential for residents to experience boredom, depression, an increase in negative behaviors, and lack of meaningful engagement throughout their stay. Findings include: The facility's policy for activities, dated 11/28/19, documented the following: *The facility provided an ongoing program of activities to meet the resident's interests and support the physical, mental and psychosocial well-being of each resident. *Activities were individualized and customized	F 679	F679E Resident Specific Residents #14 and #62 no longer reside at the facility. Resident #66 had activities evaluation completed and care plan individualized and customized based on his preferences. Other Residents IDT reviewed current residents activities care plan for individualization and customization.	2/4/20

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F 679	Continued From page 91 based on resident's preferences. *Care Plans addressed activities that are appropriate for each resident *The recreation program promoted a sense of usefulness and provided a sense of belonging and stimulation for residents. This policy was not followed. The facility's activity calendar, for November 2019 and December 2019, documented there were no activities on Sundays. For November 2019 activities, the calendar documented: * Six daily activities were cancelled. * Bingo was offered every weekday morning at the same time, for the entire month. * Each Saturday activity, except November 2, bingo, a movie, and Lawrence Welk, were scheduled. On Saturday, November 2, bingo was not offered. * Each Movie Night was scheduled for the same TV channel at the same time. For December 2019 activities, the calendar documented: * Six activities were cancelled (from December 1 to December 13). * Bingo was offered every day except on December 25th. * Each Movie Night for the month was on the same TV channel at the same time. * Each Saturday activity was a movie and Lawrence Welk. 1. Resident #14 was admitted to the facility on 11/5/18 with multiple diagnoses including chronic	F 679	Facility Systems Activities Director was educated by CNO and/or designee to facility Activity Programs Policy and the need to ensure activities meet the needs of the residents and are varied to provide residents mental stimulation, to include room bound and/or cognitively impaired residents. In addition, residents are up timely to attend activities as scheduled. The system is amended to include a broad variety of activities that residents voice an interest in participating in, and adjustment in activity hours, and enhancement of volunteer programs. Monitoring The CEO and/or designee will audit activities program to ensure activities are meeting the interest/needs of residents weekly for 12 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion	

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F 679	Continued From page 92 respiratory failure (when the airways in the lungs become narrow and damaged), quadriplegia (paralysis of all four limbs), and West Nile virus infection with encephalitis (inflammation of the brain). Resident #14's MDS assessment documented he was rarely or never understood, and Resident #14's cognitive skills for daily decision making were severely impaired. Resident #14's care plan, dated 9/30/19, documented his activities of interest included watching movies, watching hunting and fishing shows, watching the History Channel, listening to old country music, and being outdoors. Resident #14's activity assessment, dated 11/6/19, documented Resident #14 enjoyed activities, including watching the History Channel, playing card games, and watching drag racing. Resident #14's activity flow sheet for October 2019, documented he participated in two group activities for the month. His 1:1 activities were documented as family visits and audio stimulation. The flow sheet documented Resident #14's independent activities were watching television 24 of 31 days and two activities of playing board games. Resident #14's activity flow sheet for November 2019, documented 1:1 activity visits as family/friend visits and audio stimulation. Self-directed activities were watching television 21 out of 30 days and participating in a board game on two days.	F 679	February 4, 2020	

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F 679	Continued From page 93 Resident #14's activity flow sheet for December 2019, documented 1:1 activities were family visits and audio stimulation with the self-directed activity as watching television. On 12/8/19 at 10:14 AM, Resident #14's wife stated there were no activities he was interested in at the facility. On 12/9/19 at 10:45AM, Resident #14's wife stated he did not like the activities at the facility and she had to do activities with him. 2. Resident #62 was readmitted to the facility on 11/12/19, with multiple diagnoses including quadriplegia, dependence on a ventilator (a machine that helps a person breathe), and a colostomy (a surgical opening in the abdominal wall to bypass a damaged colon). Resident #62's care plan, dated 11/12/19, documented he had a communication problem and staff should anticipate and meet his needs. His care plan documented staff should invite, encourage, remind, and escort Resident #62 to activity programs consistent with his interests. Resident #62's activity assessment, dated 8/22/19, documented he enjoyed activities which included walking, football, classical and gospel music, reading the comics, cooking and pet visits. Resident #62's activity record for November 2019, documented he had 1:1 activity once for the month of November, categorized as a family visit and audio stimulation. The activity record documented his self-directed activities were	F 679		

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CASCADIA OF BOISE	6000 W DENTON ST BOISE, ID 83704

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F 679	Continued From page 94 watching television, reading mail, and family visits. There was no documentation Resident #62 participated in group activities. Resident #62's activity record for December 2019, documented he had two 1:1 activities, and self-directed activities were watching television and current events. There was no documentation Resident #62 participated in group activities. On 12/8/19 at 11:39 AM, Resident #62's daughter stated he liked to go to activities, but they did not get him out of bed. 3. Resident #66 was admitted to the facility on 10/11/19, with multiple diagnoses including stroke, muscle weakness, transient paralysis (unable to move intermittently), and diabetes. Resident #66's admission MDS assessment, dated 10/17/19, documented his cognitive skills for daily decision making were severely impaired. Resident #66's care plan, dated 10/11/19, documented Resident #66 had impaired communication and needed staff to anticipate and meet his needs. Resident #66's care plan documented his activities needed to be related to his areas of interest. The care plan documented staff interventions were to arrange 1:1 visits with Resident #66 and allow him to participate in sports, card, and music activities as much as he could participate. Resident #66's activity assessment, dated 10/16/19, documented some of his enjoyed	F 679		

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F 679	Continued From page 95 activities were football, poker, reading, walking, and pet visits. Resident #66's November 2019 activity record documented he participated in three group activities for the month and 19 of 22 self-directed activities were watching TV. The activity record also documented a single 1:1 activity for the month that was documented as a family/friend visit. There were no activity preferences documented on his activity plan. Resident #66's December 2019 activity record for the first 13 days of the month documented he participated in one group activity, had three family visits, and 7 of 8 independent activities were watching television. On 12/9/19 at 12:50 PM, Resident #66 was observed alone, sitting in a manual wheelchair in front of the facility's Christmas tree without interaction with staff. On 12/12/19 at 11:10 AM, the Activities Director stated she completed the baseline activity assessments. When asked about activities, she stated the facility counted any activity as an activity, even those not organized by the activity department. On 12/12/19 at 11:25 AM, the Activity Director was asked how residents activities were documented on the activity assessment or flow sheet. She replied she did not do all the activities she put on the care plan. The Activity Director stated activities noted on residents' care plan depended on the CNAs to carry out as she "can't do everything for everyone."	F 679		

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F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, and staff and resident interview, it was determined the facility failed to ensure professional standards of practice were followed for 5 of 26 residents (#10, #15, #55, #120, and #600) reviewed for standards of practice. * Resident #10's order for application and removal of her heel protector and hand splint were not followed. * Resident #15's wound dressings were not completed as ordered, he did not have hyperglycemic protocol order, his blood glucose (BG) of over 300 mg (milligrams)/dl (deciliter) were not referred to the physician, referral for endocrinologist and laboratory order for an A1C (blood test that measures your average blood sugar levels over the past 3 months) were not completed. * Resident #55 was not assessed for positioning, and her order for positioning after meals was not followed.	F 684	F684E Resident Specific Resident #10 was evaluated for use of offloading boots and d/t refusal an alternative offloading device was implemented. Resident #10 was evaluated by Occupational Therapy for use of resting hand splint and adjustments implemented. Resident #15 assessed and noted to have wound dressings completed as ordered. Resident #15□s BGs were reviewed with MD and new orders received for hyperglycemic protocol. Resident #15 was seen by endocrinologist as ordered on 1/14/20 and A1C was performed on 12/12/20. Residents #120 and #600 no longer reside in the facility. Resident #55 wheelchair positioning was	2/4/20

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F 684	Continued From page 97 * Resident #120 received her Parkinson's medications late several times. * Resident #600 was not monitored when her blood pressure was high and an ordered blood pressure medication was not available. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include: 1. Resident #15 was admitted to the facility on 12/13/18, and again readmitted on 9/6/19, with multiple diagnoses including obesity, diabetes mellitus with chronic kidney disease (condition characterized by gradual loss of kidney function over time) and a rectal fistula (small tunnel that develops between the end of the bowel and the skin near the anus). a. Resident #15' physician's order, dated 9/26/19, directed staff to cleanse his wound on his right buttock daily and as necessary (PRN), and cover it with a Border Foam. Resident #15's October 2019 through December 2019, documented his wound dressing was not completed on 10/27/19, 11/16/19 and on 11/23/19. On 12/8/19 at 10:54 AM, RN #7 and CNA #16 entered Resident #15's room and said they would provide pericare to him. CNA #16 asked Resident #15 to turn on his left side while RN #7 stood on the left side of his bed supporting him. There was no Border Foam observed on Resident #15's	F 684	evaluated and adjusted as needed. Other Residents IDT reviewed current residents with offloading boots ordered and/or splints ordered, wound care orders for implementation, hyperglycemia management and notification, residents with referrals to specialists for completion, residents with A1C ordered for completion, Parkinson□s medications timely administration, unavailable medication management, and post event management to include assessment and vital signs. Any discrepancies were addressed as indicated. Facility Systems Nursing staff educated by CNO and/or designee regarding upholding professional standards of care to include but not limited to, implementation of physician directives, communication with physician to receive a plan when plan is not implemented, placing offloading boot, utilizing resting hand splints as per order, positioning residents post meals as directed by the care plan, and to follow post event monitoring protocols. In addition, licensed nursing staff were educated to complete wound care as ordered, follow facility hyperglycemic and	

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F 684	Continued From page 98 buttock wound. On 12/8/19 at 3:08 PM, Resident #15 said a nurse placed a cover on his wound. Resident #15 said he had to remind the nurses to clean his wound and was always told the Wound Care Certified (WCC) nurse would do the wound dressing changes. When asked who performed his wound dressing changes when the WCC nurse was not on duty, Resident #15 said "Whoever feel sorry for me." On 12/9/19 at 10:44 AM, the WCC nurse was observed to remove the undated Border Foam dressing covered Resident #15's wound. Wound dressings are often dated to verify when the wound dressing was last changed. The WCC nurse said Resident #15's wound should be cleaned every day and PRN, and covered with Border Foam 24 hours a day to prevent infection. The surveyor informed the WCC nurse Resident #15's wound was observed to have no cover on Sunday, 12/8/19, during pericare. The WCC nurse said she worked Monday through Friday and left the wound dressing supplies in Resident #15's room before she left on Friday, 12/6/19, so the nurse on duty could change the dressing during the weekend. The WCC nurse said she did not know why Resident #15's wound did not have a Border Foam cover on 12/8/19. b. The facility's Hyperglycemia and Diabetic Coma policy, revised 3/1/19, directed staff to call the physician if the resident's BG level was over 300 mg/dl (milligrams per deciliter - measurement that indicates the amount of a particular substance, such as glucose, in a specific amount of blood) and the resident was	F 684	Diabetic Coma Policy, complete referrals and labs as ordered in a timely manner, administer medications timely and as ordered in order to avoid side effects, complete monitoring for medication parameters as indicated when medication is unavailable, arrange for consultation as referred by physician, and provide monitoring post event (assessment and vital signs as indicated). The system is amended to include review of admissions, change of condition, and new orders in clinical meeting for monitoring directives. Department manager and nursing leadership rounds will monitor for implementation of care plan at the bedside. Monitoring The CNO and/or designee will audit new admissions, change of condition, and new orders for professional standards on 10 residents weekly for 4 weeks, then 5 residents weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion	

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F 684	Continued From page 99 not on sliding scale insulin. Resident #15's December 2019 MAR, documented the following medications: * Victoza Solution Per-injector 18 mg/ml, inject 1.2 mg subcutaneously one time a day for diabetes mellitus, ordered on 9/6/19. *Humulin R U-500 KwikPen Solution Per-injector 500 unit/ml, inject 100 unit subcutaneously with meals for diabetes ordered on 11/16/19. Resident #15's Diabetic Administration Record, dated 11/1/19 through 12/12/19, documented his BG level was checked three times a day, and he had 70 BG levels ranging from 302 mg/dl to 535 mg/dl, during the 42 day time period. A Nurse Practitioner's Progress Note, dated 8/7/19, documented Resident #15's A1C was 6.8% on 6/25/19 and would be repeated on 9/7/19. The CDC website, accessed on 1/3/20, states an A1C result of 6.5% or above, indicates a person is diabetic. A Nurse Practitioner's Progress Note, dated 11/6/19, documented Resident #15's BGs levels were trending in the 300-400's mg/dl range despite aggressive insulin therapy with Humulin R U-500 and Victoza. The note documented while it was likely somewhat related to his current infection, he had difficulty in the past with adequately controlling his blood glucose levels. The Nurse Practitioner's Progress Note further documented "Will consult endocrine for assistance in management." A Nursing Note, dated 11/6/19, documented orders were received for an endocrinology	F 684	February 4, 2020	

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F 684	Continued From page 100 referral for Resident #15. A Nursing Note, dated 11/15/19 at 8:30 PM, documented Resident #15's BG level was 427 mg/dl and he was asymptomatic. The note documented the Nurse Practitioner was informed and the facility was awaiting a response from the Nurse Practitioner. A Nursing Note, dated 11/15/19 at 9:00 PM, documented an order to give Resident #15 an additional 10 units of Humulin R U-500 for BG of 427 and to increase the dose from 75 units to 85 units at 2:00 PM and at 9:00 PM. A Nursing Note, dated 11/16/19 at 9:10 PM, documented the Nurse Practitioner was notified of Resident #15's BG level of 429 and the staff was directed to give him 10 units of Humulin R U-500 insulin. A Nursing Note, dated 11/16/19 at 9:43 PM, documented a new order for Resident #15 to receive 100 units of Humulin R U-500 with breakfast, lunch, and dinner. A Physician Progress Note, dated 11/19/19, documented the physician ordered a nutrition consult for Resident #15. A Nursing Note, dated 11/19/19 at 3:15 PM, documented a nutrition referral was received from the physician and the message was sent to the RD. A Nursing Note, dated 11/19/19 at 9:56 PM, documented Resident #15 was seen by the physician related to uncontrolled BG levels. The	F 684		

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F 684	Continued From page 101 note documented Resident #15 said he had a life changing talk with the physician and decided to go on diet. A Nursing Note, dated 11/28/19 at 6:57 PM, documented the Nurse Practitioner was notified of Resident #15's BG level of 518 mg/dl. A Nursing Note, dated 12/9/19 at 10:50 AM, documented the Nurse Practitioner reviewed Resident #15's BG levels and they remained uncontrolled. The note stated an endocrinology follow-up was pending. The need for an endocrinology follow up was documented by the Nurse Practitioner on 11/13/19. There was no other documentation the Nurse Practitioner or physician was notified of Resident #15's BGs levels over 300 mg/dl. On 12/10/19 at 8:41 AM, LPN #4 was observed to take Resident #15's BG level and said it was 505 mg/dl. LPN #4 said Resident #15 asked her to recheck his BG level because it was 520 mg/dl when she checked it earlier. On 12/12/19 at 10:08 AM, UM #1 said he did not find Resident #15's A1C test result in Resident #15's record. UM #1 said it was in the physician's plan to recheck Resident #15's A1C on 9/7/19, but there was no order given to the nurse. UM #1 also said he did not find Resident #15's report from the endocrinologist in his record. UM #1 said the Transportation Coordinator scheduled the residents' appointments. On 12/12/19 at 11:18 AM, the Transportation Coordinator said she received the order to	F 684		

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F 684	Continued From page 102 schedule Resident #15 for an endocrinology consult on 12/9/19, and faxed the request to the Endocrinology clinic on 12/11/19. On 12/12/19 at 11:39 AM, the DON reviewed the Nurse Practitioner's progress note, dated 8/7/19 and said the nurse should have scheduled the A1C blood test of Resident #15. The DON said also said when the Nurse Practitioner requested the endocrinology consult, it should have been given to the appointment scheduler immediately. On 12/12/19 at 11:43 AM, the Clinical Resource Nurse said she did not find documentation Resident #15 was seen by the RD after he was seen by the physician on 11/19/19, and the physician ordered a nutrition consult. On 12/12/19 at 1:17 PM, LPN #4 said Resident #15 had a hypoglycemic (low blood glucose) protocol but not hyperglycemic (high blood glucose) protocol. LPN #4 said she was told to notify the physician if a resident's BG level was over 400 mg/dl. When asked if she had notified the physician of Resident #15's blood glucose levels over 500 mg/dl on 12/10/19, LPN #4 said she had not because she was running busy. LPN #4 said she had 24 residents and she prepared 3 residents to go to their dialysis appointments. On 12/12/19 at 1:27 PM, UM #1 said he did not find an individualized hyperglycemic protocol order for Resident #15. UM #1 said he knew the physician should be notified when a resident's BG was over 300 mg/dl. UM #1 also said they had a hypoglycemic protocol order but he did not know if they have hyperglycemic protocol order.	F 684		

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F 684	Continued From page 103 On 12/12/19 at 2:25 PM, the RD said he was not aware the physician had ordered the nutrition consult for Resident #15. The RD said he saw Resident #15 on 11/18/19, and he expressed no interest in making changes with his meals. On 12/12/19 at 3:57 PM, the Clinical Resource Nurse said Resident #15 should have a hyperglycemic protocol order in his record. 2. Resident #10 was admitted to the facility on 9/24/18, with multiple diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following a cerebral infarction (stroke). Resident #10's physician's order, dated 3/9/19, directed staff to apply a hand splint on her right upper extremity at 10:00 PM and removed it at 6:00 AM (total of 8 hours). Resident #10's care plan, directed the staff to apply a hand splint to her as she could tolerate for eight hours a day. Resident #10's care plan also directed staff to apply heel protectors to her when she was in bed. On 12/12/19 at 1:06 PM, UM #1 and the surveyor observed Resident #10 in bed with a hand splint applied on her right hand. UM #1 then removed Resident #10's hand splint and said it should have been removed at 6:00 AM. The surveyor asked UM #1 to check Resident #10's lower extremities. UM #1 asked Resident #10 if he could check on her lower extremities and Resident #10 agreed. UM #1 said Resident #10's right leg was floated on top of a pillow and she was not wearing a heel protector. UM #1 said	F 684		

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F 684	Continued From page 104 Resident #10 had an order to wear a heel protector and had a care plan for it. 3. Resident #120 was admitted to the facility on 11/26/19, with multiple diagnoses including Parkinson's disease (a progressive disease of the nervous system that affects movement). Resident #120's physician order, dated 11/26/19, directed licensed nurses to provide Carbidopa-Levodopa 25-100 MG three times a day and at bedtime. Resident #120's 11/2019 and 12/2019 MARs, directed licensed nurses to provide Carbidopa-Levodopa 25-100 MG at 5:00 AM, 10:00 AM, 3:00 PM, and at 8:00 PM. The 11/2019 MAR documented she received the medication on 11/26/19 at 5:32 PM for the 3:00 PM medication time, and at 10:24 PM for the 8:00 PM medication time. The 12/2019 MAR documented she received the medication on 12/7/19 at 11:01 AM for the 10:00 AM medication time, and on 12/8/19 at 10:01 PM for the 8:00 PM medication time. On 12/9/19 at 10:08 AM, Resident #120 said she had received her medication for her Parkinson's disease as late as two hours on a few occasions. She said when her medication was late, her feet and legs can become stiff, making it difficult to walk; and her arms and hands spasmed. On 12/12/19 at 11:21, the DON said she expected nurses to deliver Resident #120's medications on time to avoid side effects. 4. The American Heart Association website,	F 684		

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F 684	Continued From page 105 accessed on 1/6/20, states normal blood pressure is a Systolic (top number) reading less than 120 and a Dystolic (bottom number) reading less than 80. Resident #600 was admitted to the facility on 9/12/19, with multiple diagnoses including hypertension, atrial fibrillation (irregular heartbeat, and a stroke with hemiplegia and hemiparesis affecting her left side. Resident #600's Admission Evaluation Assessment, dated 9/12/19, documented her cognition was impaired with a confused conversation and her pupils were equal and reactive. Resident 600's vital signs were: blood pressure 159/88, pulse 77, and she had regular cardiac (heart) rhythm. Resident #600's left side had no motor skill response. A nurse's progress note, dated 9/12/19 at 6:41 PM, Resident #600 was alert and oriented to self. The note documented she was unable to carry on a viable conversation and required extensive assistance with bed mobility and transfers. A nurse's progress note, dated 9/12/19 at 9:28 PM, documented Resident #600 was alert and was a new admission with a diagnosis of a stroke with left sided weakness. The note documented she required a Hoyer (mechanical) lift to transfer with the assistance 2 staff members and staff would continue to monitor her. A nurse's progress note, dated 9/13/19 at 9:53 AM, documented Resident #600 was admitted to the facility for therapy services.	F 684		

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F 684	Continued From page 106 A nurse's progress note, dated 9/13/19 at 5:58 PM, documented Resident #600's blood pressure was 169/107 and new physician's orders were received to administer Hydralazine 25 mg four times a day, as needed, for hypertension. There was no documentation Resident #600 was further assessed for changes of condition. A nurse's progress note, dated 9/13/19 at 8:40 PM, documented Resident #600 was found unresponsive at 7:13 PM, was reassessed by the RN, and was pronounced deceased at 7:15 PM. The note documented Resident #600's family and physician was notified and her body was released to the mortician on 9/13/19 at 8:05 PM. The nurse's notes did not include documentation of assessments between 5:58 PM and 7:15 PM on 9/13/19. On 12/12/19 at 2:47 PM, the DON stated Resident #600 had high blood pressure and the nurse notified the physician and received new orders for the Hydralazine. The DON stated the medication was not in the facility's emergency medication kit and had to be ordered and delivered from the pharmacy. The DON stated the nurse's progress notes should have included Resident #600's condition throughout the day on 9/13/19 up to when Resident #600 passed away. 5. Resident #55 was admitted to the facility on 11/1/19, with multiple diagnoses, which included Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors) and Lewy Body Dementia (progressive brain disorder triggered by abnormal deposits of protein in the brain).	F 684		

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F 684	Continued From page 107 A quarterly MDS assessment, dated 11/11/19, documented Resident # 55 was cognitively intact and was totally dependent on two staff members with bathing, bed transfers, and bed mobility. Resident #55 was observed sitting in specialized wheelchair leaning over the left side of the wheelchair as follows: *On 12/8/19 at 10:27 AM, 12:22 PM, 12:42 PM, 12:54 PM *On 12/9/19 at 10:37 AM, 12:40 PM, 12:52 PM *On 12/10/19 at 8:38 AM On 12/10/19 at 11:50 AM, Resident #55's wife stated staff were not keeping him upright and not using his pillow on his left side to keep him upright. On 12/10/19 at 1:33 PM, the Director of Therapy stated Resident #55 leaned to his left side in the wheelchair and needed more than a pillow for positioning.	F 684		
F 686 SS=G	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	F 686		2/4/20

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F 686	Continued From page 108 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, policy review, and resident and staff interview, it was determined the facility failed to ensure residents received appropriate care to prevent and treat pressure ulcers. This was true for 2 of 4 residents (#52 and #62) reviewed for pressure ulcers. This deficient practice resulted in harm to Resident #52 when he developed an avoidable pressure ulcer and harm to Resident #62 when he developed two avoidable pressure ulcers and he did not receive treatment for the wounds as ordered. Findings include: The National Pressure Ulcer Advisory Panel, 2016, defined pressure ulcers as follows: Stage 1- Intact skin with a localized area of non-blanchable erythema (red discoloration of skin as a result of injury) which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate a deep tissue pressure injury. 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	F 686	F686G Resident Specific Resident #62 no longer resides in the facility. Resident #52 had a skin evaluation completed and no skin impairments noted. Other Residents IDT reviewed current residents with high risk for developing pressure injuries and/or with pressure injuries present, were reviewed for preventative and treatment interventions and adjustments made as indicated. Facility Systems Nursing staff educated by CNO and/or designee to facility Prevention and Treatment of Pressure Ulcers and Other Skin Alterations Policy, to include but not limited to complete assessment on admission/re-admission, transcription and implementation of physician orders at the	

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F 686	Continued From page 109 (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. 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 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. 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. 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,	F 686	time they are received in order to prevent a delay in treatment, consistent identification of wound sites and healing progress, prevention devices and repositioning consistently implemented, identification of medical devices that are prone to pressure, implementation of preventative measures when medical devices are required. The system is amended to include review by the clinical management team in clinical meeting of residents identified as high risk for pressure injuries, those with medical devices, and those with newly developed pressure injuries for treatment initiated as well as preventative interventions. Bedside interventions are coded from the care plan to the kardex for line staff review and implementation. Clinical rounds to include review of person-centered skin prevention plan implementation. Monitoring The CNO and/or designee will audit skin preventative interventions in place and timely implementation of wound treatment orders 3 times a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems	

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F 686	Continued From page 110 adherent, intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be softened or removed. 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 darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The Lippincott Manual for Nursing Practice, tenth edition, stated measures to prevent pressure ulcer development included repositioning every two hours, using special devices to cushion the specific area, and use an alternating pressure mattress or air fluidized bed for patients who are at high risk. The facility's "Prevention and Treatment of Pressure Ulcers and Other Skin Alterations" policy and procedure, released 11/28/17, documented: "The facility has a system in place to promote skin integrity, prevent pressure ulcer development/other skin alterations...unless the individual's clinical condition demonstrates they were unavoidable...'Avoidable' means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with the resident needs, resident goals, and professional standard of practice; monitor and evaluate the impact of	F 686	appropriate. Date of Completion February 4, 2020	

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F 686	Continued From page 111 the interventions; or revise the interventions as appropriate." The facility's policy and procedure stated "Procedure Prevention Steps:.. A risk assessment is completed upon admission and at designated intervals throughout the resident's stay to evaluate the resident's intrinsic risk...that may have an impact on the development, treatment and/or healing of [pressure ulcers/pressure injuries]...Residents at risk for developing pressure ulcers are identified by using the Braden Scale (a tool that predicts the risk for developing a facility acquired pressure injury)...Pressure ulcer and other wound and skin related interventions are created in collaboration with the interdisciplinary team and implemented in order to identify, prevent or reduce the risk of acquiring pressure and/or non-pressure related wounds or skin issues..." This policy was not followed. 1. Resident #62 was admitted on 8/16/19 and readmitted on 11/12/19, with multiple diagnoses including acute respiratory failure (fluid buildup in the air sacs of the lungs), quadriplegia (paralysis of all four limbs), congestive heart failure (a weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues), and a colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon). a. An admission MDS assessment, dated 8/23/19, documented Resident #62 was at high risk for developing pressure ulcers and had one	F 686		

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F 686	Continued From page 112 unhealed Stage 1 pressure ulcer on admission. A significant change MDS assessment, dated 10/16/19, documented Resident #62 had three unstageable pressure ulcers with suspected deep tissue injury and two of these unstageable pressure ulcers were present upon admission/reentry. However, his admission MDS assessment, dated 8/23/19, did not include documentation that Resident #62 had two unstageable pressure ulcers upon admission. A nurse's progress note, dated 11/2/19 at 7:08 PM, documented Resident #62 was not feeling well during the afternoon; he had an elevated temperature and his abdomen was round, firm, and tender to touch. The note documented the Medical Director was notified and x-rays were ordered. The note documented Resident #62's family wanted him sent to the Emergency Department for an evaluation and not to wait for the x-rays at the facility. There was no further documentation if Resident #62 was transferred out of the facility. A nurse's progress note, dated 11/12/19 at 3:46 PM, documented Resident #62 was readmitted from a local hospital. The progress note stated Resident #62 had existing pressure ulcers to his coccyx (tailbone), right buttock, and left ankle. The progress note did not include descriptions or measurements of the pressure ulcers. A weekly skin report, dated 11/12/19, documented Resident #62 was readmitted to the facility and had pressure ulcers to his coccyx, right buttock, and left ankle. The report also documented Resident #62 had scabbing to his	F 686		

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F 686	Continued From page 113 abdomen and arms and mentioned his neck/tracheostomy but did not document what skin impairment was present in that area. There was no further descriptions or measurements of the pressure ulcers. The report stated "[Resident #62] readmitted to [facility name] with the above-mentioned injuries to skin; some he had prior to discharge." It was unclear in the documentation which skin injuries/wounds Resident #62 had prior to his discharge to the hospital. A care plan, initiated on 11/12/19, identified Resident #62 had skin impairment/pressure ulcers and the interventions included offloading pressure to the back of his head with an occipital ring, Prevalon boots (boots used to minimize pressure, friction and shear on the feet, heels and ankles of non-ambulatory individuals) to both lower extremities at all times, a pressure relieving cushion for his wheelchair, turning and repositioning every 2 to 3 hours as tolerated, a pressure reducing air mattress on his bed, and following wound clinic orders for treatment of pressure ulcers. Resident #62's record documented he developed avoidable pressure ulcers while at the facility, which included a wound to his right ankle and a wound to his right heel, as follows: * A nurse's progress note, dated 11/15/19 at 7:52 PM, documented Resident #62 had a new suspected deep tissue injury to his right ankle (developed within 3 days of his readmission to the facility). The note documented Resident #62 was wearing the Prevalon boots with hard wedges attached to both sides. The note stated	F 686		

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F 686	Continued From page 114 there was a linear shaped purple area surrounded swelling with redness which did not blanch. The nurse documented the wedges were removed from the Prevalon boots and the area was cleansed with normal saline, skin prep (a liquid protective film or barrier) was applied, and the wound was covered with a foam dressing. A wound clinic assessment note, dated 11/19/19, documented Resident #62 had four pressure wounds and that the wound on his coccyx was moisture associated skin damage, not a pressure wound. The clinic note documented the pressure wounds as three unstageable pressure wounds (one on his left ankle with an unknown date of origin, one on the back of his left lower leg which was acquired on 9/17/19, and one on his right buttock which was acquired on 11/12/19), and one deep tissue pressure injury (on his right ankle which was acquired on 11/15/19). * On 12/8/19 at 10:33 AM, Resident #62 was lying in his bed, the sheets were not covering his legs and he had a pillow positioned under each leg. In addition to the right and left ankle pressure wounds, Resident #62 was observed to have an 8 cm, dark rusty-brown, blood blister on his right heel. A wound clinic assessment note, dated 12/10/19, documented the wound to Resident #62's right heel as an unhealed pressure ulcer. The assessment note stated "Deep Tissue Pressure Injury, persistent non-blanchable deep red, maroon or purple discoloration" measuring 4.2 cm x 1.7 cm x 0. The assessment note did not include information related to when the wound was acquired.	F 686		

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F 686	Continued From page 115 On 12/11/19 at 8:38 AM, the Wound Nurse stated the left ankle pressure ulcer and the deep tissue pressure injury to Resident #62's right heel developed in the facility. b. Resident #62's record documented treatment orders, which were not implemented and inconsistent healing of Resident #62's wounds. A wound clinic assessment note, dated 11/19/19, documented Resident #62 had four pressure wounds. The clinic note documented the pressure wounds as three unstageable pressure wounds and one deep tissue injury. The wound clinic note documented the status of the wounds as follows: *The left ankle pressure ulcer had an unknown date of origin. It was an unstageable pressure ulcer with full-thickness skin and tissue loss with measurements of 1.5 cm x 1.3 cm x 0.1 cm. *The left back lower leg wound was acquired on 9/17/19. It was an unstageable pressure injury with full-thickness skin and tissue loss with measurements of 0.4 cm x 0.2 cm x 0.1 cm. *The right ischial (buttock) pressure ulcer was acquired on 11/12/19. It was an unstageable pressure injury with full-thickness skin and tissue loss with measurements of 1.3 cm x 0.5 cm x 0.1 cm. *The right ankle pressure ulcer was acquired on 11/15/19. It was described as a deep tissue pressure injury with a small amount of fluid coming from the wound with measurements of	F 686		

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F 686	Continued From page 116 3.5 cm x 1.5 cm x 0.1 cm. Wound clinic treatment orders for the pressure wounds, dated 11/19/19, included the following: * Left ankle: cleanse wound with normal saline or wound spray, apply skin protectant, apply Alginate with silver (absorbent wound dressing that contains silver), cover with a bordered foam dressing, change the dressing three times a week and as needed for soiling, saturation, or accidental removal. * Left lower leg: cleanse wound with normal saline or wound spray, apply skin protectant, apply Alginate with silver, cover with a bordered foam dressing, change the dressing three times a week and as needed for soiling, saturation, or accidental removal. * Right buttock: cleanse wound with normal saline or wound spray, apply zinc oxide-based cream four times a day and as needed with peri-care. * Right ankle: cleanse wound with normal saline or wound spray, apply skin protectant, cover wound with bordered foam dressing, change dressing every other day and as needed for soiling, saturation, or accidental removal. Resident #62's wound clinic assessment note, dated 11/26/19, documented his left lower leg pressure ulcer had healed and his left ankle wound had decreased in size, but his two other wounds increased in size as follows: * The right ischial pressure ulcer advanced to a	F 686		

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F 686	Continued From page 117 Stage 3 with a measurement of 1.5 cm x 2.9 cm x 0.1 cm with a scant amount of drainage. * The right ankle pressure ulcer was described as an unstageable pressure injury with full-thickness skin and tissue loss and had increased in size to 5 cm x 1 cm x 0.2 cm. Resident #62's wound clinic assessment did not include documentation regarding why Resident #62's right buttock and right ankle pressure wounds had increased in size. Resident #62's 11/26/19 wound treatment orders, modified the dressing changes and included Santyl (an enzyme used to heal skin ulcers). The orders stated: * Right and left ankles: Cleanse with normal saline or wound spray, apply skin protectant, apply debriding (removal of dead or infected skin) agent Santyl (an enzyme used to heal skin ulcers) and cover with slightly moist gauze, then cover with dry gauze securing with a cloth tape, change dressing daily and as needed for soiling, saturation, or accidental removal. * Right buttock: cleanse the wound with normal saline or wound spray and apply skin protectant, it did not include applying a zinc oxide-based cream. Resident #62's wound clinic assessment note, dated 12/3/19, documented his buttocks and right ankle wounds had decreased in size, but his left ankle wound had increased in size from 1.5 cm x 1.3 cm x 0.1 cm on 11/19/19 to 1.8 cm x 1.6 cm x 0 cm. The note also documented the left ankle	F 686		

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F 686	Continued From page 118 wound had a scant amount of drainage. Wound clinic treatment orders for Resident #62, dated 12/3/19, stated to continue the previous wound care recommendations. Resident #62's December 2019 TAR did not include documentation the 11/26/19 orders were implemented until 12/05/19 (nine days after the 11/26/19 order). The December 2019 TAR documented the Santyl start date for the left and right ankles was 12/5/19. The December 2019 TAR documented the dressing changes, also started on 12/5/19, that the dressing were to be changed Monday through Friday, which was not consistent with the 11/26/19 order which stated the dressings were to be changed every day and as needed for soiling, saturation, or accidental removal. The December 2019 TAR did not include documentation that the wound dressings on Resident #62's left and right ankles were changed on 12/7/19 and 12/8/19. On 12/8/19 at 10:33 AM, Resident #62 was lying in his bed and the sheets were not covering his legs and he had a pillow positioned under each leg, there were no dressings observed on his ankle wounds. On 12/8/19 at 10:56 AM, at 11:28 AM, at 11:40 AM, and at 12:02 PM, Resident #62's feet were touching the footboard of his bed and there were no dressings observed on his ankle wounds. On 12/9/19 at 9:32 AM, Resident #62 was lying in his bed with his heels resting on pillows. There were no dressings observed on his ankle	F 686		

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F 686	Continued From page 119 wounds. On 12/11/19 at 8:24 AM, UM #1 was asked about Resident #62 not having any dressing on his pressure ulcers on 12/8/19 and 12/9/19. He stated if the dressings got wet they were changed and Resident #62 was "a very edematous guy" so the dressings may have slipped off. The facility failed to ensure Resident #62's treatment orders were followed. c. Resident #62 was not observed to receive preventative measures for his pressure wounds as ordered: On 12/11/19 at 8:38 AM, the Wound Nurse stated the staff were offloading Resident #62's legs to help prevent pressure ulcers. The Wound Nurse stated Resident #62 was wearing Prevalon boots to prevent pressure ulcers from developing. The Wound Nurse also stated Resident #62 was wearing Prevalon boots since admission and was being followed by a wound clinic since admission. Resident #62's wound clinic assessment note, dated 11/26/19, documented interventions which included repositioning Resident #62 every 2 to 3 hours to alleviate pressure and wearing off-loading boots (Prevalon) to both lower extremities. Wound clinic treatment orders for Resident #62, dated 12/3/19, stated to continue the previous wound care recommendations. Resident #62's December 2019 TAR did not include documentation the 11/26/19 orders were	F 686		

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F 686	Continued From page 120 implemented until 12/8/19 (twelve days after the 11/26/19 order). The December 2019 TAR documented Resident #62 was to have bilateral heel protectors while in bed, with a start date of 12/8/19. * On 12/8/19 at 10:33 AM, Resident #62 was lying in his bed and the sheets were not covering his legs and he had a pillow positioned under each leg. He did not have the Prevalon boots on. * On 12/8/19 at 10:56 AM, at 11:28 AM, at 11:40 AM, and at 12:02 PM, Resident #62's feet were touching the footboard of his bed and he did not have the Prevalon boots on. * On 12/9/19 at 9:32 AM, Resident #62 was lying in his bed with his heels resting on pillows. He did not have the Prevalon boots on. On 12/8/19 at 11:28 AM, Resident #62 was repositioned by four staff. On 12/8/19 at 11:06 AM, Resident #62 said staff did not reposition him "that much," he said they did it a couple of times a day. On 12/11/19 at 9:56 AM, UM #1 stated for pressure ulcer care the staff "floated" both hips then rolled Resident #62 from side to side throughout the day. He stated staff did not document position changes in Resident #62's record, but he trusted it was being done by staff. UM #1 stated it was not unexpected Resident #62's Prevalon boots were not on and it was everyone's responsibility to ensure they were. When asked if Prevalon boots were normally on the MAR/TAR UM #1 stated Resident #62 had	F 686		

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F 686	Continued From page 121 them as of 11/17/19. When asked why they were not in his orders, UM #1 stated he did not know if it was the facility policy to have them in orders.When asked if he knew Resident #62 had not been wearing the boots, he stated Resident #62 should have Prevalon boots on at all times and there was no reason he would not have them on that he could think of. The facility failed to ensure Resident #62's received preventative measures for his pressure wounds as ordered. 2. Resident #52 was admitted to the facility on 12/19/18, with multiple diagnoses including a stroke affecting his right dominant side, aphasia (an impairment of language due to brain injury, affecting the production or comprehension of speech and the ability to read or write), dysphagia (difficulty swallowing), and edema (swelling). Resident #52's record included a care plan which documented he was at risk for skin impairment related to his impaired mobility. The care plan included interventions, initiated on 2/6/19, for the use of pillows for positioning, keep his skin clean and dry, offload heels while in bed using heel protectors, use of a pressure reducing mattress and wheelchair cushion, and to reposition 2 to 3 times a shift and as needed. A quarterly MDS assessment, dated 9/20/19, documented Resident #52 was at risk for the development of pressure ulcers and had no unhealed pressure ulcers. A Braden Scale for Predicting Pressure Sore	F 686		

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F 686	Continued From page 122 Risk, dated 11/4/19, documented Resident #52 was at high risk for the development of pressure ulcers. A significant change MDS assessment, dated 11/15/19, documented Resident #52 had severe cognitive impairment and he was dependent on staff for activities of daily living including bed mobility, transferring, toilet use, personal hygiene, and bathing. The assessment documented he had an indwelling catheter and was always incontinent of bowel. The assessment documented Resident #52 was at risk for developing pressure ulcers and had two Stage 3 pressure ulcers which were not present upon admission. A weekly skin report, dated 10/31/19 at 5:28 PM, documented Resident #52 had a new skin condition or change since the last documented skin check. The report documented Resident #52 had a medical device related pressure injury to his right outer ankle and both of his lower extremities were edematous (swollen). The report documented this was a new pressure ulcer and the Comments/Summary section documented Resident #52 had an unstageable pressure injury, potentially caused by suprapubic catheter tubing in his pant leg. A Weekly Pressure Ulcer report, dated 11/1/19 at 1:53 PM, documented Resident #52 had a new onset unstageable pressure ulcer to his right outer ankle. The measurements were 5.5 cm x 2.0 cm x 0.2 cm and the report stated it was caused by a medical device. The report documented Resident #52's wound had a small amount of serosanguineous (yellowish fluid with	F 686		

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F 686	Continued From page 123 small amounts of blood) drainage and was obscured by necrosis/unstageable/deep tissue injury. Progress notes dated 11/6/19, 11/12/19, 11/19/19, 11/26/19, and 12/4/19 all documented Resident #52's right outer ankle pressure ulcer was decreasing in size. On 12/13/19 at 9:49 AM, the Wound Nurse was observed while changing the dressing for Resident #52's pressure ulcer. The Wound Nurse stated Resident #52's pressure ulcer to his right outer ankle measured approximately 2.0 cm x 0.5 cm x 0 cm. The Wound Nurse stated Resident #52's legs were very swollen at the time the pressure ulcer developed. The Wound Nurse stated Resident #52 was at a higher risk for the development of pressure ulcers due to the edema in his bilateral lower extremities. On 12/10/19 at 3:30 PM, the DON stated Resident #52 was at a higher risk for development of pressure ulcers with edema in his bilateral lower extremities. The DON stated the development of the pressure ulcer on Resident #52's right outer ankle could have been avoided if the staff had monitored the position of the catheter tubing and the length of time the catheter tubing had been applying pressure to his skin.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		2/4/20

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F 688	Continued From page 124 range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and family and staff interview, it was determined the facility failed to ensure residents received treatment and services to prevent a decrease in range of motion (ROM). This was true for 2 of 9 residents (#14 and #62) reviewed for restorative therapy. This failure created the potential for residents to experience a decline in ROM. Findings include: The facility's policy for restorative nursing, dated 2/28/19, documented: * Restorative nursing helped the resident restore function. * Restorative nursing programs were initiated when the resident was discharged from formal therapy. * Successful functional maintenance programs helped to prevent pressure ulcers and contractures, prevent physical and/or cognitive deterioration, and enhanced the resident's	F 688	F688D Resident Specific Residents #14 and #62 no longer reside in the facility. Other Residents IDT reviewed current residents with referrals to and/or orders for restorative nursing programs to validate they are implemented and provided per directives. Facility Systems Nursing staff was educated by CNO	

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F 688	Continued From page 125 well-being. This policy was not followed. 1. Resident #14 was admitted to the facility on 11/5/18, with multiple diagnoses including chronic respiratory failure (when the airways in the lungs become narrow and damaged), quadriplegia (paralysis of all four limbs), and West Nile virus infection with encephalitis (inflammation of the brain). Resident #14's MDS assessment, dated 10/10/19, documented his functional status was total dependence with two or more staff physical assistance for all ADLs, and he was not receiving restorative nursing care. Resident #14's physician orders, dated 11/26/19, documented an active order for Resident #14 to receive restorative nursing care. Resident #14's care plan, dated 9/30/19, documented staff was to monitor the need for consultation, and provide or screen Resident #14 as needed for physical therapy. On 12/8/19 at 10:17 AM, Resident #14's wife stated the facility no longer offered physical or restorative therapy for him. A review of Resident #14's record, included documentation he was not receiving physical or occupational therapy. The record documented he was removed from physical and occupational therapy on 8/16/19. On 12/12/19 at 9:02 AM, RN #4 stated Resident	F 688	and/or designee on the restorative program to include but not limited to, restorative program directives, frequency of program, documentation of program as implemented, and validate a plan is implemented for residents to receive their restorative program as scheduled. The system is amended to review staffing plan for restorative nursing and to validate new restorative directives are complete in clinical meeting. Implement weekly restorative meetings to review residents on a restorative program for effectiveness and validate treatment is provided as ordered. Monitoring The CNO and/or designee will audit restorative program completion and restorative referrals 2 times a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 688	Continued From page 126 #14's restorative care was provided by RNA #2. RN #4 stated Resident #14 was receiving massage therapy and passive range of motion restorative therapy. On 12/12/19 at 9:30 AM, RNA #1 stated Resident #14 was not receiving restorative care. RNA #1 stated Resident #14 was taken off restorative care because he was so stiff it hurt him too much to move. He stated Resident #14's wife was not notified why Resident #14 was removed from restorative therapy. The facility failed to implement a restorative therapy program for Resident #14 as ordered by his physician. 2. Resident #62 was admitted on 8/16/19, and readmitted on 11/12/19, with multiple diagnoses including acute respiratory failure (fluid buildup in the air sacs of the lungs), quadriplegia (paralysis of all four limbs), congestive heart failure (a weakness of the heart that leads to buildup of fluid in the lungs and surrounding body tissues) and colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon). Resident #62's MDS assessment, dated 10/16/19, documented Resident #62 needed extensive to total assistance with activities of daily living with one to two-person assistance for completing tasks. Resident #62's physician orders, dated 11/12/19, documented Resident #62's rehabilitation potential was fair.	F 688		

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F 688	Continued From page 127 Resident #62's care plan, dated 11/12/19, documented physical therapy and occupational therapy were to evaluate and treat Resident #62 as indicated. On 12/8/19, at 10:33 AM, Resident #62's daughter stated the facility was cutting back on his physical therapy and he was declining. Resident #62's daughter stated she saw a decline in her father's ability to move. Resident #62's physical therapy treatment encounter notes, dated 11/21/19, documented an RNA was instructed on range of motion for Resident #62 to include bilateral lower extremities, 10 to 15 times for each extremity to increase and maintain his range of motion. On 12/12/19 at 9:33 RNA #1 stated Resident #62 was put into the restorative program on 12/9/19 but had not yet received a restorative therapy session, 21 days after the recommended resorative therapy was made by physical therapy. The facility failed to implement a restorative program for Resident #62 as recommended by physical therapy.	F 688		
F 689 SS=G	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	F 689		2/4/20

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F 689	Continued From page 128 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, Incident and Accident (I&A) report review, policy review, record review, and staff interview, it was determined the facility failed to ensure residents were protected from falls and did not sustain injuries due to incorrect use of sit-to-stand lifts (STS - used to assist people with limited mobility when they are unable to transition from a sitting position to a standing position on their own). This was true for 1 of 3 residents (Resident #55) reviewed for falls and 1 of 5 residents (Resident #10) reviewed for abuse and neglect. Resident #10 was harmed when she sustained extensive bruising and experienced intense fear and anxiety due to dangling from the sling of a STS lift. These failures also placed Resident #55 at risk of bone fractures or other serious injuries from from repeated falls. Findings include: 1. Resident #10 was admitted to the facility on 9/24/18, with multiple diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) following a cerebral infarction (stroke) and anxiety. Resident #10 annual MDS assessment, dated 10/1/19, documented she was severely cognitively impaired and required extensive assistance of 1-2 staff members for her ADLs. Resident #10's physician's orders included Aspirin (may interfere with blood clotting at low doses) 81 mg (milligrams) one tablet one time a	F 689	F689G Resident Specific Resident #10 evaluated by Physical Therapy for current transfer status and does not cause her harm. Resident #55 care plan for fall prevention reviewed and rounds performed to validate interventions in place at the bedside and adjustments made as indicated. Other Residents Current residents reviewed who use a sit to stand lift to validate transfer status does not cause harm and is appropriate. Adjustments to transfer status were made as needed. Current residents with falls within the last 30 days were reviewed for care plan revision after each fall and adjustments completed as needed. Facility Systems Nursing and therapy staff had competencies completed for the appropriate use of a sit to stand lift. Lift	

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F 689	Continued From page 129 day for cardiac (heart) precautions, ordered on 12/4/18. Resident #10's care plan included the following: - She was at risk for abnormal bleeding or hemorrhage due to anticoagulant use related to use of Aspirin and staff were directed to monitor for signs and symptoms of bleeding such as bruising. - She had mood problems related to anxiety and staff were directed to provide 1:1 reassurance, offer two staff members to assist during these times, offer repositioning, offer warm blankets and soothing music. A Nursing Note, dated 1/17/19 at 9:13 AM, documented Resident #10 had an order for a physical therapy (PT) evaluation for ROM and evaluation of options to help assist with pain in her right leg/knee. A PT Evaluation and Plan of Treatment, dated 1/8/19, documented Resident #10 was severely deconditioned and would benefit from increased postural stability for eating and ADLs. The short and long term goals for Resident #10 were for her to safely perform bed mobility, sit at side of bed up to 30 minutes to increase socialization and to improve postural stability, and to safely propel herself in a wheelchair. A Nursing Note, dated 1/27/19 at 5:30 PM, documented the nurse was called by a CNA to check on the bruise found on Resident #10's arm. The bruise measured 11 cm (centimeter) x (by) 9 cm extending down to her right breast	F 689	competencies are included in new hire orientation for therapists and nursing staff. Licensed nursing staff educated by CNO and/or designee regarding the need to update resident care plan following each fall for new interventions. The system is amended to include review post fall of residents in clinical meeting for additional interventions to address root cause of fall and periodic review for effectiveness. HR will review employee competencies are documented as completed during the orientation process. Monitoring The CNO and/or designee will audit transfers and fall CP revisions 3 times a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. The HR director and/or designee will audit new hires during the orientation process to validate completion of competencies to include sit-to-stand transfers for therapy and nursing staff. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee	

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F 689	Continued From page 130 measuring 8 cm x 5 cm. Resident #10 denied pain and did not know how it happened. A Weekly Skin Alteration Report, dated 1/30/19, documented Resident #10 had an 11 cm x 9 cm bruise on her right inner arm and an 8 cm x 5 cm bruise on her right lateral breast. A Weekly Skin Check Report, dated 2/5/19, documented Resident #10 had a 15 cm x 4 cm bruise on her right arm and 15 cm x 5 cm bruise on her right breast. An I&A report documented Resident #10's bruise was found on 1/27/19 and her representatives were notified. The I&A documented during witness statement collection Staff A went and looked at Resident #10's bruise and reported to the nurse she thought the bruise could have happened during her therapy session on 1/26/19 with the STS lift. The I&A report documented the Administrator and DON were notified and Staff F was put on suspension pending investigation. Staff A's written statement, dated 1/27/19 at 5:15 PM, documented on 1/26/19 she went to Resident #10's room to provide pericare and Staff F was in the room working with Resident #10 with the STS lift, and told her to wait. Staff A said on her report she left the room and when she came back she saw Resident #10 "dangling" from the STS lift and was crying. Staff A asked Staff F if she was done with Resident #10 and was told "Not yet." Staff A said she left the room to answer another call light. When Staff A came back to Resident #10's room she saw Staff F still trying to get her to stand using the STS lift. Staff A said on her report Resident #10 was dangling	F 689	may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 689	Continued From page 131 and crying and saying she could not breathe. Staff A said Staff F attempted one more time and Resident #10 was saying she could not do it and she could not breathe. Staff F then put Resident #10 down on the bed and Staff A provided pericare to Resident #10. Staff A's report said Staff F assisted her in providing pericare to Resident #10. A Sit to Stand Lift Criteria - Interior Health Website, accessed on 12/19/19, documented the patient should be able to hold onto both handles on the machine to avoid too much pressure in patient's armpit and should be able to keep both feet flat on the footplate of the lift throughout the transfer. An undated and unsigned statement of Staff F, with handwritten note "sometime around 9:30-10ish per [Staff F's name]" on the right top corner, documented on 1/26/19 she was with Resident #10 and asked if she was ready to stand up. Resident #10 said "No" as she had with every other treatment they had. Staff F explained to Resident #10 the benefits of getting out of bed and returning to her prior level of function (PLOF), and that they would just practice standing up. Staff F said on her report that she could tell Resident #10 was not comfortable and resisting too much to achieve standing using the STS lift so she returned her back to a sitting position immediately. Staff F's report documented Resident #10 told Staff F she could not breath and Staff F recognized Resident #10's shortness of breath. Staff F documented she asked Resident #10 to take a deep breath, relax and gave her time to calm down. Staff F's report documented she initiated Resident #10 to stand	F 689		

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F 689	Continued From page 132 up again using the STS lift but noticed she had quicker resistance and fear with standing and was much quicker to return to sitting position. Staff F's report documented Resident #10 continued to report difficulty of breathing. Staff F told Resident #10 it was perfectly normal to be scared and it was her job to safely show and encourage residents to return to their PLOF. Staff F then put Resident #10 to bed and assisted Staff A with completing pericare to Resident #10. The I&A report further documented the interdisciplinary team (IDT) determined abuse did not occur to Resident #10 and the bruise was caused by the sling from the STS lift. Staff F was working with her scope of practice and with proper plan of treatment. Staff A did not feel Resident #10 was harmed or abused but had questioned in her head why STS lift was being used and it may have gone on too long without stopping the session. Both Staff A and Staff F were given education regarding customer service and abuse training. There was no documentation Staff F was evaluated for proper use of the STS lift or provided additional training related to its use. On 12/10/19 at 9:31 AM, the Director of Therapy said Staff F choose to leave the facility about six weeks ago. On 12/11/19 at 10:25 AM, the Administrator said Resident #10's bruise was caused by the sling from the STS lift. 2. The facility's Fall Response and Management policy, dated 11/28/17, documented staff were to:	F 689		

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F 689	Continued From page 133 * Revise the plan of care, as appropriate * Document in the patient medical record: - Review post fall evaluation and fall investigation - Determine causal factors, if possible - Revise the care plan with interventions Resident #55 was admitted to the facility on 11/1/19, with multiple diagnoses, which included Parkinson's Disease (a progressive disease of the nervous system that affects movement) and Lewy Body Dementia (progressive brain disorder triggered by abnormal deposits of protein in the brain). A quarterly MDS assessment, dated 11/11/19, documented Resident #55 was cognitively intact and was totally dependent on two or more staff members with bathing, bed transfers and bed mobility. The assessment also documented Resident #55 was not steady and required stabilization with assistance when moving from a seated to standing position and walking. A Fall Risk assessment, dated 11/1/19, documented Resident #55 had a prior history of falls within the last 3 months and scored at risk for falls. A Bed Safety Evaluation, dated 11/1/19, documented Resident #55's bed was to be in the low position. Resident #55's care plan did not document an intervention for his bed to be in the low position, until 11/25/19, 24 days after his Bed Safety Evaluation on 11/1/19 assessed his bed was to	F 689		

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F 689	Continued From page 134 be in the low position. A Post Fall Investigation documented Resident #55 fell on 11/14/19 at 12:40 AM. The investigation documented Resident #55 rolled out of bed and fell onto the floor. The investigation documented Resident #55's bed was not in the low position as directed by his Bed Safety Evaluation. Resident #55's care plan documented staff were to use a bedside impact absorbing floor mat next to Resident #55's bed when he was in bed, initiated on 11/15/19. A Post Fall Investigation documented Resident #55 had an unwitnessed fall on 11/22/19 at 7:00 AM. There were no new documented interventions on Resident #55's care plan to prevent further falls. A Post Fall Investigation documented Resident #55 had an unwitnessed fall on 11/24/19 at 7:20 PM, while transferring out of the wheelchair and into the bed. No new interventions were documented on Resident #55's care plan. A physician's order, dated 11/25/19, documented Resident #55 was to have a fall mat to the right side of his bed. A physician's order, dated 12/2/19, documented Resident #55 was to have his bed in the lowest position. On 12/10/19 at 10:07 AM, Resident #55 was observed lying in bed. There was no fall mat on the floor by his bed and the bed was not in the	F 689		

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F 689	Continued From page 135 lowest position as directed by his care plan and physician orders. On 12/10/19 at 10:56 AM, UM #2 stated there was no floor mat in Resident #55's room and he should have one. On 12/10/19 at 10:58 AM, UM #2 stated Resident #55's fall risk score indicated he was a high fall risk. UM #2 stated care plan interventions should be completed after each fall. The facility did not follow its policy to reassess and revise the care plan after each fall. The facility did not follow the interventions that were documented on Resident #55's care plan and subsequently ordered by his physician, for his bed to be in low position and a floor mat next to his bed.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690		2/4/20

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F 690	Continued From page 136 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility protocol for treatment, and resident, family and staff interview, it was determined the facility failed to ensure the bowel protocol was followed and implemented for 1 of 5 residents (Resident #55) reviewed for bowel and bladder care. This had the potential to place residents at risk for fecal impaction. Findings include: The facility's Bowel Care Protocol, updated 1/27/11, documented the bowel regime if a resident had no bowel movement for 48 hours was to administer 30 ml of Milk of Magnesia (MOM). If the resident had no bowel movement for 72 hours, administer 10 mg Dulcolax suppository. If the resident did not have a bowel movement documented by the following morning, administer a Fleets enema rectally. If no bowel	F 690	F690D Resident Specific Resident #55 has received bowel care medications as ordered and they were effective. Other Residents Current residents reviewed for bowel care administration as ordered and any findings addressed.	

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F 690	Continued From page 137 movement within 2 hours, notify the physician for additional orders. This protocol was not followed. Resident #55 was admitted to the facility on 11/1/19, with multiple diagnoses including Parkinson's disease (a progressive disease of the nervous system that affects movement) with Lewy body dementia (abnormal protein deposits in the brain). The admission MDS assessment, dated 11/11/19, documented Resident #55 was cognitively intact, required extensive assistance of 2 staff members with toileting, and was occasionally incontinent of bowel. Resident #55's physician's orders, dated 11/1/19, directed staff to provide Senna-Docusate (a stool softener and laxative) 8.6-50 mg 1 tablet twice a day and Miralax powder 17 gram mixed with 8 ounces of liquid daily as needed for bowel care. Resident #55's physician's orders also included the facility's bowel protocol for MOM if no bowel movement for 2 days, Dulcolax Suppository 10 mg if no results from MOM, and if no results in 12 hours, a Fleets Enema, if no results after the Fleets enema in 4 hours, notify the physician for further instructions. Resident #55's Bowel Function Monitoring for November 2019, documented he did not have a bowel movement from 11/3/19 to 11/8/19, 6 days. The November 2019 MAR documented Resident #55 was administered 30 ml of MOM on 11/7/19 at 9:11 AM, four days after no bowel movement, and the results were unknown. The MAR documented Resident #55 was administered a	F 690	Facility Systems Licensed nursing staff educated by CNO and/or designee to facility Bowel Care Protocol, to include documentation of interventions. The system is amended to include review in clinical meeting for resident bowel care provided as per protocol and monitoring for effectiveness. Monitoring The CNO and/or designee will audit bowel care 3 days a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 690	Continued From page 138 Fleets Enema on 11/8/19 at 5:48 PM, and the results were effective. There was no documentation Resident #55 received a Dulcolax suppository prior to receiving a Fleets enema per the facility's protocol and his physician orders. Resident #55's Bowel Function Monitoring for November 2019, documented he did not have a bowel movement from 11/12/19 to 11/18/19, 7 days. The November 2019 MAR documented Resident #55 was administered 30 ml of MOM on 11/14/19 at 11:48 AM, and the results were ineffective. Resident #55's record did not include documentation he was administered the Dulcolax and the Fleets Enema per the facility's protocol and his physician orders. Resident #55's Bowel Function Monitoring for November 2019 and December 2019, documented he did not have a bowel movement from 11/24/19 to 12/2/19, 9 days. The November 2019 MAR documented Resident #55 was administered 30 ml of MOM on 11/26/19 at 5:05 PM, and the results were ineffective. The MAR documented Resident #55 received a Dulcolax suppository on 11/27/19 at 5:48 AM, and the results were ineffective. The December 2019 MAR documented Resident #55 received a Dulcolax suppository on 12/1/19 at 5:19 AM, and the results were ineffective. There was no documentation Resident #55 received a Fleets enema per the facility's protocol and his physician orders. On 12/10/19 at 11:50 AM, Resident #55's spouse	F 690		

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F 690	Continued From page 139 stated he has had constipation since he was admitted to the facility. Resident #55 and his spouse stated if he received the Miralax daily that seemed to keep him regular and the facility would not administer it to him. The spouse stated she had talked with the facility staff and the hospice agency and they "do not seem to want to listen." On 12/10/19 at 1:23 PM, UM #2 stated he reviewed residents' bowel function and if a resident had not had a bowel movement for 2 days or longer, he added the resident to the bowel list for the floor nurse to follow the facility's bowel protocol. UM #2 stated Resident #55 should not have gone more than 3 days without having a bowel movement. UM #2 stated the nurses were not following the bowel protocol for Resident #55. Resident #55 did not receive bowel care per the facility's protocol or his physician's orders.	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the	F 693		2/4/20

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F 693	Continued From page 140 resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure a feeding tube was checked for placement and residuals before medication administration. This was true for 1 of 3 residents (Resident #18) reviewed for medication administration through a feeding tube. This deficient practice placed the resident at risk of complication due to improper feeding tube management. Findings include: The facility's Administration of Medication through an Enteral Feeding Tube, dated 1/1/18, documented: * If not using a pump, use a 60 ml syringe, check the tube for placement and patency, and flush the tube with 15-30 ml of warm fresh water. * Mix medication with warm tap water. * Administer medication. * After medication administration, flush the tube with 15-30 mls of tap water either using a 60 ml syringe or pushing the flush option on the pump.	F 693	F693D Resident Specific: Resident #18 assessed and no adverse effects noted from citation. Other Residents: Current residents with feeding tubes in use were reviewed to validate they are receiving medications via feeding tube as ordered and per facility policy. Facility Systems Licensed nursing staff educated by CNO and/or designee to facility Administration of Medication through an Enteral Feeding Tube Policy, to include but not limited to, checking placement, checking residuals, and flushing the tube with 15-30mls of warm water before and in between each	

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F 693	Continued From page 141 Resident #18 was admitted to the facility on 10/9/19, with multiple diagnosis including traumatic brain injury and dysphagia (difficulty swallowing). She had a PEG tub (percutaneous endoscopic gastrostomy tube used to supply nutrition or fluids). Resident #18's admission MDS assessment, dated 10/15/19, documented she received more than 51% of her total nutrition through a feeding tube. Resident #18's physician's orders documented the following: * On 10/9/19: Check feeding placement every shift by auscultation and aspiration before initiation of formula, medication administration, and flushing tube or at least every 8 hours. Record residual [amount of gastric contents aspirated]. If greater than 100 mls notify the physician. * On 11/14/19: Propranolol (medication for high blood pressure) HCl (hydrochloride), 10 mg give one tablet via PEG tube three times a day for hypertension, hold for HR (heart rate) less than 60 and SBP (systolic blood pressure) less than 100. * On 12/4/19: Flush feeding tube with 30 mls of water before and after medication administration and 5 mls between each individual medication. On 11/12/19 at 9:45 AM, RN #4 was observed as he administered Resident #18's propranolol through her PEG tube. RN #4 mixed the propranolol to about 30 - 60 mls of water. RN #4	F 693	medication administration. The system is amended to include competencies completed on hire with licensed nursing staff for administration of medications via enteral feeding tube. In addition, staff development will include enteral feeding observation in medication surveillance monitoring process. Monitoring The CNO and/or designee will audit medication administration through feeding tubes 2 times a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 693	Continued From page 142 then attached a 60 cc syringe to the end of Resident #18's PEG-tube and poured the medication into the 60 ml syringe, followed it with water filling the syringe up to the 60 ml mark. The syringe did not drain for 3 - 5 minutes, then began to flow slowly. When the syringe was almost empty, RN #4 poured another 60 mls of water into the syringe after it had emptied. RN #4 was not observed to check the placement of Resident #18's PEG tube or to check her residuals. RN #4 was also not observed to flush Resident #18's PEG-tube prior to administering her Propranolol. After RN #4 administered Resident #18's medication, RN #4 said she could receive about 200 mls of water every four hours. RN #4 said Resident #18's total water for this medication was 20 mls of free water and about 30 - 60 mls of water that was used to mix her medication. When asked if he checked Resident #18's PEG tube placement. RN #4 said he did not check Resident #18's PEG tube placement and he did not check her residuals or flush her PEG tube with water before he administered her medication. RN #4 said "I probably should have done that." On 12/12/19 at 1:35 PM, the Clinical Resource Nurse said PEG tube placement should be checked and flushed with water before administering medications.	F 693		
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	F 695		2/4/20

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F 695	Continued From page 143 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, it was determined the facility failed to ensure residents received respiratory care as ordered by a physician. This was true for 1 of 6 residents (Resident #15) reviewed for oxygen therapy. This failure created the potential for harm if residents did not receive oxygen therapy to maintain oxygen levels. Findings include: Resident #15 was readmitted to the facility on 9/6/19, with multiple diagnoses including acute respiratory failure with hypoxia (decreased oxygen supply to the body tissues) and hypercapnia (excessive carbon dioxide in the bloodstream caused by inadequate respiration). An admission MDS, dated 10/11/19, documented Resident #15 received oxygen. A physician order, dated 9/6/19, documented "Oxygen at 2 liters/minute (LPM) via nasal cannula continuously as needed and every shift." On 12/8/19 at 11:17 AM, Resident #15 was observed sitting at the table in his power wheelchair in the dining room. He had oxygen in place by nasal cannula connected to a portable oxygen tank. On 12/8/19 at 12:34 PM, Resident #15 said his	F 695	F695D Resident Specific: Resident #15 was reviewed while outside of his room and using his portable oxygen tank and the tank contained a supply of oxygen. Other Residents: IDT reviewed current residents with oxygen ordered to validate their portable tanks contained oxygen. Facility Systems Nursing staff educated by CNO and/or designee to facility Respiratory Care Policy including and not limited to, checking portable oxygen tanks when placing in use to validate sufficient amount of oxygen available, as well as prior to outing. The system is amended to include check of oxygen levels in portable tanks during clinical rounds and periodically during meals.	

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F 695	Continued From page 144 portable oxygen tank was filled by a CNA before he went to the dining room. Resident #15 said while he was at the dining room waiting for his lunch he felt dizzy and UM #1 found his oxygen tank was empty. Resident #15 said this was not the first time he found his portable oxygen tank empty. On 12/8/19 at 12:35 PM, UM #1 came back with the portable oxygen tank. UM #1 said Resident #15 complained of feeling dizzy and when he checked the portable oxygen tank it was empty. UM #1 then checked Resident #15's oxygen saturation and it was 88 to 90 percent. UM #1 said Resident #15 was on continuous oxygen at 2 LPM and staff should make sure his portable oxygen tank was not empty whenever he was out of his room.	F 695	Monitoring The CNO and/or designee will audit portable oxygen use for 3 times a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	
F 725 SS=F	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		2/4/20

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	135146		12/13/2019

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F 725	Continued From page 145 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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, Facility Assessment review, review of Resident Council meeting minutes, resident and resident representative interview, and staff interview, it was determined the facility failed to ensure there were sufficient numbers of staff to meet ADL needs, answer call lights in a timely manner, and deliver food in a timely manner for residents. This was true for 13 of 74 residents (#9, #12, #20, #24, #25, #27, #30, #44, #47, #55, #70, #120, and #569) reviewed for staffing concerns. These systemic deficient practices placed residents at risk of adverse events due to delayed call light response times, skin breakdown, and embarrassment or decrease in feelings of self-worth due to lack of cares. Findings include: The facility's policy Sufficient Qualified Nurse Staffing, dated 11/28/17, stated the facility provided licensed nurses and other nursing personnel to provide nursing care to all residents in accordance with resident care plans. The	F 725	F725F Resident Specific Residents #20, #70 and #120 no longer reside at the facility. Residents #9, #12, #24, #25, #27, #30, #44, #47, #55, and #569 were reviewed to validate they had necessary care provided. Other Residents All residents have the potential to be affected, and it was determined that necessary care has been provided. Facility Systems	

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F 725	Continued From page 146 policy stated nursing and related services were provided to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by their assessments and individual plans of care. The policy also stated these services were provided with consideration to the number, acuity, and diagnoses of the facility's resident population in accordance with the required facility assessment. This policy was not followed. Facility staffing was insufficient to meet the care and needs of the residents and to respond to resident concerns. Examples include: a. Residents and their representatives were interviewed and stated the facility did not have sufficient staff to meet their needs. - On 12/8/19 at 10:22 AM, Resident #9 said her roommate was put to bed in her pants but had sat in her wheelchair prior to transfer and had peed and wet her pants. Resident #9 said she called staff to come and change her roommate's pants. Resident #9 said her roommate is unable to advocate for herself, had sat wet for an hour, and the staff had not checked on her. Resident #9 said when she moved here in February of 2019, there were 50 residents. She said the census went up to 75 residents, but they did not hire more people. Resident #9 said there were 2 CNAs most of the time on day shift, with 1 CNA at night. She said they needed an extra CNA in the morning and afternoon, and 2 CNAs at night, and they were not provided.	F 725	The CEO and CNO reviewed the current nursing staffing schedule and made adjustment to ensure that the facility has an adequate number of staff to meet the needs of residents based on acuity and census. Positions added as follows: 1 full time weekend Nurse Supervisor, 1 full time shower aid, 1 full time lead C.N.A that works varied shifts for ongoing training and preceptorship. Staff were educated regarding meeting resident ADL needs, the importance and expectation of call light response time, and that it is the responsibility of all staff to answer call lights and if they are unable to meet the residents needs to leave the call light on until their care needs are resolved, and timely delivery of meal trays. The system is amended to include department manager/clinical rounds to validate care implementation at the bedside, call light response time, timely/effective meal service delivery, and adequate staffing to meet resident needs. Results are communicated to the CEO and CNO in clinical meeting. Resident satisfaction will be monitored to determine plan effectiveness. Monitoring The nurse staffing scheduled is reviewed daily by the CNO and/or designee and appropriate adjustments are made according to resident census and acuity	

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F 725	Continued From page 147 - On 12/8/19 at 11:33 AM, Resident #120 said there were not enough staff to administer her medications on time, give her showers when she was scheduled, and said on the weekends call lights were not answered timely. - On 12/8/19 at 5:20 PM, Resident #569 stated he came to the facility from an acute care hospital on 12/6/19, and he was admitted for physical therapy and to gain strength in his legs prior to hip surgery. Resident #569 said since he was admitted to the facility, the service had been very slow. He said sometimes when he put on his call light it took 10 to 15 minutes to get a response, and sometimes no one came at all. Resident #569 stated, "I believe they are under-staffed here." - On 12/9/19 at 10:54 AM, Resident #25's spouse said there were not enough staff on the weekends to assist with residents with their meals, meals are generally late, and there are not enough staff to take care of residents' hygiene needs. - On 12/10/19 at 12:25, Resident #12's daughter stated hospice has helped her with addressing her problems with the facility staff. She stated last Thursday evening the staffing board documented there were 3 nurses and they had to get someone from another hall to assist Resident #12 to bed. Resident #12's daughter stated she has been sent to appointments without her hair being brushed. - On 12/10/19 at 2:35 PM, during the Resident Group interview, Residents #9, #20, #27, #30, and #44 said showers were not being completed,	F 725	level. The CNO and/or designee will audit call lights for 3 times per week on various shifts for 12 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 725	Continued From page 148 especially on Saturdays. - On 12/10/19 at 3:02 PM, the co-guardians for Resident #70 stated when they went in to visit or take him to an appointment he often had a wet adult brief and the staff were not changing him. One of the guardians stated they had taken Resident #70 to an appointment and at the appointment a wound was found on his leg. The guardian stated the nurse at the appointment stated the wound should have been identified by the facility it had been there "for a while." The guardian stated the staff at the facility should have been performing weekly skin checks to identify these types of issues. b. Staff were interviewed and stated there was not sufficient staff to provide the cares required and to meet the needs of the residents. - On 12/8/19 at 10:22 AM, CNA #9 said there were not always enough staff to meet the needs of the residents. - On 12/8/19 at 10:42 AM, LPN #1 said there are not enough staff because there were several residents who required 2-person assistance with transfers. - On 12/9/19 at 1:57 PM, CNA #18 said she started working as Shower Aide about 3 months ago. CNA #18 said she was asked about 3 times to work on the floor because of staff call offs. CNA #18 said showers were not completed on those days she was asked to work on the floor as a CNA. - On 12/10/19 at 9:10 AM, RNA #1 said he was	F 725		

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F 725	Continued From page 149 working as a CNA and said would not be able to do the RNA program today. When asked who would be doing the RNA program for the residents. RNA #1 said "Nobody." RNA #1 said he was pulled out to work as a CNA about four to five times since he started working as an RNA six months ago. - On 12/11/19 at 2:04 PM, CNA #6 stated they don't have enough care givers. CNA #6 said residents who were using "mechanical" lifts received their showers on Wednesdays and Saturdays and there was not enough staff scheduled on Saturdays. CNA #6 said there was no shower aides on Saturdays. CNA #6 also said the razor blade got dull and one resident had not been shaved for a week, and he got shaved only during his shower days. CNA #6 said she had requested to have the Saturday's showers changed because of there was no shower aide but she got no response. -On 12/11/19 at 3:45 PM, CNA #7 was asked if the facility staffing was adequate to assist residents with meals. CNA #7 said there was not enough staff to assist residents during meals or anything else unless the survey team was in the building. Then all personnel from the office would come on the floor and help. - On 12/12/19 at 9:04 AM, CNA #10 said there were "only two CNAs over here and sometimes when we ask for help, we just get ignored. Some of the resident can take up to an hour to help, leaving only one CNA on the floor and that is not enough. It leaves us rushing around trying to get things done."	F 725		

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F 725	Continued From page 150 On 12/13/19 at 9:45 AM, RN #5 said there was staffing problem in the facility that was why she worked as a CNA on 12/8/19. c. The Resident Council expressed concerns regarding lengthy call light response times, showers, and dining which were not addressed by the facility. The facility's Grievance policy, dated 11/28/17, documented the facility would make prompt efforts to resolve grievances, including Resident Council concerns, and to keep residents notified of progress toward resolution. Resident Council Meeting minutes, dated 9/4/19, documented concerns with call light response times up to 30 minutes and very slow response times during meals. Resident Council Meeting minutes, dated 10/2/19, documented concerns with call light response times up to one and a half hours, not enough staff, staff saying they would come back to help residents and did not, and breakfast served in resident rooms were late. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19 meeting. Resident Council Meeting minutes, dated 11/6/19, documented concerns with call light response times up to two hours, long response times during shift change, staff saying they would come back to help residents and did not come back, and room trays were late due to not enough staff to pass out trays. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19 or 10/2/19 meetings.	F 725		

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F 725	Continued From page 151 Resident Council Meeting minutes, dated 12/4/19, documented concerns with not enough staff on the weekends and not all the residents were getting showers as scheduled. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19, 10/2/19, and 11/6/19 meetings. On 12/10/19 at 2:35 PM, during the Resident Group interview, Residents #9, #30, and #44 said there were still issues with slow call light response times, not enough staff, low food temperatures, and late delivery of trays. They stated these concerns were not addressed by the facility. On 12/11/19 at 9:36 AM, the Activity Director said she emailed the Resident Council meeting notes to the department heads. She said she had not been given direction to readdress the old complaints during the Resident Council meetings. The Activity Director said the Administrator met individually with the Resident Council President to address the Resident Council concerns. On 12/11/19 at 1:10 PM, the Administrator said he met with the Resident Council President and relied on the council's President to report back to the Resident Council. The Administrator provided minutes for meetings with the council's President for 11/11/19 and 11/27/19. The minutes did not document a discussion of not enough staff, staff saying they will come back to help residents and then not coming back, and late meal trays. The Administrator said he did not see where concerns were readdressed in the Resident Council	F 725		

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F 725	Continued From page 152 minutes. The Administrator said he expected Resident Council concerns to be addressed. d. Residents did not receive bathing and showers consistent with their needs. - Resident #47 was readmitted to the facility on 12/03/19, with multiple diagnoses including amyotrophic lateral sclerosis (a progressive degenerative nervous system disease that affects nerve cells in the brain and the spinal cord). A quarterly MDS assessment, dated 11/11/19, documented Resident #47 was cognitively intact and required extensive, 2-person assistance for bathing. The ADL Care Plan, undated, documented Resident #47 was dependent on staff for bathing. He was to be assisted with bathing twice per week and PRN. Resident #47's ADL Reports for October, November, and December 2019 documented he did not receive a bath/shower from 10/5/19 to 10/11/19 (6 days), from 10/16/19 to 10/22/19 (6 days), from 10/23/19 to 11/4/19 (11 days), from 11/5/19 to 11/25/19 (20 days), and from 12/7/19 to 12/11/19 (5 days). On 12/8/19 at 10:25 AM, Resident #47 stated the time between showers/baths had gotten longer. On 12/12/19 at 8:57 AM, Resident #47 said his regular scheduled shower days were Wednesdays and Saturdays and he said the facility wanted to change his Saturday schedule	F 725		

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F 725	Continued From page 153 to a different day and he told them no. On 12/12/19 at 3:56 PM, the Clinical Resource Nurse said Resident #47's record did not include additional baths/showers received in October, November, and December. - Resident #24, whose age was in the mid-30s, was admitted to the facility on 11/3/18, with multiple diagnoses including cerebral palsy (brain injury which most often happens before or during a baby's birth, or during the first 3-5 years of a child's life, that affects muscle tone, movement, and motor skills, and may also cause sight, hearing, and learning problems) and intellectual disability. Resident #24's annual MDS assessment, dated 10/21/19, documented she required extensive, 2-person assistance with personal hygiene and was totally dependent, requiring 2-person assistance with bathing. Resident #24's care plan, dated 11/21/19, documented she was dependent on staff and directed staff to provide assistance with her bathing and personal hygiene. Resident #24's ADL Reports for November and December 2019, documented her bathing days were Tuesday and Friday and PRN. The reports documented she was not bathed from 11/20/19 to 11/26/19 (7 days) and from 11/27/19 to 12/3/19 (7 days). On 12/8/19 at 11:52 AM, Resident #24 was in her wheelchair in the Alpine unit day room watching TV. Her hair was matted and appeared unkempt.	F 725		

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F 725	Continued From page 154 She had a non-stained clothing protector around her neck and chest area. She had on a sweater that was stained with streaks of food and excessive oral secretions underneath the clothing protector. The top left of her pants was soiled with food stains, near her hip. On 12/8/19 at 11:59 AM, RN #8 assisted Resident #24 to her room and changed her sweater with a new shirt and a new clothing protector. RN #8 said the stain to Resident #24's shirt was probably pudding she had eaten earlier in the day. RN #8 then assisted Resident #24 out of her room. RN #8 did not attempt to change Resident #24's pants or brush her matted hair. On 12/9/19 at 9:56 AM, CNA #2 assisted Resident #24 to her room to change her wet and stained shirt. After placing the new shirt on her, CNA #2 began to take Resident #24 from the room. CNA #2 said Resident #24's chest had been wet from oral secretions and CNA #2 had not attempted to clean Resident #24's chest before placing the new shirt on. On 12/10/19 at 8:13 AM, CNA #12 said Resident #24 received 2 showers a week. She said as long as staff wiped off her excessive oral secretions and groomed her hair, then 2 showers a week was fine for Resident #24. CNA #12 said if showers were not completed during the day shift then the evening shift was to complete them. On 12/11/19 at 3:53 PM and 4:19 PM and on 12/12/19 at 11:09 AM, the DON, with the Clinical Resource Nurse present, said she expected staff to provide Resident #24 with showers as scheduled, to wipe her oral secretions off,	F 725		

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F 725	Continued From page 155 provide grooming, and to change her clothes when soiled. The Clinical Resource Nurse said due to Resident #24's age she might need to be reassessed to see if 2 showers a week was adequate. - Resident #55 was admitted to the facility on 11/1/19, with multiple diagnoses, which included Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors) and Lewy Body Dementia (progressive brain disorder triggered by abnormal deposits of protein in the brain). An admission MDS assessment, dated 11/11/19, documented Resident #55 was cognitively intact and was totally dependent on two staff members with bathing, bed transfers and bed mobility. The facility's shower schedule documented Resident #55's shower schedule was Mondays and Thursdays in the morning. Resident #55's care plan, revised on 11/18/19, documented he required extensive assistance of 1-2 staff for bathing. Resident #55's ADL report for November 2019 documented there were no showers given or offered from 11/6/19 through 11/10/19 (5 days), and 11/12/19 through 11/17/19 (6 days). Resident #55's ADL report for December 2019 documented there were no showers given or offered from 12/6/19 through 12/10/19 (5 days). On 12/10/19 at 2:15 PM, Resident #55 stated his last shower was on 12/5/19.	F 725		

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F 725	Continued From page 156 On 12/10/19 at 2:22 PM, UM #2 stated that Resident #55 refused his shower on 12/9/19, and he was scheduled to receive a makeup shower. UM #2 said hospice services did most of Resident #55's showers. UM #2 was unable to find documentation that Resident #55 refused his shower on 12/9/19. On 12/13/19 at 9:19 AM, UM #2 stated Resident #55 did not receive showers as scheduled. - Resident #120 was admitted to the facility on 11/26/19, with multiple diagnoses including muscle weakness and Parkinson's disease. Resident #120's admission MDS assessment, dated 12/2/19, documented she required 1-person assistance with bathing. Resident #120's care plan, dated 11/26/19, directed staff to provide 1-person assistance with bathing. Resident #120's ADL Reports for November and December 2019, documented her bathing days were Wednesday and Saturday and PRN. The reports documented she was not bathed from 11/28/19 to 12/2/19 (5 days) and from 12/5/19 to 12/9/19 (5 days). On 12/8/19 at 11:33 AM, Resident #120 said since she had been admitted to the facility, she had not received her showers as scheduled. On 12/12/19 at 11:10 AM, the DON said Resident #120's showers were missed on 11/30/19 and 12/7/19. She said if staff did not complete the	F 725		

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F 725	Continued From page 157 residents' showers she expected staff to offer the shower the next day. e. The facility's policy Facility Assessment, dated 11/28/17, documented the following: * The facility evaluated its resident population and identified the resources needed to provide the necessary care and services to its residents competently during daily operations and during emergencies. * The facility reviewed and updated the assessment whenever there was, or the facility planned for, any changes that required a substantial modification to any part of the assessment. The facility assessment addressed or included the following: - The facility's resident population, including but not limited to the number of residents and the facility's resident capacity. - The care required by the resident population with consideration of the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other relevant facts that were present within that population. - The facility's resources, including but not limited to all personnel, including managers and staff (facility employees and those who provided services under contract). The Facility Assessment Tool, dated 7/1/19, was compared to the Resident Census and	F 725		

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F 725	Continued From page 158 Conditions of Residents form completed during the survey on 12/9/19. The Facility Assessment Tool had not been updated to reflect the facility's population. Examples included, but were not limited to, the following: - The Facility Assessment Tool documented the average daily census was 58 residents. However, the Resident Census and Conditions of Residents form documented the facility's census was 74 residents. On 12/13/19 at 8:40 AM, the Administrator was shown the Facility Assessment Tool, dated 7/1/19. The Administrator stated the average daily census was 58 at the time the assessment was completed, and the current average daily census was 72. - The Facility Assessment Tool documented the number of residents in the facility who required the specified treatment/services which included: Respiratory Treatments: Oxygen therapy: 16-18 residents Suctioning: 10-12 residents Tracheostomy care: 2-3 Mental Health: Behavioral Health Needs: 15-20 residents Other: Injections: 3-4 residents Dialysis: 3 residents Ostomy care: 2-3 residents However, the Resident Census and Conditions of Residents form documented the following current	F 725		

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F 725	Continued From page 159 resident needs: Respiratory Treatments: Respiratory treatment: 27 residents Suctioning: 13 residents Tracheostomy care: 13 residents Mental Health Behavioral Health Needs: 58 residents Other Injections: 17 residents Dialysis: 4 residents Ostomy care: 5 residents The Facility Assessment Tool documented the facility's staffing plan for nursing care, which included RNs, LPNs, CNAs, NAs, and hospitality aides (non-skilled care), was to be at 4.5 to 5.5 hours per resident per day. Hospitality aides are not allowed to provide nursing care and should not be reflected in the nursing care hours. The direct care nursing hours worked from 11/17/19 through 12/7/19 were reviewed. The staffing levels did not meet the 4.5 to 5.5 hours planned in the Facility Assessment Tool. The days for which the hours did not meet nursing care were as follows: Sunday, 11/17/19 - 4.01 Saturday, 11/23/19 - 4.3 Sunday, 11/24/19 - 3.82 Saturday, 11/30/19 - 4.32 Sunday, 12/1/19 - 3.90 Saturday, 12/7/19 - 4.09 On 12/12/19 at 4:38 PM, the DON together with	F 725		

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F 725	Continued From page 160 the Clinical Resource Nurse was asked if the Facility Assessment included a determination of the level and competency of staff needed to meet each residents' needs each day and during emergencies. The DON said "Yes." Both the DON and the Clinical Resource Nurse said the planned nursing hours per resident per day was 4.5 hours to 5.5 hours. The DON and the Clinical Resource Nurse stated they were not aware the staffing levels for the past three weekends did not meet the planned staffing levels according to the Facility Assessment. On 12/13/19 at 8:40 AM, the Administrator stated the assessment was a "fluid document," which could be updated and changed. The Administrator stated it was "not indicative of the current staffing" because the average daily census was 58 at the time the assessment was completed, and the current average daily census was 72. (This represented an increase of 24% in the average daily census since the Facility Assessment Tool was completed).	F 725		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on review of staff training and performance review records, facility policy review, and staff interview, it was determined the	F 730	F730E Resident Specific	2/4/20

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F 730	Continued From page 161 facility failed to ensure all CNAs received the required competency evaluations and completed the required hours of yearly training. This was true for 5 of 5 CNAs (Staff G, H, I, J, and K) reviewed for competency evaluations and annual training. This failed practice had the potential to affect all 74 residents in the facility and created the potential for harm if residents received incompetent care from CNAs. Findings include: The facility's policy for Sufficient Qualified Nurse Staffing, dated 11/28/17, stated "Sufficient qualified nursing staff with the appropriate competencies and skill 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 required facility assessment." The facility's policy for Nurse Aide Staffing, dated 11/28/17, documented the following: * At least 12 hours of in-service training was provided to nurse aides each employment year based on the outcome of the annual performance review and special needs of the resident population. * Nurse aides must demonstrate competency in areas such as communication and personal skills, basic nursing skills, personal care skills, mental health and social service needs, basic restorative services, and Resident Rights. These policies were not followed.	F 730	No specific resident(s) identified Staff members G, H, I, J and K had required competency evaluations to include required annual training hours completed unless they no longer work at the facility. Other Residents Current staff reviewed to validate that required annual training hours and competency evaluations were completed and any identified as not in compliance were completed as required. Facility Systems Human Resources Director and Staff Development Coordinator were educated on the facility policy and regulatory requirement for required annual training hours and competency evaluations. The system is amended to include tracking of the training hours for staff through the Relias training computer system. Evaluations are coordinated with annual competencies and educational hours. Compliance is tracked by HR and monitored by CEO in department manager meetings.	

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F 730	Continued From page 162 The following information regarding the training and performance evaluations for Staff G, H, I, J, and K was provided by the facility's SDC: 1. Staff G, a CNA whose hire date was 9/10/18, received a total of 0.5 hours of training/in-service since 12/1/18. Staff G did not have a performance evaluation after 9/20/18. 2. Staff K, a CNA whose hire date was 9/25/18, received 8 hours of training/in-service since 12/1/18. Staff K did not have a performance evaluation after 9/28/18. 3. Staff I, a CNA whose hire date was 11/5/18, received a total of 8.25 hours of training/in-service since 12/1/18. Staff I did not have a performance evaluation after 11/19/18. 4. Staff J, a CNA whose hire date was 6/14/18, received a total of 2.25 hours of training/in-service since 12/1/18. Staff J did not have a performance evaluation after 6/26/18. 5. Staff H, a CNA whose hire date was 5/3/18, did not have a performance evaluation after 6/18/18. On 12/12/19 at 3:11 PM, the above findings were reviewed with the SDC. When asked if the CNAs identified above had received 12 hours of training/in-services since 12/1/18, she stated Staff G, I, J and K did not. When asked whose responsibility it was to ensure the CNAs received the required training/in-services, she stated, "I don't know. I'm going to assume it's me." The SDC was asked if there were additional performance evaluations for the 5 CNAs, she	F 730	Monitoring The HR and/or designee will audit nurse aid training hours and competency evaluations weekly for 12 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 730	Continued From page 163 stated, "I don't know. What you have is what I had." On 12/12/19 at 4:38 PM, the DON stated the SDC was responsible for overseeing nursing competencies. The DON stated nursing staff should be evaluated to assess their competencies, skills, and knowledge "Yearly or if there is a change." The facility failed to complete annual performance evaluations and develop a training program based on the review.	F 730		
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 worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §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.	F 732		2/4/20

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F 732	Continued From page 164 (B) In a prominent place readily accessible to residents and visitors. §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. §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 nurse staffing information was posted daily and at the beginning of each shift, only included the licensed and unlicensed nursing staff directly responsible for residents' care, and was accurate based on actual staff working for 74 of 74 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 to be informed of the facility's staffing levels. Findings include: The facility's Posting Licensed and Unlicensed Direct Care Staff policy, dated 11/28/17, documented the facility posted the following information daily: total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for residents' care per shift. This policy was not followed. On 12/8/19 from 10:22 AM to 11:10 AM, the daily	F 732	F732C Resident Specific No specific resident(s) were identified. Other Residents Rounds were made to ensure facility staffing was posted and accurately reflected staffing level. Any findings were corrected. Facility Systems Staff coordinator, licensed nurses, and department managers were educated on the facility staffing posting policy and	

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F 732	Continued From page 165 nurse staff posting was not observed in the facility. At 11:20 AM, the DON said the postings were not at the nurse's stations. She said she expected the nurses to post the daily staffing at each nurse's station. On 12/9/19 at 12:00 AM, the staff postings were on the nurse's station counter. The information was for 24 hours, not the current night shift. The staff posting documented there were 10 CNAs working from 2:00 PM to 10:00 PM for a total of 88 hours. Under the section with the number of CNAs working "RSA," which stood for a hospitality aide, was handwritten. The hospitality aide's hours were included with the nursing hours of the CNAs. It was also not clear how many hospitality aides were scheduled and included as CNAs for the 2:00 PM to 10:00 PM shift. Hospitality aides are not allowed to provide nursing care and should not be reflected in the nursing care hours. On 12/9/19 at 12:00 AM, the staff postings also documented there were to be 6 LPNs and no RNs for a total of 72 hours for the 6:00 PM to 6:00 AM shift. There were 2 LPNs and 1 RN in the facility. At 12:00 AM, RN #6 said she was the only RN in the facility. At 12:15 AM, LPN #3 said there were 2 LPNs in the facility. The staff postings did not accurately reflect the nursing staff working at the facility for the shift. On 12/9/19 at 9:30 AM, the Administrator said the hospitality aide should not have been posted and counted in the CNA total hours. He said the staff posting for the evening shift was inaccurate and	F 732	requirements to include but not limited to, accuracy of census, posting by shift, direct care staff only are included, and timely update of posting made available for resident or public view. Education also included that the posting is to include licensed and unlicensed nursing staff directly responsible for resident care per shift and not person such as hospitality aides. The system is amended to include review of posting during department manager/clinical rounds. Monitoring The CEO and/or designee will audit posting of Nurse Staffing for 5 days a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 732	Continued From page 166 should have been corrected to reflect staffing as worked.	F 732		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) 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 record review, policy review, and staff interview, it was determined the facility failed to ensure residents were free of both significant and non-significant medication errors. This was true for 2 of 5 residents (#70 and #569) whose medications were reviewed. This failure placed residents at risk for harm when symptoms related to adverse side effects from the medications given in error are not recognized and acted upon promptly and if their condition worsened due to not receiving their prescribed medications as ordered by their physician. Findings include: 1. The facility's policy for Medication Errors, dated 11/28/17, documented the following: * "Medications are managed and safely administered to residents with a minimum of medication errors (not 5% or greater) and residents are free of any significant medication errors." * A significant medication error is one which causes the resident discomfort or places the resident's health and safety in jeopardy. * "Facility staff monitor the resident for possible medication-related adverse consequences, including mental status and level of consciousness, when the following conditions	F 760	F760G Resident Specific Resident #70 no longer resides at the facility and RN#3 no longer works at the facility. Resident #569 was reviewed by licensed nurse with no s/s of adverse effect. A medication error report was completed for cited event with physician and family notification completed. No new orders were received. Resident #569 medication administration record was reviewed and any discrepancies addressed. The LPN on duty related to the cited event was re-educated on the 8 rights of medication administration. A medication competency was also completed with no concerns identified.	2/4/20

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F 760	Continued From page 167 occur: A clinically significant change in condition/status, unexplained decline in function or cognition, worsening of an existing problem or condition, new or worsening psychiatric manifestation or distressed behavior, acute onset of signs or symptoms or worsening or a chronic problem or condition, ...medication error e.g. wrong or expired medication..." * In the event of a significant medication error or adverse drug reaction, immediate action is taken, as necessary, to protect the resident's safety and welfare ... The prescriber is notified promptly of any significant error or adverse medication reaction ... Any new prescribed orders are implemented, and the resident is monitored closely for 24 to 72 hours or as directed." This policy was not followed. The Nursing 2019 Drug Handbook documented the eight rights of medication administration were: 1. The right drug. 2. The right patient. 3. The right dose. 4. The right time. 5. The right route. 6. The right reason. 7. The right response. 8. The right documentation. Resident #70 was admitted to the facility on 3/14/19, with diagnoses including atrial fibrillation (irregular heart rhythm), hypertension (high blood pressure), chronic kidney disease, Type 2 diabetes mellitus, and stroke. Resident #70 had two guardians appointed to him through the courts.	F 760	Other Residents Rounds were during medication pass times and medication carts checked to validate that medications were not pre-poured Medication errors for the last 30 day reviewed to validate physician and family notifications as well as appropriate monitoring documented following the error. New Admissions for the last 30 days reviewed to validate medications were started timely and any discrepancies were addressed. Facility Systems Licensed nurses were educated by the CNO and/or designee to the Pharmacy Services policy, to include but not limited to following the 8 rights of medication administration, not to pre pour medication, notify the Director of Nurses promptly regarding medication errors, documenting resident status post medication error to include vital signs or physician ordered evaluations/interventions, and to notify	

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F 760	Continued From page 168 Resident #70's record included physician orders for the following medications: - Apixaban 5 mg twice a day for atrial fibrillation - Atorvastatin 40 mg once a day for high cholesterol - Digoxin 62.5 mcg (microgram) once a day for high heart rate - Famotidine 20 mg once a day for gastroesophageal reflux disease (causes heartburn or indigestion) - Finasteride 5 mg once a day for prostate disorder - Humulin (insulin) 10 units injected before meals for diabetes - Glargine Insulin 10 units injected before bedtime for diabetes - Lasix 20 mg one time a day (for water retention) - Lisinopril 40 mg once a day for high blood pressure - Metoprolol 50 mg twice a day for high blood pressure - Potassium Chloride 10 mEq (milliequivalent) once a day for low potassium - Terazosin 4 mg once a day for enlarged prostrate - Cholecalciferol 1000 unit once a day for supplement - Melatonin 3 mg at bedtime for insomnia A nurse's progress note, dated 7/10/19 at 5:28 AM, documented "Patient is sleeping soundly in bed, no complaints at this time. Water and call light are within reach. At approximately 1900 [7:00 PM], patient was given Ranitidine, Lithium, morphine IR, Soma, Lyrica, gabapentin, simvastatin, and trazadone [sic]. MD [Medical	F 760	resident□s physician and responsible party with any changes, increases in s/s or decline for further instruction to include possible transfer to hospital for further evaluation. Resident evaluation, vitals, physician and family notification are to be placed into the resident record. Licensed nurses were also educated to the process of completing alert charting at least 72hrs post significant medication error, the need to administer medications as ordered by physician to include new admissions, and to notify physician if medication is delayed or unavailable for possible change in schedule or alternate treatment available. Medication administration competencies completed with licensed nursing staff. The system is amended to include review of medication errors or medications that are unavailable in clinical meeting to validate timely management, resident current status, physician and family notification. Monitoring The CNO and/or designee will audit medication administration for medication errors and unavailable meds 3 times a week for 4 weeks, then weekly for 8 weeks. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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F 760	Continued From page 169 Doctor] notified and orders to monitor patient q [every] 30 min[utes] then to increase to 1 hr [hour] checks of pulse and oxygen. Patient [oxygen saturation] ranged from 92-99% on RA [room air], and pulse of 51-60, normal for patients [sic] baseline." The next nurse's progress note was 25 hours later at 6:39 AM on 7/11/19. The note documented report was given by the day shift nurse about the medication error and that Resident #70 was being monitored. The nurse documented after receiving report from the day shift nurse she checked on Resident #70 at 6:30 PM on 7/10/19, and he was sitting up in bed sleeping. The nurse documented she performed a sternal rub (using the knuckles of the hand to rub the chest to elicit a response due to pain) and Resident #70 was aroused from his sleep. The nurse documented Resident #70 was checked on by staff at 10:15 PM and at 12:30 AM. At 2:15 AM on 7/11/19, the nurse documented Resident #70 stated he was feeling "slightly dizzy" and she encouraged fluids since " ...dayshift staff had stated that Res [Resident #70] did not take in any PO [oral] fluids all day." The nurse documented at 4:40 AM on 7/11/19, staff went to check on Resident #70 and he was found face down on the floor next to his bed and he told a CNA he fell out of bed. The nurse documented she stayed in the room with Resident #70 while the CNA went to get the Hoyer lift (a mechanical lift) and when she attempted to roll him over his face was red and she felt for a pulse and Resident #70 did not have one. The nurse documented the CNA came into the room and she instructed her to call 911 and to call a code (an alert to staff for an emergency to begin cardiopulmonary	F 760	Date of Completion February 4, 2020	

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F 760	Continued From page 170 resuscitation efforts). The nurse documented Emergency Medical Services arrived a short time later and pronounced Resident #70 dead after they attempted resuscitation for 30 minutes. The note stated the police and coroner were called. The medications Resident #70 received had the following significant side effects according to Drugs.com a nationally recognized resource for medication information, website accessed 12/31/19: - Lithium: lithium toxicity which may cause tremors, trouble walking, kidney problems, and an altered level of consciousness; confusion, fainting, irregular heartbeat, increased thirst, unusual tiredness or weakness - Morphine IR: respiratory depression, confusion, dizziness, faintness, lightheadedness, irregular heartbeat, drowsiness - Soma: difficult or troubled breathing, shakiness, unsteady walk - Lyrica: dizziness, fast heartbeat, weakness, drowsiness, confusion - Gabapentin: clumsiness, unsteadiness, tiredness or weakness - Trazodone: confusion, dizziness, faintness, tiredness or weakness, irregular heartbeat - Simvastatin: dizziness, fainting, irregular heartbeat A Medication Error report, dated 7/9/19, documented the wrong medication was given to the wrong patient, Resident #70, at 7:15 PM on 7/9/19. The report documented the reason for the error was because the medication was "pre-poured." Pre-pouring of medication was removing the medication from the packaging and	F 760		

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F 760	Continued From page 171 setting it aside for administration at a later time. The report documented the Medical Director was notified at 8:10 PM on 7/9/19, and the DON was notified at 8:15 PM on 7/9/19. The report also documented the Medical Director ordered for Resident #70 to have his oxygen saturation and heart rate monitored every 30 minutes for two hours and then every hour until the end of the shift. The report documented the outcome to Resident #70 was lethargy (abnormal drowsiness) and his vital signs were stable. Resident #70's record did not include documentation of vital signs or assessments after the medication error as ordered by the Medical Director. An untitled document signed by UM #1, dated 7/10/19, documented he was called to Resident #70's room and when he entered the medication nurse was taking vital signs for Resident #70. UM #1 stated the nurse at the bedside demonstrated Resident #70 was not responsive to painful stimuli. UM #1 stated he observed Resident #70 for two minutes then in a loud voice called Resident #70 by his name and requested he open his eyes. UM #1 stated Resident #70 promptly opened his eyes. UM #1 stated he asked Resident #70 several questions which he answered accurately. UM #1 stated Resident #70 said he was dizzy and stated that "someone had given him something." UM #1 stated he was at the bed side for about 10 minutes. UM #1 stated Resident #70 told him it was not necessary for him to go to the Emergency Department. UM #1 stated he requested the medication nurse continue closely monitoring Resident #70, which was put in place earlier that day.	F 760		

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F 760	Continued From page 172 An untitled document dated 7/11/19 and signed by CNA #13 on 7/15/19, documented Resident #70 was very drowsy during the day and it " ...took 20 minutes to get up with sternal rubs." CNA #13 documented Resident #70 was lethargic during the times she provided care. An untitled and undated document signed by CNA #2, documented Resident #70 was "pretty drowsy" during the day and was hard to wake up. CNA #2 also stated Resident #70 was lethargic but was able to be roused. A police report, dated 7/11/19, documented RN #3 stated Resident #70 was given the wrong medications between 7:00 PM and 8:30 PM on 7/9/19, he was given his roommate's medications, and stated Resident #70 was lethargic most of the day, was sleeping a lot, and was dizzy. RN #3 stated this was not normal behavior for Resident #70. An untitled document signed by RN #2, dated 7/16/19, stated it was a late entry for Resident #70. The note documented at 6:00 AM on 7/10/19 RN #2 received report from the night nurse that a medication error occurred for Resident #70 at 8:00 PM on 7/9/19. RN #2 stated the night nurse told her she received orders from the on-call physician to monitor Resident #70 throughout the night and the observation was to end with the day shift. RN #2 stated the night nurse told her the on-call physician told her Resident #70 would "sleep it off the next day." RN #2 stated at 7:30 AM she instructed the CNAs to continue hourly monitoring of Resident #70 by taking vital signs hourly and to leave the	F 760		

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F 760	Continued From page 173 pulse oximeter (for monitoring oxygen saturation) on him and to report to her if his oxygen level dropped below 92% or his blood pressure dropped below 110/60 (Normal oxygen saturation levels are 90 to 100%). RN #2 stated Resident #70 had stable vital signs and was easily roused when spoken to from 8:00 AM to 3:30 PM on 7/10/19. RN #2 stated between 3:30 PM and 4:00 PM on 7/10/19 Resident #70 was more difficult to rouse and mumbled "um-hmm" when asked questions. RN #2 stated around 4:30 PM to 5:00 PM on 7/10/19, a CNA informed her Resident #70's oxygen saturation was in the high 70s. RN #2 stated she went into his room to rouse him and he was "deep asleep" and she repositioned him and took his vital signs and his oxygen saturation went up to 93%. RN #2 stated she radioed for the Unit Manager to come to Resident #70's room for further assessment. RN #2 stated when the Unit Manager entered the room he spoke to Resident #70 in a loud voice asking him to wake up, Resident #70 opened his eyes and sat up and told the Unit Manager he was sleeping and asked what the Unit Manager wanted. RN #2 stated Resident #70 was awake and stable when nursing staff left the room. On 12/10/19 at 9:28 AM, the case worker from the Veteran's Administration stated they were called by Resident #70's sister to say he had died. The case worker stated they had called Resident #70's daughter to see if there was anything of concern and she told them she was concerned about the medication error. The case worker stated she did not know how Resident #70's daughter and sister found out about the medication error. She stated Resident #70 was doing well at the last visit she had with him.	F 760		

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F 760	Continued From page 174 On 12/10/19 at 1:05 PM, the Medical Director said he generally expected the nurses to call if there were abnormal vital signs or symptoms that were concerning. He said he would rely on the nurse's assessment of these situations. The Medical Director said he reviewed some of the documentation related to this situation, and some words used in the documentation could have been used inappropriately. He said for example, when the resident responded to voice, but did not respond to painful stimuli, he would then question what was meant by painful stimuli. The Medical Director said Resident #70's medication and the medications he was given in error were reviewed. The Medical Director said the medication given to Resident #70 in error was a big dose of a centrally acting medication, and he would have expected him to be sleepy. On 12/10/19 at 1:52 PM, UM #1 said the incident regarding the medication error for Resident #70 happened at about 5:00 PM. UM #1 said he was getting ready to leave for the day when the nurse asked him to come down and look at Resident #70. UM #1 said the nurse was giving Resident #70 a sternal rub, and after watching the nurse apply the sternal rub he used a low, slow, loud voice and Resident #70 "woke right up." UM #1 said the nurse used her knuckles to apply the sternal rub, and he thought the sternal rub was appropriate. UM #1 said, "Honestly, I think that conversation was one of the more honest conversation I have had with this resident. He knew where he was and what was going on. I know I wasn't aware of what the doctor had recommended. When we walked out of the room the nurse told me that they were doing enhanced	F 760		

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F 760	Continued From page 175 monitoring of the resident. In the conversation that I had with the nurse the vitals we were monitoring were within parameters. She said the blood pressure and pulse were fine she just couldn't get the resident to respond to her." UM #1 said nursing would generally contact the doctor for change of condition, vital signs out of parameter, and any sort of acute condition. UM #1 said he could not remember what Resident #70 said that made him think he was disoriented, but when he attempted to orient him, he responded quickly that he knew where he was and what happened to him. UM #1 said Resident #70 told him he was given something that he should not have been given. UM #1 said he did not have any idea where the vital signs were documented throughout the day. UM #1 said [Resident #70] had a tendency to "play possum a lot." On 12/10/19 at 3:02 PM, the co-guardians for Resident #70 stated they were not notified of the medication error by the facility, it was his sister who informed them. The co-guardians stated the facility notified them of his death but did not mention the medication error. The co-guardians stated they notified his providers, including the Veteran's Administration, about his death. The co-guardians stated a case worker from the Veteran's Administration called them back and stated they were unaware of the medication error also and the case worker told them she was concerned because they oversaw the care of Resident #70 as well. On 12/10/19 at 4:19 PM, the Clinical Resource Nurse said she found a note that documented nursing would continue to monitor Resident #70	F 760		

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F 760	Continued From page 176 after the medication error, but she did not find documentation they were going to continue taking vital signs. The Clinical Resource Nurse said she was unable to find documented vital signs after the night shift on the evening of the medication error. On 12/10/19 at 7:23 PM, RN #2 said her shift on 7/10/19 was from 6:00 AM to 6:00 PM, and "The entire situation was very bizarre." RN #2 said when she arrived at the facility and took over for the night shift nurse, she asked whether Resident #70 was transferred to the Emergency Department (ED) and RN #1 told her the Medical Director had given orders which ended with her shift at 6:00 AM. RN #2 said RN #1 told her she talked to the Medical Director at length, and if Resident #70 did not have any trouble by that time, he would be fine. RN #2 said she was not comfortable with not following up with someone who had taken that many medications in error. RN #2 said she told the CNAs they would continue to monitor Resident #70, the vitals machine was in his room all day, and the pulse oximeter was on him continuously. RN #2 said Resident #70 woke up a few times and mumbled a few words, but other than that he slept all day. RN #2 said she told UM #2 that she was not comfortable with that and she thought he needed to be sent to the ED for fluids or the facility could provide IV (intravenous) fluids onsite for him. RN #2 said UM #2 was very confused about what to do, and he asked the other Unit Manager what to do. UM #1 came over and said not to do any more charting on Resident #70 than we usually do, and "if he just sleeps just let him sleep it off." RN #2 said UM# 1 said something like "don't chart anything out of the usual" and he said if	F 760		

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F 760	Continued From page 177 everything was stable or fine, the extra monitoring should not be documented and to "keep it at a minimum." RN #2 said Resident #70 then just slept for the rest of the day. He had no bowel movement or urine and he just kept sleeping. RN #2 said between lunch and dinner, the aide came to her and said he was unable to rouse Resident #70. The CNA said he tried to rouse Resident #70 and he would moan, but he would not rouse. RN #2 said when Resident #70 could not be roused, the pulse oximeter was on him and vital signs were being taken, but staff could not rouse him. RN #2 said she called for UM #1 on the radio and he came right away. RN #2 said she thought Resident #70 needed to be sent to the ED, and UM #1 yelled out Resident #70's name and "wake up" in a loud, deep, baritone voice and Resident #70 opened his eyes and was rousable at that point. RN #2 said UM #1 said, "It's just like I thought he was playing possum." RN #2 said, "I don't think he is playing possum we couldn't rouse him." RN #2 said UM #1 said Resident #70 did not need to be sent to the ED, RN #2 said she kept asking UM #1 if he was sure and he kept saying Resident #70 did not need to go to the ED. She said Resident #70 woke up and made a short/brief comment like "What do you want? I'm sleeping." RN #2 said UM #1 said staff were to make sure Resident #70 ate dinner. RN #2 said Resident #70 did not really get up and eat or drink, and later on the aides brought a meal into his room. RN #2 said she was told by UM #1 and UM #2 throughout the day just to follow the order, and the drug half-life (an estimate of the period of time that it takes for the concentration or amount in the body of that drug to be reduced by exactly one half) had passed through his system, and he was just	F 760		

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F 760	Continued From page 178 sleeping as the Medical Director said he would. RN #2 said Resident #70's vital signs were stable, so she did not call the physician. RN #2 said she remembered charting the incident on Resident #70, but she stepped away and the note did not get saved. RN #2 said she was contacted the next morning and was told she needed to write a progress note, and she told the facility she did write a progress note. On 12/11/19 at 8:31 AM, RN #3 said she worked on 7/10/19 during the 6:00 PM to 6:00 AM shift. RN #3 said the day shift nurse told her that the night nurse had administered several incorrect medications to Resident #70. RN #3 said she went to Resident #70's room first after she received shift report. RN #3 said Resident #70 was awake, still lethargic, groggy, and sitting up. RN #3 said Resident #70's blood sugar and vital signs were checked, his pulse oximeter reading was in the low 90s at the beginning of the shift, and he could answer questions appropriately. RN #3 said staff checked Resident #70 approximately every hour throughout the night. RN #3 said Resident #70 kept saying he was okay, but he was still lethargic. RN #3 said when he fell, he was able to tell her that he rolled out of bed, and when she tried to get him to roll him over he had a red face. RN #3 said she did not receive any instructions regarding documentation of the incident, and she did not think she needed to contact the physician because Resident #70 was up and answering questions appropriately prior to going to bed. RN #3 said she felt Resident #70 was okay, and he was just lethargic. RN #3 said she initially thought he should have been sent out to the ED. RN #3 said when Resident #70 coded, she asked the	F 760		

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F 760	Continued From page 179 physician why he was not sent out to the ED. RN #3 said the physician told her he was not informed of all of the medications that were included in the medication error, and she could not remember which medications the physician was aware of. On 12/11/19 at 10:35 AM, when asked about what should be documented when monitoring and assessing a resident after a significant medication error, UM #1 said "I don't know that." He said, "All I really know was I wasn't working on that unit, but as I recall they were monitoring his BP [blood pressure] and pulse for that shift, and level of consciousness." UM #1 said he did not know what was ordered regarding documentation for Resident #70. On 12/12/19 at 8:18 AM, Resident #70's sister said the facility had called her and told her about her brother passing, but she was not aware of the medication error. She said it surprised her that he died because he seemed to be doing really well. Resident #70's sister stated it may have been his daughters that brought the medication error to the attention of his case managers. On 12/12/19 at 1:12 PM, the DON said there was no documentation of vital signs that were taken after the time frame that was ordered by the Medical Director. She stated the nurse working the day shift on 7/10/19 did not write a progress note. The DON stated she could not answer why the assessments conducted by the nurse were not documented in Resident #70's record but stated they should have documented the assessments.	F 760		

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F 760	Continued From page 180 2. The facility's policy for Pharmacy Services, dated 11/28/17, documented the facility provided pharmaceutical services including assuring the accurate acquiring, receiving, dispensing, and administering of drugs and biologicals to meet the needs of each resident. The policy stated the pharmacy worked with the facility to ensure that medications were requested, received, and administered in a timely manner and as ordered by the prescriber. This policy was not followed. Resident #569 was admitted to the facility on 12/6/19, with multiple diagnoses including end stage renal disease, chronic obstructive pulmonary disease (COPD - a progressive lung disease that results in increasing breathlessness), and diarrhea. Resident #569's record included physician orders, dated 12/6/19, for Symbicort (an inhaled medication to treat COPD)160-4.5 mcg inhale 2 puffs orally two times a day for COPD, sodium bicarbonate (antacid) 650 mg 2 tablets by mouth two times a day for heartburn, and Creon capsule (a pancreatic enzyme replacement) delayed release particles 6000 Units 1 capsule by mouth three times a day for diarrhea. Resident #569's record included progress notes dated 12/6/19 at 5:09 PM and 5:17 PM, respectively, which documented the facility was awaiting delivery from the pharmacy to administer the Symbicort, sodium bicarbonate, and Creon. A packing list from the pharmacy documented medications were delivered to the facility on	F 760		

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F 760	Continued From page 181 12/6/19 at 6:46 PM. The packing list included the 3 medications ordered for administration to Resident #569 that evening. The medications were not administered as ordered. Resident #569's December 2019 MAR documented he had not received the sodium bicarbonate tablets, the Symbicort inhaler, or the Creon capsule on the evening of 12/6/19. On 12/10/19 at 1:30 PM, the DON was interviewed regarding Resident #569 not receiving the 3 ordered medications on 12/6/19. The DON said she did not know why the LPN did not administer the medications as ordered to Resident #569.	F 760		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, review of Resident Council minutes, resident interview, Resident Group interview, test tray evaluation, and staff interview, it was determined the facility failed to ensure palatable food was served. This was true for 5 of 9 residents (#8, #34, #47, #120, and #420) reviewed for food and nutrition who ate in the Alpine and Beacon dining rooms and/or	F 804	F804E Specific Resident Resident #8, #34, #47, #120, #420, #20, #27, #30, #44, #9, and #67 were all invited to and resident #4, #26, #51, #9, #33, #27, #56, #58, #13, #20 attended a	2/4/20

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F 804	Continued From page 182 in their rooms, and 6 of 8 residents (#9, #20, #27, #30, #44, and #67) in the Resident Group interview. This failed practice had the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include: The facility's food preparation and timely meal service policy, dated 11/28/17 and 02/2017; respectively, documented food was to be kept at appropriate levels to maintain flavor and palatability, and food would be delivered promptly. These policies were not followed. 1. On 12/8/19 at 10:22 AM, CNA #9 said there was not always enough staff to meet the needs of the residents. On 12/8/19 at 10:26 AM, CNA #6 said not all of the residents' needs were met due to low staffing levels. Resident Council Meeting minutes, dated 10/2/19, documented concerns of late breakfast room trays and Resident Council Meeting minutes, dated 11/6/19, documented concerns of late room trays. On 12/11/19 at 9:46 AM, the CDM said when the hall carts were ready, dietary staff called over the facility's radio to each unit and the CNAs on those units were expected to come to the kitchen to retrieve them and distribute the trays to the residents. She said there were times when staff would not come to retrieve the carts and dietary staff had to radio again to have unit staff deliver the carts. The facility's meal times were posted on the walls	F 804	Chef meeting conducted by the facility CDM and corporate dietitian consultant on Thursday, 1/9/20. At this meeting concerns regarding food temperature and palatability, tray service and timeliness of meal service was addressed. " Social Services met with Resident #34, #47, #30, #44, #67 to specifically to address and resolve their individual grievances related to food/dining. " Weekly meetings (Snack and Chat) with the CEO and monthly food committee meetings are conducted and residents #8, #34, #47, #120, #420, #20, #27, #30, #44, #9, and #67 are all encouraged to attend. Other Residents All residents in the facility have the potential to be affected and are invited to attend the weekly Snack and chat meetings with the CEO and the monthly food committee meetings. Facility System Dietary, nursing, and department manager staff were educated by the CEO and/or designee regarding the changes to dining services which include but are not limited to, staffing restructure to provide	

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F 804	Continued From page 183 near the dining room of the Beacon and Alpine units. The meals times documented breakfast was from 8:00 AM to 9:00 AM and lunch was from 12:00 PM to 1:00 PM. On 12/11/19 at 1:10 PM, the Administrator said he expected all residents to receive their breakfast by 9:00 AM and lunch by 1:00 PM. Observations of meal service were conducted. Meals were not served to all residents in a timely manner or at an appropriate temperature, as follows: a. Resident #47 was readmitted to the facility on 12/3/19, with multiple diagnoses including amyotrophic lateral sclerosis (ALS- a progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord). Resident #47's quarterly MDS assessment, dated 11/11/19, documented he was dependent on staff for all of his ADLs, including eating. On 12/8/19 at 1:08 PM, Resident #47's lunch tray had not been delivered or set up for him. No staff member was available to deliver the tray from the food cart, which was stationed in the hall near Resident #47's room. Other residents had received their meal trays, but a tray had not been provided to Resident #47 at that time. At 1:22 PM, an aide was in the hall cleaning a Hoyer mechanical lift (a device to help transfer residents), and she was returning dishes to the meal cart from resident rooms. A Regional staff member was in the hall walking past resident rooms and asking residents if they needed anything. No staff members went to Resident #47's room. At 1:29 PM, CNA #10 arrived at the	F 804	prompt and courteous dining services, new allocation/assignments of staff in dining room and halls, supervision of meals by licensed staff, and department manager dining coordinator responsibilities to oversee meal and dining program and report concerns to the CEO. In addition, an initiative to improve resident dining experience and reduce the number of hall trays to improve timeliness, increase staff ratios in the dining rooms, allow more choice at meals, and improve food temperatures and palatability. The system is amended to include adjustment of dining approach and staff allocation, meal times, tray line process, and plan adjustments based on resident feedback. Monitoring The Registered Dietician and/or designee will complete dining service review, quality control audits and resident satisfaction reviews weekly x 4 weeks, then monthly for 2 months. Sampling of residents will be surveyed 3 times annually. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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F 804	Continued From page 184 meal cart, picked up a meal tray, and delivered it to Resident #47's room. CNA #10 began to set up the meal tray for Resident #47. The surveyor requested to check the temperature of the food on the tray. All the food was pureed or soft in texture. At 1:32 PM, the food temperatures were measured as follows: mashed potatoes were 115.3 degrees Fahrenheit, roast beef was 94.6 degrees Fahrenheit, carrots were 83.3 degrees Fahrenheit, and cottage cheese was 49.8 degrees Fahrenheit. CNA #10 left the room and talked to a nurse in the hall. The nurse told her to warm the food on Resident #47's tray. CNA #10 returned to the room and took the tray out of the room. On 12/9/19 at 9:40 AM, Resident #47 said his food was a "little cooler," but staff warmed it up if he asked them to. Resident #47 said staff was often busy, and he received his lunch meal anywhere from before 1:00 PM to 1:30 PM. On 12/12/19 at 9:04 AM, CNA #10 said on 12/8/19 she "was giving care in another room, and called for help about three times, and no one came to help and that was why I was late to deliver that tray." CNA #10 said a nurse called over the radio and asked if she was going to assist Resident #47, and CNA #10 said she was in another room providing assistance and asked if someone else would be able to assist Resident #47. CNA #10 said she did not receive a response to her request for someone else to assist Resident #47. CNA #10 said Resident #47 told her a nurse came to his room and asked him if he was ready to eat, and he said yes. Resident #47 told CNA #10 the nurse left the room and never came back, "so he didn't get to eat until I	F 804	Date of Completion February 4, 2020	

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F 804	Continued From page 185 got to him." CNA #10 said there were "only two CNAs over here and sometimes when we ask for help, we just get ignored. Some of the residents can take up to an hour to help, leaving only one CNA on the floor and that is not enough. It leaves us rushing around trying to get things done." On 12/11/19 at 2:25 PM, the CDM said the kitchen staff started dishing up the hall trays at about 12:20 PM. The CDM said the aides then picked up the carts from the kitchen and took them out to the nursing unit at about 12:50 PM to deliver the meal trays to the residents. b. On 12/8/19 at 1:13 PM, lunch meal hall trays in the Alpine unit were observed to be delivered by UM #2 and he said hall trays were delivered after the dining rooms were served. At 1:18 PM, he delivered a hall tray to Resident #120. UM #2 came out of the room and said Resident #120 only wanted the cake from her meal tray. At 3:23 PM, Resident #120 said she refused her lunch tray because her tray was late again. She said because she could not wait for her tray, she ate snacks and was no longer hungry when her tray arrived. Resident #120 said her breakfast tray usually arrived late and her eggs were always cold. She said her lunch tray usually arrived between 1:30 PM and 2:30 PM. c. On 12/9/19 at 2:49 PM, Resident #9 said the "good cooks" went elsewhere so the facility hired from within, promoted other kitchen staff, and the quality dropped. She said the flavor, variety, and temperatures could be improved. Resident #9 reviewed the menu for the week and said potatoes were planned for 5 of 7 days that week. She said the facility offered a few options, but	F 804		

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F 804	Continued From page 186 she was getting tired of those. d. On 12/10/19 at 8:30 AM, Resident #420, who normally ate in the Alpine dining room, said his fried eggs were cold and tasted like they were left in the refrigerator for the past year. e. On 12/10/19 at 8:36 AM, Resident #8, who normally ate in the Alpine dining room, said his fried eggs and the plate were cold. f. On 12/10/19 at 9:23 AM, Resident #120 was in her room and said she did not receive her breakfast hall tray. She said she was concerned she had not received her tray yet because she had therapy scheduled at 10:00 AM and needed the food for energy. At 9:32 AM, the hall tray cart arrived on the Alpine unit and the first breakfast hall tray was delivered to room A-6. At 9:41 AM, PTA #1 was near the nurses' station engaged in a conversation with Resident #120. PTA #1 asked Resident #120 if she was ready for therapy and Resident #120 told PTA #1 she needed to eat breakfast before therapy. At that time the meal tray cart passed by both of them toward Resident #120's room and Resident #120 followed the cart back to her room. At 9:43 AM, PTA #1 said she did not want Resident #120 to start her therapy session until after she ate and would come back later. At 9:55 AM, Resident #120 was in her room eating scrambled eggs and bacon and said her breakfast was barely lukewarm. g. On 12/10/19 at 2:35 PM, during the Resident Group interview, Resident #9, #20, #27, #30, #44, and #67 said meals were always served late and the food was lukewarm.	F 804		

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F 804	Continued From page 187 h. On 12/12/19 at 9:22 AM, breakfast hall trays on the Beacon unit were delivered by two staff from separate sister facilities. On 12/13/19 at 8:56 AM, one of the staff members who was a DON, said she and the other staff member were at the facility the previous day to help support the facility staff. She said they helped pass out hall trays the previous day and said they did not do that on a regular basis at the facility. i. On 12/11/19 at 3:00 PM, the RD provided a dining policy and said, "Our policy is hot-things-hot, cold-things-cold. It is resident preference." On 12/12/19 at 9:15 AM, Cook #1 had five plates on the counter in front of the kitchen steam table. She plated breakfast meals and placed them on a warming pellet and were covered and placed on the hall cart. At 9:19 AM, one of the plates on the counter was used for a requested test tray, which included scrambled eggs, an over easy fried egg, sausage links, and french toast. At 9:24 AM, the test tray was evaluated by two surveyors along with the CDM. The french toast was 118 degrees Fahrenheit and the fried egg was 120 degrees Fahrenheit. The CDM said the fried egg and french toast could have been warmer. The surveyors determined the fried egg and french toast were not palatable due to the low temperature. The CDM said dietary staff normally kept plates warm in the steam table compartment prior to plating the food. The facility failed to ensure meals were served to all residents in a timely manner and at an appropriate temperature.	F 804		

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F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a diet that was consistent with physician orders. This was true for 1 of 4 residents (Resident #19) whose diet orders were reviewed. This failed practice created the potential for harm if residents experienced choking or adverse effects from ingesting a diet that was not in accordance with physician orders. Findings include: The facility's policy for Therapeutic Diets and Meal Plans, dated 11/28/17, documented the following: * The facility provided therapeutic diets when a resident's medical/nutrition diagnosis identified the need to modify the resident's meal plan. * The registered dietician assessed residents for the necessity of a therapeutic meal plan at the initial nutrition assessment, throughout the resident's admission, and as necessary. * A diet order was obtained for the appropriate therapeutic meal plan. * The resident's therapeutic meal plan was documented in the medical record and on the meal tray ticket, as a method of communicating the prescribed diet to staff.	F 805	F805D Specific Resident Resident #19 receives a diet as prescribed by the physician. Her diet has been upgraded per SLP to Mechanical Soft with Nectar Thick Liquid diet and has been served as such. All foods that were brought in by her family that were not allowed on her diet were removed from her room (with resident approval). Other Residents All residents on therapeutic or mechanically altered diets have the potential to be affected. Resident observations were made for those on altered diets, no other residents were identified with food items not compatible with their diet orders. Facility System	2/4/20

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F 805	Continued From page 189 The facility's policy for Aspiration (when food or liquid becomes inhaled into the lungs) Risk with Dysphagia (a swallowing disorder), dated 2/28/18, documented the following: * A trained dysphagia clinician performed assessment of the resident and assisted with determining the best approach and interventions on a "person-centered basis." * The primary methods to prevent aspiration included texture modification of food/liquids. These policies were not followed. Resident #19 was admitted to the facility on 2/7/19, with multiple diagnoses including stroke, hemiplegia and hemiparesis (weakness and paralysis on one side), and dysphagia. Resident #19's care plan documented she had a nutritional problem or potential nutritional problem related to stroke and altered textures, initiated on 2/12/19 and revised on 12/3/19. The care plan directed staff to provide and serve the diet as ordered: Regular mechanical soft, nectar thick, fortified, puree vegetables. The intervention was initiated on 2/12/19 and revised on 12/3/19. Resident #19 had an order dated 4/5/19 for a regular diet, mechanical soft texture, nectar thick consistency, fortified meals, and pureed vegetables were okay. The diet was order was revised on 12/9/19 to regular diet, pureed texture, nectar thick consistency, and Resident #19 could have thin liquids between meals. On 12/9/19 at 2:45 PM, Resident #19 was lying	F 805	Dietary was educated by the Registered Dietician and/or designee regarding food textures and order process to include but not limited to moving meal service tray line to a central location in the kitchen to improve accuracy for food in a form to meet individual resident needs. Nursing and dietary staff are educated to the procedural adjustment in processing diet changes and submission to the kitchen for timely tray ticket updates, and how to manage food items brought from the outside for individual resident consumption. In addition, SLP and/or designee will educate current residents/families on therapeutic diets and items that may or may not meet directives for physician directives which may be brought from home for resident consumption. Written information will be included on admission for residents with altered textured diets. The Registered Dietician will provide education to the resident upon evaluation as foods the meet their diet prescription. Monitoring The Registered Dietician and/or designee will complete quality controls for tray accuracy, diet card accuracy, dining room review and room rounds to include observation of foods brought to residents from the outside weekly x 4 weeks, then monthly for 2 months. Starting the week of 2/4/2020 the review will be	

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F 805	Continued From page 190 awake in bed turned slightly towards her right side, and the head of the bed was elevated at approximately 20 to 30 degrees. An overbed table was in place over Resident #19's lap, and a box of Cheeze-It crackers and chocolate-covered peanut butter balls were on the table and were open in front of her. On 12/9/19 at 2:50 PM, UM #1 said Resident #19 should not eat unattended, and he was not sure of her diet order or if the items in front of her were consistent with her ordered diet but he would check. UM #1 said perhaps Resident #19's family brought the food in for her. On 12/10/19 at 8:29 AM, Resident #19 was at the dining table for breakfast. The food items in front of her included toast, a Danish pastry, ground sausage and gravy, and a bowl of Fruit Loops cereal partially covered in thickened milk. Resident #19's meal ticket documented her diet order was mechanical soft/pureed vegetables, and nectar thick fluids. Resident #19's physician orders at that time documented a regular diet, pureed texture, nectar thick consistency, and she could have thin liquids between meals, which started on 12/9/19. CNA #11 was present at the table with Resident #19, and he fed her a total of 4 bites of the Danish pastry. CNA #11 said the cereal in front of Resident #19 was probably not mechanical soft, and he was not aware of any changes to her diet orders. CNA #11 said he would find out about changes to residents' diet orders by looking at their meal ticket, or he could ask the Speech Therapist. On 12/10/19 at 8:38 AM, UM #1 observed Resident #19's breakfast meal on the table in	F 805	documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 805	Continued From page 191 front of her, and he said her diet order was mechanical soft and thickened liquids. UM #1 then reviewed Resident #19's physician orders and said Resident #19's diet order was for pureed food. UM #1 said the food on the table in front of Resident #19 did not look pureed, and he was not aware of the new diet order. On 12/10/19 at 8:50 AM, the CDM said Resident #19's diet was changed to pureed, and the order came in the previous night. The CDM said when a resident's diet order was changed, the UM was given a diet slip and there was diet information for staff to refer to. The CDM said Resident #19's diet slip was not correct. On 12/10/19 at 10:18 AM, the Speech Therapist said when she had diet recommendations for a resident, she completed a diet order form, then she provided a copy to the nurse and to the kitchen. The Speech Therapist said if a diet order was completed right before a meal, she provided it to the kitchen in writing and verbally. The Speech Therapist said she recommended pureed solids and nectar thick liquids for Resident #19, and the diet change was ordered on 12/9/19 due to increased coughing in the dining room. The Speech Therapist said she was informed Resident #19's son was bringing in outside food to her, so it was time to reassess her. The Speech Therapist said the Cheeze-It crackers and chocolate covered peanut butter balls were not appropriate for Resident #19, and the food provided to her at breakfast that morning was "absolutely not appropriate. I recommended pureed." The Speech Therapist said Resident #19 had a long-term swallowing problem and a history of stroke.	F 805		

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F 805	Continued From page 192	F 805		
	On 12/10/19 at 4:28 PM, the RD said the Cheeze-It crackers and chocolate covered peanut butter balls were not on Resident #19's diet, and her family brought them into the facility.			
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to follow a resident's meal preference. This was true for 1 of 4 residents (Resident #420) reviewed for food preferences. This failure created the potential for harm if residents experienced hunger or weight loss for not having complete meals served. Findings include: Resident #420 was admitted to the facility on 12/5/19, with multiple diagnoses including failure to thrive. Resident #420's breakfast ticket documented his standing orders for breakfast were oatmeal with raisins.	F 806	F806D Specific Resident Resident #420 gets his raisins each day per his request. This request is prominently displayed on his tray card ticket. Other Residents All residents in the facility have the potential to be affected. Resident preferences are moved to be prominently displayed on the tray card ticket.	2/4/20

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F 806	Continued From page 193 On 12/10/19 at 8:36 AM, Resident #420 did not have raisins for his oatmeal. Resident #420 stated he received oatmeal with raisins every day for breakfast per his preferences. Resident #420 picked up his breakfast ticket and pointed at the preferences for oatmeal and in parentheses the ticket documented, "W/Raisins." Resident #420 stated he would only eat his oatmeal with raisins and he refused to eat his oatmeal until he received raisins to put in his oatmeal. Resident #420 requested raisins to the Director of Rehabilitation and she delivered a cup full of raisins to him at 8:42 AM. Resident #420 stated his oatmeal was cold and did not want to eat it now. On 12/10/19 at 8:43 AM, CNA #12 stated Resident #420's breakfast ticket was specific on his preferences. CNA #12 stated Resident #420's raisins should be delivered to him in a small cup with his whole meal and he should not have to wait for them. On 12/10/19 at 8:45 AM, UM #2 stated the meal tickets included resident preferences to notify the staff member delivering the tray what specific requests residents wanted to avoid a delay in waiting for the completed meal. UM #2 stated Resident #420's meal ticket documented he wanted oatmeal with raisins and the raisins should have been delivered at the same time with his oatmeal.	F 806	Facility System Dietary staff are educated by the Registered Dietician and/or designee to address resident preferences and consistently provide items requested on the tray card ticket. The meal tray service is revamped to expedite service and provide efficiency in food service staff responsibilities for how food orders are reviewed for preference and accuracy, meal delivery sequencing and timing, and a tray line double check prior to serving. In addition, nursing staff is educated to check tray for accuracy against the tray card prior to delivery. Monitoring The Registered Dietician and/or designee will complete quality control audits for tray line, diet card accuracy, and tray delivery point review weekly x 4 weeks, then monthly for 2 months. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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F 806	Continued From page 194	F 806	Date of Completion February 4, 2020	
F 835 SS=F	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 record review, policy review, review of Resident Council minutes, review of staffing schedules, review of the Facility Assessment, review of the Resident Census and Conditions, and resident, resident representative, and staff interview, it was determined the facility failed to ensure services were provided which maintained residents' highest practicable level of well-being for 26 of 26 residents (#4, #6, #9, #10, #12, #13, #14, #15, #19, #20, #24, #30, #33, #34, #39, #44, #47, #52, #55, #56, #57, #62, #65, #66, #120, #420, and #569) who were reviewed, and had the potential to affect the other 48 residents in the facility. This 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: The facility's Facility Administration policy, dated 11/28/17, documented the Administrator was responsible for establishing and implementing policies regarding the management and operation of the facility. The policy stated the	F 835	F835 Resident Specific Residents #4, #6, #9, #10, #12, #13, #15, #19, #20, #24, #30, #33, #34, #39, #44, #47, #52, #55, #56, #57, #65, #66 and #569 were evaluated with concerned managed. Residents #14, #62, #120 and #420 no longer reside at the facility. Other Residents Facility assessment was reviewed and revised by IDT with CEO and CNO updating the document to reflect current census, resident needs, acuity and staffing levels. The CEO enables	2/4/20

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F 835	Continued From page 195 facility operates and provides services that follow accepted professional standards and principles of practice. The policy also stated the facility has a governing body consisting of the Administrator, Director of Nursing Services, and Medical Director that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. 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. The facility's policy Facility Assessment, dated 11/28/17, documented the following: * The facility evaluated its resident population and identified the resources needed to provide the necessary care and services to its residents competently during daily operations and during emergencies. * The facility reviewed and updated the assessment whenever there was, or the facility planned for, any changes that required a substantial modification to any part of the assessment. The facility assessment addressed or included the following: - The facility's resident population, including but not limited to the number of residents and the facility's resident capacity.	F 835	resources to be utilized to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Resident council concerns and grievance process is reviewed, revised, and resident concerns addressed. Facility staffing and care assignments are reviewed and addressed to meet resident needs. Adjustments are made as indicated. Facility Systems CEO and CNO was educated by the President on the process to review and revise the facility assessment, to include but not limited to meet current resident needs, acuity and staffing levels. In addition, CEO and CNO are educated to act upon the knowledge they have obtained to attain\maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Also see F838, F585, F550, F552, F677, F684, F686, F689, F725, and F760. The system is amended to include QAPI oversight by the President.	

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F 835	Continued From page 196 - The care required by the resident population with consideration of the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other relevant facts that were present within that population. - The facility's resources, including but not limited to all personnel, including managers and staff (facility employees and those who provided services under contract). a. The Facility Assessment Tool, dated 7/1/19, documented the average daily census was 58 residents. The tool documented the number of residents in the facility who required the specified treatment/services listed, but did not account for all 58 residents. Examples included, but were not limited to, the following: - The "Assistance with Activities of Daily Living" section of the tool documented the assistance residents required for dressing which stated 1 resident was independent, 15-20 residents required assistance of 1-2 staff, and 5-7 residents were dependent upon staff, for a maximum total of 28 residents' needs being accounted for (i.e. 1 independent, plus 20 requiring 1-2 staff, plus 7 dependent on staff, equaling 28 total residents accounted for). The Assessment Tool did not include information related to the dressing needs of the 30 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 28 residents accounted for, equaling 30 residents not accounted for). - The "Assistance with Activities of Daily Living"	F 835	Monitoring The President and/or support staff designee will audit that resources are utilized as per plan to meet resident changes in census/acuity monthly for 3 months. Starting the January 2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Completion February 4, 2020	

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F 835	Continued From page 197 section of the tool documented the assistance residents required for bathing which stated 1 resident was independent, 15-20 residents required assistance of 1-2 staff, and 10-15 residents were dependent upon staff, for a maximum total of 36 residents' needs being accounted for (i.e. 1 independent, plus 20 requiring 1-2 staff, plus 15 dependent on staff, equaling 36 total residents accounted for). The Assessment Tool did not include information related to the bathing needs of the 22 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 36 residents accounted for, equaling 22 residents not accounted for). - The "Assistance with Activities of Daily Living" section of the tool documented the assistance residents required for transfers which stated 2 residents were independent, 15-20 residents required assistance of 1-2 staff, and 10-15 residents were dependent upon staff, for a maximum total of 37 residents' needs being accounted for (i.e. 2 independent, plus 20 requiring 1-2 staff, plus 15 dependent on staff, equaling 37 total residents accounted for). The Assessment Tool did not include information related to the transfer needs of the 21 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 37 residents accounted for, equaling 21 residents not accounted for). - The "Assistance with Activities of Daily Living" section of the tool documented the assistance residents required for eating which stated 15-20 residents were independent, 5-10 residents required assistance of 1-2 staff, and 4-7	F 835		

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F 835	Continued From page 198 residents were dependent upon staff, for a maximum total of 37 residents' needs being accounted for (i.e. 20 independent, plus 10 requiring 1-2 staff, plus 7 dependent on staff, equaling 37 total residents accounted for). The Assessment Tool did not include information related to the eating needs of the 21 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 37 residents accounted for, equaling 21 residents not accounted for). The facility failed to ensure the Assessment Tool accounted for all resident needs based on the facility's average daily census. b. The Facility Assessment Tool, dated 7/1/19, was compared to the Resident Census and Conditions of Residents form completed during the survey on 12/9/19. The Facility Assessment Tool had not been updated to reflect the facility's population. Examples included, but were not limited to, the following: - The Facility Assessment Tool documented the average daily census was 58 residents. However, the Resident Census and Conditions of Residents form documented the facility's census was 74 residents. On 12/13/19 at 8:40 AM, the Administrator was shown the Facility Assessment Tool, dated 7/1/19. The Administrator stated the average daily census was 58 at the time the assessment was completed, and the current average daily census was 72. - The Facility Assessment Tool documented the	F 835		

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F 835	Continued From page 199 number of residents in the facility who required the specified treatment/services which included: Respiratory Treatments: Oxygen therapy: 16-18 residents Suctioning: 10-12 residents Tracheostomy care: 2-3 Mental Health: Behavioral Health Needs: 15-20 residents Other: Injections: 3-4 residents Dialysis: 3 residents Ostomy care: 2-3 residents However, the Resident Census and Conditions of Residents form documented the following current resident needs: Respiratory Treatments: Respiratory treatment: 27 residents Suctioning: 13 residents Tracheostomy care: 13 residents Mental Health Behavioral Health Needs: 58 residents Other Injections: 17 residents Dialysis: 4 residents Ostomy care: 5 residents The facility failed to ensure the Assessment Tool was updated to account for the increased number of residents and their increased needs. c. The Facility Assessment Tool documented the	F 835		

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F 835	Continued From page 200 facility's staffing plan included providing a total of 4.5 to 5.5 hours of nursing care per resident per day, which included RNs, LPNs, CNAs, NAs, and hospitality aides (non-skilled care). Hospitality aides are not allowed to provide nursing care and should not be reflected in the nursing care hours. The direct care nursing hours worked from 11/17/19 through 12/7/19 were reviewed. The staffing levels did not meet the 4.5 to 5.5 hours planned in the Facility Assessment Tool. The days for which the hours did not meet nursing care were as follows: Sunday, 11/17/19 - 4.01 Saturday, 11/23/19 - 4.3 Sunday, 11/24/19 - 3.82 Saturday, 11/30/19 - 4.32 Sunday, 12/1/19 - 3.90 Saturday, 12/7/19 - 4.09 On 12/12/19 at 4:38 PM, the DON together with the Clinical Resource Nurse was asked if the Facility Assessment included a determination of the level and competency of staff needed to meet each residents' needs each day and during emergencies. The DON said "Yes." Both the DON and the Clinical Resource Nurse said the planned nursing hours per resident per day was 4.5 hours to 5.5 hours. The DON and the Clinical Resource Nurse stated they were not aware the staffing levels for the past three weekends did not meet the planned staffing levels according to the Facility Assessment. The staffing plan was not updated to include additional staff based on the facility's increased number of residents and their increased needs,	F 835		

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F 835	Continued From page 201 as documented on the Resident Census and Conditions of Residents form. On 12/12/19 at 5:15 PM, the Administrator and the Director of Operations were interviewed regarding the facility's staffing and the nursing hours per resident per day documented in the Facility Assessment Tool. The Administrator stated the nursing hours per resident per day in the assessment would have changed because the census was now higher than when the assessment was completed. On 12/13/19 at 8:40 AM, the Administrator stated the assessment was a "fluid document," which could be updated and changed. When asked if the per resident per day staffing referenced in the assessment was current and valid, the Administrator stated it was "not indicative of the current staffing" because the average daily census was 58 at the time the assessment was completed, and the current average daily census was 72. (This represented an increase of 24% in the average daily census since the Facility Assessment Tool was completed). The facility failed to ensure the Assessment Tool was updated to account for the facility's increased staffing needs. 2. The facility's Grievance policy, dated 11/28/17, documented the facility would make prompt efforts to resolve grievances, including Resident Council concerns, and to keep residents notified of progress toward resolution. Resident Council Meeting minutes, dated 9/4/19, documented concerns with call light response	F 835		

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F 835	Continued From page 202 times up to 30 minutes and very slow response times during meals. Resident Council Meeting minutes, dated 10/2/19, documented concerns with call light response times up to one and a half hours, not enough staff, staff saying they would come back to help residents and did not, and breakfast served in resident rooms were late. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19 meeting. Resident Council Meeting minutes, dated 11/6/19, documented concerns with call light response times up to two hours, long response times during shift change, staff saying they would come back to help residents and did not come back, and room trays were late due to not enough staff to pass out trays. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19 or 10/2/19 meetings. Resident Council Meeting minutes, dated 12/4/19, documented concerns with not enough staff on the weekends and not all the residents were getting showers as scheduled. There was no documentation what actions were taken to resolve the concerns identified in the 9/4/19, 10/2/19, and 11/6/19 meetings. On 12/10/19 at 2:35 PM, during the Resident Group interview, Residents #9, #30, and #44 said there were still issues with slow call light response times, not enough staff, low food temperatures, and late delivery of trays. They stated these concerns were not addressed by the facility.	F 835		

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F 835	Continued From page 203 On 12/11/19 at 9:36 AM, the Activity Director said she emailed the Resident Council meeting notes to the department heads. She said she had not been given direction to readdress the old complaints during the Resident Council meetings. The Activity Director said the Administrator met individually with the Resident Council President to address the Resident Council concerns. On 12/11/19 at 1:10 PM, the Administrator said he met with the Resident Council President and relied on the council's President to report back to the Resident Council. The Administrator provided minutes for meetings with the council's President for 11/11/19 and 11/27/19. The minutes did not document a discussion of not enough staff, staff saying they will come back to help residents and then not coming back, and late meal trays. The Administrator said he did not see where concerns were readdressed in the Resident Council minutes. The Administrator said he expected Resident Council concerns to be addressed. 3. Facility staffing was insufficient to meet the care and needs of the residents and to respond to resident concerns. Examples include: a. Residents and their representatives were interviewed and stated the facility did not have sufficient staff to meet their needs. - On 12/8/19 at 10:22 AM, Resident #9 said her roommate was put to bed in her pants but had sat in her wheelchair prior to transfer and had peed and wet her pants. Resident #9 said she called staff to come and change her roommate's pants. Resident #9 said her roommate is unable	F 835		

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F 835	Continued From page 204 to advocate for herself, had sat wet for an hour, and the staff had not checked on her. Resident #9 said when she moved here in February of 2019, there were 50 residents. She said the census went up to 75 residents, but they did not hire more people. Resident #9 said there were 2 CNAs most of the time on day shift, with 1 CNA at night. She said they needed an extra CNA in the morning and afternoon, and 2 CNAs at night, and they were not provided. - On 12/8/19 at 11:33 AM, Resident #120 said there were not enough staff to administer her medications on time, give her showers when she was scheduled, and said on the weekends call lights were not answered timely. - On 12/8/19 at 5:20 PM, Resident #569 stated he came to the facility from an acute care hospital on 12/6/19, and he was admitted for physical therapy and to gain strength in his legs prior to hip surgery. Resident #569 said since he was admitted to the facility, the service had been very slow. He said sometimes when he put on his call light it took 10 to 15 minutes to get a response, and sometimes no one came at all. Resident #569 stated, "I believe they are under-staffed here." - On 12/9/19 at 10:54 AM, Resident #25's spouse said there were not enough staff on the weekends to assist with residents with their meals, meals are generally late, and there are not enough staff to take care of residents' hygiene needs. - On 12/10/19 at 12:25, Resident #12's daughter stated hospice has helped her with addressing	F 835		

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F 835	Continued From page 205 her problems with the facility staff. She stated last Thursday evening the staffing board documented there were 3 nurses and they had to get someone from another hall to assist Resident #12 to bed. Resident #12's daughter stated she has been sent to appointments without her hair being brushed. - On 12/10/19 at 2:35 PM, during the Resident Group interview, Residents #9, #20, #27, #30, and #44 said showers were not being completed, especially on Saturdays. - On 12/10/19 at 3:02 PM, the co-guardians for Resident #70 stated when they went in to visit or take him to an appointment he often had a wet adult brief and the staff were not changing him. One of the guardians stated they had taken Resident #70 to an appointment and at the appointment a wound was found on his leg. The guardian stated the nurse at the appointment stated the wound should have been identified by the facility it had been there "for a while." The guardian stated the staff at the facility should have been performing weekly skin checks to identify these types of issues. b. Staff were interviewed and stated there was not sufficient staff to provide the cares required and to meet the needs of the residents. - On 12/8/19 at 10:22 AM, CNA #9 said there were not always enough staff to meet the needs of the residents. - On 12/8/19 at 10:42 AM, LPN #1 said there are not enough staff because there were several residents who required 2-person assistance with	F 835		

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F 835	Continued From page 206 transfers. - On 12/9/19 at 1:57 PM, CNA #18 said she started working as Shower Aide about 3 months ago. CNA #18 said she was asked about 3 times to work on the floor because of staff call offs. CNA #18 said showers were not completed on those days she was asked to work on the floor as a CNA. - On 12/10/19 at 9:10 AM, RNA #1 said he was working as a CNA and said would not be able to do the RNA program today. When asked who would be doing the RNA program for the residents. RNA #1 said "Nobody." RNA #1 said he was pulled out to work as a CNA about four to five times since he started working as an RNA six months ago. - On 12/11/19 at 2:04 PM, CNA #6 stated they don't have enough care givers. CNA #6 said residents who were using "mechanical" lifts received their showers on Wednesdays and Saturdays and there was not enough staff scheduled on Saturdays. CNA #6 said there was no shower aides on Saturdays. CNA #6 also said the razor blade got dull and one resident had not been shaved for a week, and he got shaved only during his shower days. CNA #6 said she had requested to have the Saturday's showers changed because of there was no shower aide but she got no response. -On 12/11/19 at 3:45 PM, CNA #7 was asked if the facility staffing was adequate to assist residents with meals. CNA #7 said there was not enough staff to assist residents during meals or anything else unless the survey team was in the	F 835		

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F 835	Continued From page 207 building. Then all personnel from the office would come on the floor and help. - On 12/12/19 at 9:04 AM, CNA #10 said there were "only two CNAs over here and sometimes when we ask for help, we just get ignored. Some of the resident can take up to an hour to help, leaving only one CNA on the floor and that is not enough. It leaves us rushing around trying to get things done." On 12/13/19 at 9:45 AM, RN #5 said there was staffing problem in the facility that was why she worked as a CNA on 12/8/19. 4. On 12/13/19 at 9:53 AM, the Administrator, with the President Cascadia South present, said the Quality Assessment Performance Improvement (QAPI) committee had identified treatment of pressure ulcers was an issue and had addressed it by sending the Wound Nurse through specialized training. The Administrator said the facility was not perfect yet and was still trying to work on prevention of facility acquired pressure ulcers. The President Cascadia South said the facility admitted complex residents with lots of care needs and staff were still adjusting to the increase in the number of residents that were being admitted. The Administrator and the President Cascadia South said the staffing levels of 4.5 to 5.5 hours per resident per day, documented in the Facility Assessment, was the goal for the facility. The Administrator said the facility did not always have the staff to meet that level. He said the facility was still working on trying to provide resident meals on time, which was generally 50% of the time. The Administrator presented a QAPI meal service monitoring	F 835		

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F 835	Continued From page 208 document, he said it was used for staff to be able to better monitor tray delivery. The Administrator said as part of QAPI, the facility had added a shower aide but still had issues completing all of the necessary showers. He said the previous day a DON from a sister facility was working with the facility staff to help modify the residents' shower schedule to make sure showers were not being missed. The President Cascadia South said the facility was still trying to build "the core group" of staff who could turn the facility in the right direction. The Administrator said during the last survey, the facility was cited for lack of hand hygiene during wound care. He was informed of the infection control observations during the current survey and he said he expected the SDC and the DON to monitor infection control practices. The Administrator said during the last survey, the facility was also cited for dignity for not offering residents clothing protectors prior to placing them on and it was part of QAPI. He was informed of the dignity concerns and the dignity with dining experiences and he said the facility did not do a good job at complying with that regulation. 5. Please refer to F550 as it related to the facility's failure to ensure residents were not harmed due to a lack of respect and dignity. 6. Please refer to F552 as it related to the facility's failure to ensure appropriate consent was obtained. 7. Please refer to F677 as it related to the facility's failure to provide bathing and showers to meet the residents' needs. 8. Please refer to F684 as it related to the	F 835		

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F 835	Continued From page 209 facility's failure to provide care and services which were provided following professional standards of practice. 9. Please refer to F686 as it related to the facility's failure ensure residents were not harmed due to lack of treatment and services to prevent and heal pressure ulcers. 10. Please refer to F689 as it related to the facility's failure to ensure residents were not harmed due to improper use of equipment and residents were protected from falls and injuries. 11. Please refer to F725 as it related to lack of sufficient staff to meet residents' needs. 12. Please refer to F760 as it related to the facility's failure to ensure residents were not harmed due to lack of identifying adverse effects of medications and acted upon promptly and were free of both significant and non-significant medication errors.	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 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	F 838		2/4/20

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F 838	Continued From page 210 address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (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. §483.70(e)(2) The facility's resources, including but not limited to, (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; (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	F 838		

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F 838	Continued From page 211 (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on review of the Facility Assessment Tool, policy review, and staff interview, it was determined the facility failed to ensure the Facility Assessment was updated to reflect the current levels of staffing required to meet the needs of all 74 residents residing at the facility. This had the potential to result in insufficient staffing to meet the needs of the residents. Findings include: The facility's policy Facility Assessment, dated 11/28/17, documented the following: * The facility evaluated its resident population and identified the resources needed to provide the necessary care and services to its residents competently during daily operations and during emergencies. * The facility reviewed and updated the assessment whenever there was, or the facility planned for, any changes that required a substantial modification to any part of the assessment. The facility assessment addressed or included the following: - The facility's resident population, including but	F 838	F838F Resident Specific No specific resident(s) identified. Other Residents All residents have the potential to be impacted by the facility assessment. The plan is updated to meet current census and resident needs. Facility Systems CEO and CNO was educated by the President on the process to review and revise the facility assessment, to include but not limited to meet current census, resident needs, acuity and staffing levels. In addition, CEO and CNO are educated to act upon the knowledge they have obtained to attain\maintain the highest practicable physical, mental, and	

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F 838	Continued From page 212 not limited to the number of residents and the facility's resident capacity. - The care required by the resident population with consideration of the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other relevant facts that were present within that population. - The facility's resources, including but not limited to all personnel, including managers and staff (facility employees and those who provided services under contract). a. The Facility Assessment Tool, dated 7/1/19, documented the average daily census was 58 residents. The tool documented the number of residents in the facility who required the specified treatment/services listed, but did not account for all 58 residents. Examples included, but were not limited to, the following: - The "Assistance with Activities of Daily Living" section of the tool documented the assistance residents required for dressing which stated 1 resident was independent, 15-20 residents required assistance of 1-2 staff, and 5-7 residents were dependent upon staff, for a maximum total of 28 residents' needs being accounted for (i.e. 1 independent, plus 20 requiring 1-2 staff, plus 7 dependent on staff, equaling 28 total residents accounted for). The Assessment Tool did not include information related to the dressing needs of the 30 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 28 residents accounted for, equaling 30 residents not accounted for).	F 838	psychosocial well-being of each resident. The system is amended to determine in monthly QAPI if the facility assessment may need updating. Updating will occur as indicated. Monitoring The CEO and/or designee will review the facility assessment monthly to determine if adjustments are indicated. Starting in January 2020 the review will be documented on the QAPI minutes. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 3 months, as it deems appropriate. Date of Completion February 4, 2020	

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F 838	Continued From page 213 - The "Assistance with Activities of Daily Living" section of the tool documented the assistance residents required for bathing which stated 1 resident was independent, 15-20 residents required assistance of 1-2 staff, and 10-15 residents were dependent upon staff, for a maximum total of 36 residents' needs being accounted for (i.e. 1 independent, plus 20 requiring 1-2 staff, plus 15 dependent on staff, equaling 36 total residents accounted for). The Assessment Tool did not include information related to the bathing needs of the 22 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 36 residents accounted for, equaling 22 residents not accounted for). - The "Assistance with Activities of Daily Living" section of the tool documented the assistance residents required for transfers which stated 2 residents were independent, 15-20 residents required assistance of 1-2 staff, and 10-15 residents were dependent upon staff, for a maximum total of 37 residents' needs being accounted for (i.e. 2 independent, plus 20 requiring 1-2 staff, plus 15 dependent on staff, equaling 37 total residents accounted for). The Assessment Tool did not include information related to the transfer needs of the 21 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 37 residents accounted for, equaling 21 residents not accounted for). - The "Assistance with Activities of Daily Living" section of the tool documented the assistance residents required for eating which stated 15-20	F 838		

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F 838	Continued From page 214 residents were independent, 5-10 residents required assistance of 1-2 staff, and 4-7 residents were dependent upon staff, for a maximum total of 37 residents' needs being accounted for (i.e. 20 independent, plus 10 requiring 1-2 staff, plus 7 dependent on staff, equaling 37 total residents accounted for). The Assessment Tool did not include information related to the eating needs of the 21 other residents required to account for the facility's average daily census of 58 residents (58 total residents, minus 37 residents accounted for, equaling 21 residents not accounted for). The facility failed to ensure the Assessment Tool accounted for all resident needs based on the facility's average daily census. b. The Facility Assessment Tool, dated 7/1/19, was compared to the Resident Census and Conditions of Residents form completed during the survey on 12/9/19. The Facility Assessment Tool had not been updated to reflect the facility's population. Examples included, but were not limited to, the following: - The Facility Assessment Tool documented the average daily census was 58 residents. However, the Resident Census and Conditions of Residents form documented the facility's census was 74 residents. On 12/13/19 at 8:40 AM, the Administrator was shown the Facility Assessment Tool, dated 7/1/19. The Administrator stated the average daily census was 58 at the time the assessment was completed, and the current average daily census was 72.	F 838		

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F 838	Continued From page 215 - The Facility Assessment Tool documented the number of residents in the facility who required the specified treatment/services which included: Respiratory Treatments: Oxygen therapy: 16-18 residents Suctioning: 10-12 residents Tracheostomy care: 2-3 Mental Health: Behavioral Health Needs: 15-20 residents Other: Injections: 3-4 residents Dialysis: 3 residents Ostomy care: 2-3 residents However, the Resident Census and Conditions of Residents form documented the following current resident needs: Respiratory Treatments: Respiratory treatment: 27 residents Suctioning: 13 residents Tracheostomy care: 13 residents Mental Health Behavioral Health Needs: 58 residents Other Injections: 17 residents Dialysis: 4 residents Ostomy care: 5 residents The facility failed to ensure the Assessment Tool was updated to account for the increased number of residents and their increased needs.	F 838		

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F 838	Continued From page 216 c. The Facility Assessment Tool documented the facility's staffing plan included providing a total of 4.5 to 5.5 hours of nursing care per resident per day, which included RNs, LPNs, CNAs, NAs, and hospitality aides (non-skilled care). Hospitality aides are not allowed to provide nursing care and should not be reflected in the nursing care hours. The direct care nursing hours worked from 11/17/19 through 12/7/19 were reviewed. The staffing levels did not meet the 4.5 to 5.5 hours planned in the Facility Assessment Tool. The days for which the hours did not meet nursing care were as follows: Sunday, 11/17/19 - 4.01 Saturday, 11/23/19 - 4.3 Sunday, 11/24/19 - 3.82 Saturday, 11/30/19 - 4.32 Sunday, 12/1/19 - 3.90 Saturday, 12/7/19 - 4.09 On 12/12/19 at 4:38 PM, the DON together with the Clinical Resource Nurse was asked if the Facility Assessment included a determination of the level and competency of staff needed to meet each residents' needs each day and during emergencies. The DON said "Yes." Both the DON and the Clinical Resource Nurse said the planned nursing hours per resident per day was 4.5 hours to 5.5 hours. The DON and the Clinical Resource Nurse stated they were not aware the staffing levels for the past three weekends did not meet the planned staffing levels according to the Facility Assessment. The staffing plan was not updated to include	F 838		

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F 838	Continued From page 217 additional staff based on the facility's increased number of residents and their increased needs, as documented on the Resident Census and Conditions of Residents form. On 12/12/19 at 5:15 PM, the Administrator and the Director of Operations were interviewed regarding the facility's staffing and the nursing hours per resident per day documented in the Facility Assessment Tool. The Administrator stated the nursing hours per resident per day in the assessment would have changed because the census was now higher than when the assessment was completed. On 12/13/19 at 8:40 AM, the Administrator stated the assessment was a "fluid document," which could be updated and changed. When asked if the per resident per day staffing referenced in the assessment was current and valid, the Administrator stated it was "not indicative of the current staffing" because the average daily census was 58 at the time the assessment was completed, and the current average daily census was 72. (This represented an increase of 24% in the average daily census since the Facility Assessment Tool was completed). The facility failed to ensure the Assessment Tool was updated to account for the facility's increased staffing needs.	F 838		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services	F 849		2/4/20

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CASCADIA OF BOISE	6000 W DENTON ST BOISE, ID 83704

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F 849	Continued From page 218 through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical,	F 849		

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F 849	Continued From page 219 mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.	F 849		

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F 849	Continued From page 220 (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's	F 849		

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F 849	Continued From page 221 attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to	F 849	F849D	

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F 849	Continued From page 222 ensure care was coordinated with hospice services to meet resident needs. This was true for 1 of 2 residents (Resident #55) reviewed for hospice services. This failure had the potential for harm if residents received inadequate care from the facility and/or hospice agency due to a lack of care coordination. Findings include: The facility's policy for hospice services, dated 11/29/17, documented the facility had a written agreement with hospice services which included delineation of hospice responsibilities, including nursing and all other necessary care of the resident. The policy documented the facility had the responsibility to meet the residents' personal cares or nursing needs and coordinated these with the hospice representative. This policy was not followed. Resident #55 was admitted to the facility on 11/1/19, with multiple diagnoses, which included Parkinson's Disease (a progressive disease of the central nervous system that affects movement) and Lewy Body Dementia (progressive brain disorder triggered by abnormal deposits of protein in the brain). Resident #55's MDS assessment initiated on 11/11/19, documented Resident #55 was admitted for hospice services. Resident #55's hospice delineation of duties dated 11/1/19, documented the facility was responsible for 24-hour room and board, personal care and nursing needs of residents. The delineation of duties did not include details of what cares or tasks each nursing home or	F 849	Resident Specific Resident #55 currently continues on hospice services. Resident #55 care plan was revised to include delineation of duties to include details of cares and tasks completed by facility vs those hospice is responsible for to include but not limited to, provision of showers, revision also included communication between facility and hospice services for coordination of care. Other Residents Current resident were reviewed by facility IDT for hospice orders and services. Identified residents were reviewed by Nursing Administration to validate that care plan was revised to include delineation of duties include details of cares and tasks completed by facility vs those hospice is responsible for to include but not limited to provision of showers, revision also included communication between facility and hospice services for coordination of care. Adjustments made as indicated. Facility Systems Facility CNO, Social Services Director and UMs were educated by Clinical Resource to Hospice Services Policy and	

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F 849	Continued From page 223 hospice discipline was responsible for completing. The delineation of duties document also did not include how communication would be documented between the facility and hospice agency. Resident #55's care plan, initiated 11/18/19, documented Resident #55 implemented end of life care with a hospice agency with an intervention to coordinate aspects of his care with the hospice agency. The care plan did not include documentation of the detailed responsibilities or care provided between the facility and the hospice agency. On 12/12/19 at 8:27 AM, CNA #12, who was a shower aide for the facility, stated she did not know what cares the hospice agency was responsible for. CNA #12 said she did not know when the hospice agency gave showers to Resident #55. CNA #12 said if she did not know if Resident #55 received a shower, she gave him one. On 12/10/19 at 2:36 PM, the DON stated care plans should include documentation of delineation of care with a hospice agency. The DON stated hospice coordinated with nursing staff and then provided a note that was scanned into the record. The DON was unable to find delineation of cares for Resident #55 in the care plan. On 12/13/19 at 9:19 AM, UM #2 stated he was unable to locate the delineation of cares in Resident #55's care plan which documented what services hospice, or the facility personnel, performed.	F 849	the need for hospice care plans to include documented delineation of duties include details of cares and tasks completed by facility vs those hospice is responsible for to include but not limited to provision of showers, revision also included communication between facility and hospice services for coordination of care. The system is amended to include review post hospice order for delineation of services agreement from hospice and integration into the resident plan of care. Monitoring The CNO and/or designee will audit residents on hospice services for care coordination with hospice weekly for 4 weeks, then monthly for 2 months. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 849	Continued From page 224 The facility failed to incorporate Resident #55's delineation of care, how communication was documented, or details of what tasks each discipline completed between the facility and hospice on his care plan.	F 849		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		2/4/20

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F 880	Continued From page 225 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. §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:	F 880		

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F 880	Continued From page 226 Based on observation, staff interview, and policy review, it was determined the facility failed to ensure staff performed hand hygiene and followed professional standards of practices for infection prevention. This was true for 3 of 21 residents (#15, #24, and #57) who were observed for infection prevention. These failures placed residents at risk for infection due to cross contamination and potential exposure to bacteria and other pathogens. Findings include: The facility's policy Transmission-Based Precautions, dated 10/1/17, documented the facility's staff were to notify the designated Infection Prevention Nurse of suspected infectious or communicable disease, place the resident on appropriate transmission-based precautions, post precaution signage outside the resident room, and educate the staff on the importance of hand hygiene and using appropriate personal protective equipment (PPE). The appropriate PPE included hand hygiene, gloves, gowns, and masks. The facility's Hand Hygiene/Handwashing policy, dated 11/28/19, documented hand hygiene was to be performed after removal of medical/surgical or utility gloves, intermittently after gloves were removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients of environments and during moving from a contaminated body site to a clean body site during patient care. These policies were not followed. 1. On 12/11/19 at 8:00 AM, when entering the facility there were signs posted on the front door	F 880	F880E Resident Specific Residents #15, #24 and #57 (who was identified during exit but is not listed on the resident identifiers list) were evaluated with no adverse effect noted related to cited events. Other Residents Rounds were made during cares to validate dirty items were bagged, handwashing completed, personal protective equipment used and isolation signs posted on resident doors as indicated per facility policy with no further findings noted. Facility Systems Nursing staff to include the CNO, Wound Nurse, RN #7 and CNA #16 will be educated by Clinical Resource Nurse and/or designee regarding infection control and facility Transmission-Based Precautions policy to include but not limited to posted precautions signage, staff use of personal protective equipment as indicated, hand hygiene as per policy, bagging of soiled resident items and glove changes with hand hygiene during dressing changes. The system is	

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F 880	Continued From page 227 and at the lobby desk to warn visitors the facility was experiencing a viral gastrointestinal virus and requested visitors come back later to avoid exposure. On 12/11/19 at 8:20 AM, the DON stated there were five residents who were identified as having gastrointestinal symptoms and they resided on one hall. The DON stated all the residents on the one hall were instructed to stay in their rooms for meals. The DON stated one staff member was identified as having the gastrointestinal symptoms and was not at work. The DON stated the five residents who were identified had an isolation caddy hung on their door to alert staff to follow the appropriate PPE precautions. On 12/11/19 at 8:38 AM, an isolation caddy was observed hanging on the backside of Resident #57's open door. There was no sign or direction of what precautions were to be taken. On 12/11/19 at 8:40 AM, the DON was observed entering Resident #57's room with a breakfast tray without applying a gown, gloves, or a mask. The DON exited Resident #57's room and applied hand sanitizer to both hands. On 12/11/19 at 8:46 AM, the DON was observed re-entering Resident #57's room without applying a gown, gloves, or a mask. The DON exited the room applying hand sanitizer to both hands. On 12/11/19 at 8:47 AM, the DON was observed re-entering Resident #57's room without applying a gown, gloves, or mask. The DON exited the room applying hand sanitizer to both hands.	F 880	amended to include infection control and prevention surveillance rounds by the staff development coordinator with staff re-education as needed. Monitoring The Staff Development Coordinator and/or designee will audit residents on enhanced precautions for posted precautions signage, staff use of personal protective equipment as indicated, hand hygiene as per policy, bagging of soiled resident items and glove changes with hand hygiene during dressing changes as per policy 3 times a week for 4 weeks, then twice monthly for 2 months. Starting the week of 2/4/2020 the review will be documented on the PI audit tool. Any concerns will be addressed immediately and discussed with the PI committee. The PI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Completion February 4, 2020	

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F 880	Continued From page 228 On 12/11/19 at 8:48 AM, the DON stated she did not see the isolation caddy on the back of the door. The DON stated there should have been a sign to warn the staff of isolation precautions and the isolation caddy should have been hung up on the front side of the door. 2. Resident #24 was admitted to the facility on 11/3/18, with multiple diagnoses including muscle weakness and cerebral palsy. On 12/9/19 from 1:08 PM to 1:23 PM, Resident #24 was in the Alpine day room watching TV. An oven mitt, with a detachable strap, was on the floor next to her wheelchair. LPN #2 picked up the oven mitt off the floor with her gloved right hand and placed it in Resident #24's lap. LPN #2 did not remove her gloves or perform hand hygiene after picking up the mitt from the floor. LPN #2 and CNA #2 assisted Resident #24 into her room to perform cares. In the room, LPN #2 removed the oven mitt strap with her gloved hands and set the strap on the bedside stand and the oven mitt on the dresser. LPN #2 then picked up a clean mitt from the dresser drawer and set it on the dresser. At 1:14 PM, LPN #2 then assisted CNA #2 to transfer Resident #24 with a Hoyer lift (a mechanical lift) into her bed. LPN #2 assisted CNA #2 to remove and replace Resident #24's incontinent brief. LPN #2 then removed her original gloves and washed her hands in the bathroom sink. LPN #2 then donned new gloves and retrieved a new strap from the dresser and the clean oven mitt off the dresser and placed the mitt on Resident #24's right hand and the strap around her elbow. LPN #2 then lowered the bed with the bed controls, positioned the call light on Resident #24, placed a mat on	F 880		

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F 880	Continued From page 229 the floor, moved the Hoyer lift out of the room, then removed her gloves and used hand sanitizer. On 12/9/19 at 1:24 PM, LPN #2 said she should have placed Resident #24's dirty mitt into a bag to be washed and should have removed her gloves and sanitized her hands. LPN #2 said she should not have touched clean items after she touched dirty items without sanitizing her hands. On 12/11/19 at 3:47 PM, the DON said she expected LPN #2 to not place the dirty oven mitt onto her lap, she expected her to place the dirty mitt into the laundry bag for cleaning. The DON said LPN #2 should have removed her gloves and washed her hands after each encounter with an item that was suspected to be dirty and before she touched a clean item. 3. Resident #15 was readmitted to the facility on 9/6/19, with multiple diagnoses including morbid (severe) obesity and rectal fistula (an abnormal connection between the end of the bowel and the rectum). On 12/8/19 at 10:52 AM, RN #7 and CNA #16 were observed as they provided peri-care to Resident #15. RN #7 and CNA #16 were wearing gloves, RN #7 wiped Resident #15's genitalia and CNA #16 wiped Resident #15's buttocks. RN #7 then removed her gloves and applied new gloves without performing hand hygiene. RN #7 then used wipes to clean Resident #15's body and applied deodorant under his arms. RN #7 then removed her gloves and looked for Resident #15's socks in his drawer. She did not perform hand hygiene after removing her gloves. RN #7	F 880		

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F 880	Continued From page 230 applied new gloves and put the nonskid socks on Resident #15. When RN #7 and CNA #16 finished performing cares to Resident #15, they assisted him to transfer to his power wheelchair using the ceiling Hoyer (a stationary lifting device mounted on a rail system and transfers patients between a bed and a chair or toilet). RN #7 and CNA #16 removed their gloves then performed hand hygiene before leaving Resident #15's room. On 12/10/19 at 10:38 AM, the Wound Nurse was observed as she changed Resident #15's wound dressing. The Wound Nurse wore gloves and removed Resident #15's old dressing and said it was wet. She then wet a 4 x 4 gauze with normal saline and cleansed Resident #15's wound with the same gloves she used to remove the dirty dressing. The Wound Nurse then removed her gloves, performed hand hygiene and applied new gloves. The WCC nurse then covered Resident #15's wound with border dressing and dated it. On 12/10/19 at 10:42 AM, the WCC nurse said she should have change her gloves and performed hand hygiene after she removed Resident #15's old dressing and before cleansing the wound with wet gauze.	F 880		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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March 19, 2020

Royal Jensen, Administrator
Cascadia of Boise
6000 W Denton St
Boise, ID 83704

Provider #: 135146

Dear Mr. Jensen:

On **December 8, 2019**, through **December 13, 2019** an unannounced on-site complaint survey was conducted at Cascadia of Boise. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00008029

Allegation #1: The facility failed to ensure incidents were investigated and residents were free from abuse, neglect, and mistreatment.

Findings #1: During the survey, observations and interviews were conducted and resident records, Incident and Accident reports (I&A), reportable events, grievances, and Resident Council minutes were reviewed with the following results:

Eighteen residents were observed throughout the survey. Multiple staff were observed to interact with residents in a respectful manner and safety devices were observed throughout the facility. Examples included, but were not limited to, the following:

All resident bathrooms were equipped with grab bars. In addition, on 12/8/19 at 10:52 AM, one resident was observed being transferred by a Certified Nursing Assistant (CNA) and a Registered Nurse (RN) using a Hoyer lift (mechanical lift) that was secured to the ceiling. The resident was given instruction and was transferred safely from his bed to his wheelchair. There was no concern noted.

On 12/12/19 at 8:45 AM, a Shower Aide was observed providing a bed bath to a resident. The Shower Aide was talking to the resident as she gave the resident a bed bath and the resident was smiling and conversed with the Shower Aide. Concerns related to abuse were not identified during the observations.

On 12/10/19 at 2:35 PM, 8 residents attended a group interview and no concerns were voiced regarding abuse. Fifteen residents were also interviewed individually throughout the survey. No concerns were voiced regarding abuse.

On 12/11/19 at 10:25 AM, the Administrator was interviewed. The Administrator said if staff witnessed abuse, he/she should intervene, keep the resident safe and report it immediately. The Administrator said if staff suspected abuse, staff were to stop and report all incidents of potential abuse.

Throughout the survey, 6 Certified Nursing Assistants (CNAs), 3 Licensed Practical Nurses (LPNs), and 3 Registered Nurses (RNs) were interviewed. The staff said if they saw abuse or staff threatening residents, they would stop it immediately, make sure the resident was safe, and immediately report it to their supervisor, the Director of Nursing (DON), and/or the Administrator.

Grievances and Resident Council minutes from 11/2018 to 12/2019 were reviewed. Grievances related to abuse were investigated as a reportable event. The facility's I&A reports from 10/2018 to 12/2019 were also reviewed. The I&As included several allegations of abuse involving several residents. All of the allegations had been investigated including, but not limited to, the following:

An I&A, dated 3/4/19, documented an allegation that a staff member had thrown water in a resident's face because the resident did not swallow their medications quickly enough. The accused staff was suspended from working and an investigation was conducted. Upon completion of the investigation, the allegation of physical abuse was unsubstantiated.

An I&A, dated 5/25/19, documented a resident fell out of bed and was incontinent. The facility investigated the incident and added a 1:1 sitter for the resident's safety. No resident neglect related to the incident was identified.

An I&A, dated 10/12/18, alleged that a staff member had put feces in a resident's face, flicked her fingers on the resident's forehead and asked the resident what they were thinking. The I&A also alleged the staff belittled the resident and called the resident a trouble maker. The accused staff was suspended from working and an investigation was conducted. Upon completion of the investigation, the allegation was unsubstantiated and the staff member returned to work. An I&A report documented a resident fell in September of 2019 after walking unobserved from his bed to the bathroom in his room

to use the toilet. The report documented witnesses stated the resident had not pressed the call light to request help. The report documented when found in the bathroom the resident said, "I was told they wanted me to start walking more by myself." Therapists said they worked with the resident, he was not one to walk to the bathroom, he had a history of asking CNAs to assist with his brief change in bed. No resident neglect related to the incident was identified.

An I&A report documented another resident fell in mid-November 2019. The investigation documented the resident rolled out of bed and fell onto the floor. The investigation documented the resident's bed was not in the low position as directed by his Bed Safety Evaluation. A second Post Fall Investigation documented the resident also had an unwitnessed fall in late November 2019. However, there were no new documented interventions on the resident's care plan to prevent further falls. A Post Fall Investigation documented the resident had a third unwitnessed fall in late November 2019, while transferring out of his wheelchair and into the bed. No new interventions were documented on the resident's care plan.

When asked, on 12/10/19 at 10:58 AM, the Unit Manager stated the resident's fall risk score indicated he was a high fall risk. The Unit Manager stated care plan interventions should be completed after each fall.

The resident's record was reviewed. The record included a physician's order, dated 11/25/19, which documented the resident was to have a fall mat to the right side of his bed and a physician's order, dated 12/2/19, documented the resident was to have his bed in the lowest position.

However, on 12/10/19 at 10:07 AM, the resident was observed lying in bed. There was no fall mat on the floor by his bed and the bed was not in the lowest position. On 12/10/19 at 10:56 AM, the Unit Manager stated there was no floor mat in the resident's room and he should have one.

Additionally, an I&A, dated 9/17/19, documented a resident had a bruise of unknown injury reported by facility staff. The injury was investigated and was found to be an underlying clinical condition unrelated to physical abuse. The I&A documented the injury was unsubstantiated for abuse. On 12/10/19 at 12:25 PM, a family member of the resident was interviewed. The family member stated the residents' bruises and skin tears had decreased since a Hoyer Lift was now used to transfer the resident.

However, an I&A, dated 1/27/19, documented a bruise had been found on another resident on 1/27/19. A corresponding nurse's note in the resident's closed record (meaning the resident had been discharged from the facility) documented on 1/27/19 at 5:30 PM, the nurse was called by a CNA to check on the bruise found on the resident's arm. The bruise measured 11 cm x 9 cm, extending down to her right breast measuring 8 cm x 5 cm. The resident denied pain and did not know how it happened.

The I&A report documented that during witness statement collection, the CNA went and looked at the resident's bruise and reported to the nurse she (the CNA) thought the resident's bruise could have happened during the resident's 1/26/19 therapy session with the Physical Therapy Assistant (PTA) when using the Sit to Stand (STS) lift. The I&A report documented the Administrator and the DON were notified and the PTA was suspended from working pending investigation.

The I&A report also documented the PTA was interviewed by the Director of Therapy on 1/28/19 and 2 more staff were interviewed on the same day. The I&A report also documented 5 residents who were under the care of the PTA were interviewed on 1/30/19 and there were no concerns noted.

The PTA's Time Card Report documented the PTA continued to work during the course of the investigation, as follows:

*1/27/19 - In at 9:59 PM and Out at 10:10 PM
*1/28/19 - In at 8:00 AM and Out at 4:00 PM
*1/29/19 - In at 9:15 AM and Out at 6:50 PM
*1/30/19 - In at 9:00 AM and Out at 5:49 PM

The Administrator was interviewed on 12/11/19 at 10:25 AM. The Administrator stated he was the Abuse Coordinator and he enlisted the assistance of the DON, Licensed Social Worker (LSW) and other departmental supervisors in investigating an abuse incident. The Administrator said the alleged perpetrator would be suspended immediately until the abuse was ruled out which could be from an hour to 24 hours or more and they could return to work after it was determined it was not abuse. The Administrator reviewed the PTA's Time Card Report and said PT staff could check in remotely to finish their documentation. The Administrator said the PTA was informed of the incident on Sunday, 1/27/19 and could have written her statement on 1/27/19 between 9:59 PM and 10:10 PM as shown on her Time Card Report. When asked why the PTA was allowed to come back to work on 1/28/19 through 1/30/19 while the investigation was still in progress, the Administrator said he had a conference call with the DON, LSW and the Director of Therapy on the night of 1/27/19 and they determined abuse did not occur based on staff and resident interviews, and the bruise was caused by the sling from the STS lift.

The facility did not ensure the PTA was not allowed to report for work while an investigation of alleged abuse was being conducted.

Additionally, the I&A report documented the staff were given education regarding customer service and abuse training, but there was no documentation that the PTA was evaluated for proper use of the STS lift or provided additional training related to its use.

On 12/10/19 at 9:31 AM, the Director of Therapy said the PTA had chosen to leave the facility about six weeks ago.

It could not be determined that the facility failed to ensure residents were free from abuse and mistreatment. Therefore, the allegation was unsubstantiated. However, it was determined the facility failed to ensure an alleged perpetrator of abuse was not allowed to report for work while an investigation was being conducted and deficient practice was cited at F610. The facility was also cited at F689 related to the facility's failure to ensure residents were protected from falls and that staff had used the STS lift correctly.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility failed to notify the residents' family members or guardians of significant events, including injuries from falls, changes in the residents' conditions and significant medication errors.

Findings #2: The facility's Resident Change of Condition policy, dated 11/28/17, documented the facility was to immediately inform the resident, the physician, and the resident representative when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention; 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); or a need to alter treatment significantly.

Four residents' family members and/or representatives were asked about notification of significant events by the facility and three said they were notified of significant changes. Fifteen residents were also interviewed individually throughout the survey and they said if they wanted, their family members were notified of significant events.

Grievances and Resident Council minutes from 11/2018 to 12/2019 were reviewed. There were no concerns related to the facility not notifying the residents' representatives of significant events, such as a change in the residents' condition.
The facility's I&As from 11/2018 to 12/2019 were also reviewed. The I&As included documentation that the residents' representatives had been notified of various significant events. Examples included, but were not limited to, the following:

An I&A dated, 3/7/19, documented a resident had fallen out of bed at 1:30 AM and sustained a bruise to the forehead. An investigation of the fall documented the resident's family member had been notified of the incident at 7:00 AM.

An I&A, dated 3/23/19, documented a resident had fallen in the bathroom at 10:25 AM. An investigation of the fall included documentation that the resident's family member was notified of the fall.

An I&A, dated 6/4/19, documented a resident had fallen in the dining room at 1:00 PM. An investigation of the fall included documentation that the resident's family member was notified of the fall.

Twenty-eight residents' records, including 3 closed records (meaning the resident had been discharged from the facility) were reviewed. Twenty-three of the 28 records included documentation that the residents' family members and/or representatives had been notified of any change in condition or other significant event the residents had experienced.

However, 1 resident's record included a Medication/Treatment/Lab Error Report, dated 7/9/19 at 7:15 PM, which documented the resident received the wrong medications. The report documented the resident and the resident's physician were notified of the error but documentation that the resident's guardians were notified of the error could not be found.

On 12/10/19 at 3:02 PM, one of the resident's guardians said neither of the resident's guardians were notified of the medication error that occurred on 7/9/19.

It was determined the facility failed to ensure residents were free from medication errors and that a resident's guardians were notified of the significant medication error. Therefore, the allegation was substantiated and deficient practice was cited at F580 and F760.

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

Allegation #3: The facility failed to give the residents' representatives access to the residents' medical records.

Findings #3: On 12/11/19 at 12:46 PM, the Unit Manager (UM) said family representatives could see the resident's record if the resident allowed it. The UM said the resident's representative should fill out a form requesting the resident's record and it would be submitted to the medical records office.

On 12/11/19 at 1:22 PM, a Licensed Practical Nurse (LPN) said she would verify the resident's representative information and if they were authorized to see the resident's record, she would inform her supervisor.

Grievances and Resident Council minutes from 11/2018 to 12/2019 were reviewed. There were no concerns related to the facility denying the residents' representatives accessing to the residents' medical records.

On 12/10/19 at 2:35 PM, 8 residents attended a group interview and no concerns were voiced regarding their representatives being unable to see their records. Additionally, 4 residents' representatives were interviewed and none voiced concern regarding not being allowed to access the residents' record.

It could not be determined that the facility failed to give the residents' representatives access to the residents' medical records. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: 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,

LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/ac

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HEALTH & WELFARE

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March 19, 2020

Royal Jensen, Administrator
Cascadia Of Boise
6000 W Denton St
Boise, ID 83704

Provider #: 135146

Dear Mr. Jensen:

On **December 8, 2019,** through **December 13, 2019**, an unannounced on-site complaint survey was conducted at Cascadia of Boise. The complaint allegations, findings and conclusions are as follows:

Complaint or Entity-Report Incident #ID00008194

Allegation: The facility failed to notify the residents' family members or guardians of significant events, including injuries from falls, changes in the residents' conditions and significant medication errors.

Findings: During the survey, observations and interviews were conducted and resident records, facility policy, Incident and Accident reports (I&A), reportable events, grievances, and Resident Council minutes were reviewed with the following results:

The facility's Resident Change of Condition policy, dated 11/28/17, documented the facility was to immediately inform the resident, the physician, and the resident representative when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention; 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); or a need to alter treatment significantly.

Four residents' family members and/or representatives were asked about notification of significant events by the facility and three said they were notified of significant changes. Fifteen residents were also interviewed individually throughout the survey and they said if they wanted, their family members were notified of significant events.

Grievances and Resident Council minutes from 11/2018 to 12/2019 were reviewed. There were no concerns related to the facility not notifying the residents' representatives of significant events, such as a change in the residents' condition.

The facility's I&As from 11/2018 to 12/2019 were also reviewed. The I&As included documentation that the residents' representatives had been notified of various significant events. Examples included, but were not limited to, the following:

An I&A dated, 3/7/19, documented a resident had fallen out of bed at 1:30 AM and sustained a bruise to the forehead. An investigation of the fall documented the resident's family member had been notified of the incident at 7:00 AM.

An I&A, dated 3/23/19, documented a resident had fallen in the bathroom at 10:25 AM. An investigation of the fall included documentation that the resident's family member was notified of the fall.

An I&A, dated 6/4/19, documented a resident had fallen in the dining room at 1:00 PM. An investigation of the fall included documentation that the resident's family member was notified of the fall.

Twenty-eight residents' records, including 3 closed records (meaning the resident had been discharged from the facility) were reviewed. Twenty-three of the 28 records included documentation that the residents' family members and/or representatives had been notified of any change in condition or other significant event the residents had experienced.

However, 1 resident's record included a Medication/Treatment/Lab Error Report, dated 7/9/19 at 7:15 PM, which documented the resident received the wrong medications. The report documented the resident and the resident's physician were notified of the error but documentation that the resident's guardians were notified of the error could not be found.

On 12/10/19 at 3:02 PM, one of the resident's guardians said neither of the resident's guardians were notified of the medication error that occurred on 7/9/19.

It was determined the facility failed to ensure residents were free from medication errors and that a resident's guardians were notified of the significant medication error. Therefore, the allegation was substantiated and deficient practice was cited at F580 and

F760.
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.

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/ac

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March 24, 2020

Royal Jensen, Administrator
Cascadia of Boise
6000 W Denton St,
Boise, ID 83704

Provider #: 135146

Dear Mr. Jensen:

On **December 8, 2019** through **December 13, 2019**, an unannounced on-site complaint survey was conducted at Cascadia of Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008065

Allegation #1: The facility failed to ensure sufficient numbers of trained staff were present to meet residents' needs.

Findings #1: During the survey, observations and interviews were conducted, and resident records, policies, facility grievances, Incident and Accident reports, and staffing schedules and staff training records were reviewed.

The facility's policy titled Sufficient Qualified Nurse Staffing, dated 11/28/17, stated the facility provided licensed nurses and other nursing personnel to provide nursing care to all residents in accordance with resident care plans. The policy stated nursing and related services were provided to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by their assessments and individual plans of care. The policy also stated these services were provided with consideration to the number, acuity, and diagnoses of the facility's resident population in accordance with the required facility assessment.

The Facility Assessment Tool, dated 7/1/19, documented the facility's staffing plan for nursing care, which included Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs), Nursing Assistants (NAs), and hospitality aides (non-skilled care), was to be at 4.5 to 5.5 hours per resident per day.

The direct care nursing hours worked from 11/17/19 through 12/7/19 were reviewed. The staffing levels did not meet the 4.5 to 5.5 hours planned in the Facility Assessment Tool. The days for which the hours did not meet nursing care were as follows:

Sunday, 11/17/19 - 4.01
Saturday, 11/23/19 - 4.3
Sunday, 11/24/19 - 3.82
Saturday, 11/30/19 - 4.32
Sunday, 12/1/19 - 3.90
Saturday, 12/7/19 - 4.09

On 12/12/19 at 4:38 PM, the Director of Nursing (DON) and the Clinical Resource Nurse were asked if the Facility Assessment included a determination of the level and competency of staff needed to meet each residents' needs each day and during emergencies. The DON said "Yes." Both the DON and the Clinical Resource Nurse said the planned nursing hours per resident per day was 4.5 hours to 5.5 hours. The DON and the Clinical Resource Nurse stated they were not aware the staffing levels for the past three weekends did not meet the planned staffing levels according to the Facility Assessment.

Observations were conducted at various times during all shifts throughout the survey. The residents' need were not observed to be consistently met. Examples included, but were not limited to, the following:

a. On 12/8/19 at 11:52 AM, a resident was in her wheelchair in the unit day room watching television. Her hair was matted and appeared unkempt. She had a non-stained clothing protector around her neck and chest area. She had on a sweater that was stained with streaks of food and excessive oral secretions underneath the clothing protector. The top left of her pants was soiled with food stains, near her hip.

On 12/8/19 at 11:59 AM, an RN assisted the resident to her room and changed her sweater with a new shirt and a new clothing protector. The RN said the stain to her shirt was probably pudding she had eaten earlier in the day. The RN then assisted the resident out of her room. The RN did not attempt to change the resident's pants or brush her matted hair.

b. On 12/8/19 at 1:01 PM, a resident was asked if he was cleaned up quickly when he became soiled (incontinent of stool). The resident shook his head from side to side indicating "no."

On 12/10/19 at 9:08 AM, the resident was in his room lying on his back in bed and there was a strong odor of stool. At 9:08 AM, an Activities Assistant went into the resident's room and delivered a paper for his roommate to read then left the room. At 9:14 AM, a CNA walked by the resident's room, looked in the room then walked away. At 9:18 AM, the CNA again walked by the resident's room, looked in the room then walked away. From 9:21 to 9:37 AM, a CNA and 2 RNs walked by the resident's room without entering although there was a distinct odor of stool in the hallway outside the resident's room.

An alarm sounded from the resident's roommate's ventilator. At 9:40 AM, an RN entered the room, the alarm was then quiet, and the RN exited the room. The odor was still present upon her exit. There continued to be the odor of stool in the hallway outside the resident's room. A CNA and an RN walked by the room without entering from 9:46 to 9:56 AM. At 10:24 AM, the resident was observed crying while lying in his bed. When asked if he had a soiled brief, he nodded his head up and down indicating "yes." When asked if he could reach the call light on his chest, the resident shook his head from side to side indicating "no."

Additionally, during observations on 12/8/19, it was noted an RN was completing tasks which were typically completed by a CNA. On 12/13/19 at 9:45 AM, an RN said there was a staffing problem in the facility that was why she worked as a CNA on 12/8/19. Further, on 12/10/19 at 9:10 AM, a Restorative Nursing Aide (RNA) said he was working as a CNA and said he would not be able to do the RNA program today. When asked who would be doing the RNA program for the residents. the RNA said "Nobody." The RNA said he was pulled to work as a CNA about 4 to 5 times since he started working as an RNA 6 months ago.

Twenty-eight residents' records, including 3 closed records (meaning the residents had been discharged from the facility) were reviewed. Nine of the records, including 1 closed record, documented the residents' required therapy services. Seven of the 9 records included documentation that therapy services had been provided in accordance with the residents' care plan. For example, one resident's closed record documented the resident had received physical therapy (PT) and occupational therapy (OT) during her stay at the facility from 2/7/19 to 3/3/19. Billing for the PT and OT was reviewed, and no irregularities were noted. The resident's record documented she had received range of motion as specified by the physical therapist.

However, the records of 2 residents, who were residing at the facility at the time of the survey, did not include documentation they were receiving restorative therapy as ordered. One resident's record included physician orders, dated 11/26/19, which documented an active order for the resident to receive restorative nursing care and the resident's care plan, dated 9/30/19, documented staff was to monitor the need for consultation, and provide or screen the resident as needed for physical therapy. However, the resident record documented he was removed from physical and occupational therapy on 8/16/19. When asked on 12/8/19 at 10:17 AM, the resident's family member stated the facility no longer offered physical or restorative therapy for him.

On 12/12/19 at 9:30 AM, an RNA stated the resident was not receiving restorative care. The RNA stated the resident was taken off restorative care because he was so stiff it hurt him too much to move. The RNA stated the resident's family member was not notified why the resident was removed from restorative therapy.

Another resident's record included physical therapy treatment encounter notes, dated 11/21/19, which documented an RNA was instructed on range of motion to include bilateral lower extremities, 10 to 15 times for each extremity to increase and maintain the resident's range of motion. When asked on 12/8/19 at 10:33 AM, the resident's family member stated the facility was cutting back on the resident's physical therapy and he (the resident) was declining. The resident's family member stated she saw a decline in the resident's ability to move.

On 12/12/19 at 9:33 AM, an RNA stated the resident was put into the restorative program on 12/9/19 but had not yet received a restorative therapy session, 21 days after the restorative therapy recommendation was made by physical therapy.

Additionally, grievances and Resident Council Meeting minutes from 11/2018 to 12/2019 were reviewed. A grievance dated 5/22/19 documented a water pitcher was not being changed and grievances dated 7/22/19 and 9/26/19 documented concerns regarding meals delivered late. Concerns regarding call lights not being answered in a timely manner and daily living needs not being met, including urinals (plastic urine containers) not being emptied, were found in grievances dated from 11/1/18 to 9/2019 and the Resident Council minutes dated 12/6/18, 8/7/19, 9/4/19, 10/2/19, 11/6/19 and 12/4/19, documented ongoing concerns regarding lengthy call light response times, showers, and dining which were not addressed by the facility.

A resident group interview was conducted with 8 residents on 12/10/19 at 2:35 PM. None of the residents expressed concerns regarding their water pitchers not being filled, but 3 residents said there were still issues with late delivery of meal trays, low food temperatures, slow call light response times and the facility not having enough staff. Five residents also said showers were not being completed, especially on Saturdays. The residents stated these concerns were not addressed by the facility.

Throughout the survey, 15 residents were interviewed individually. On 12/9/19 at 10:39 AM, one resident said he had missed his showers before but after his sister voiced his concern to the facility, he was now receiving his showers three times a week on Mondays, Wednesdays and Fridays, which was consistent with the documentation in the resident's record. The resident and the resident's room were observed to be clean, his urinals were empty, and no unpleasant smell was noted. When asked, the resident said he did not have to wait a long time for his meal trays to be delivered and most of the time he ate his meals in the dining room. At various times throughout the survey, the resident was observed. The resident's 2 water pitchers were observed filled with water and urinals were observed to be empty.

However, during the individual interviews, 3 other residents stated there were not enough staff to meet the residents' toileting needs and showering needs, medications were not administered on time and call lights were not responded to in a timely manner.

Four resident representatives and family members were also interviewed throughout the survey. The representatives and family members expressed concerns related to a lack of staff being available to provide sufficient supervision to residents who wandered, to prevent residents from falling, to ensure residents were provided with meals in a timely manner and to assist residents with their meals, toileting, hygiene, grooming and skin care needs. For example, on 12/10/19 at 3:02 PM, the co-guardians for a resident stated when they went in to visit or take the resident to an appointment, he often had a wet adult brief and the staff were not changing him. One of the guardians stated they had taken the resident to an appointment and at the appointment, a wound was found on his leg. The guardian stated the nurse at the appointment stated the wound should have been identified by the facility and it had been there "for a while." The guardian stated the staff at the facility should have been performing weekly skin checks to identify these types of issues. Additionally, another resident's family member stated she had been concerned with the resident receiving an appropriate diet, assistance with meals, incontinence care, bathing and grooming. The resident's family member stated hospice services had been initiated for the resident and her concerns had decreased since then.

Six CNAs and 3 LPNs were interviewed throughout the survey. The staff stated there were not enough staff to provide the care required and to meet all of the residents' needs. Staff stated several residents required 2-person assistance with transfers, and showers and grooming activities were not completed. Staff also stated there was not enough staff to assist residents during meals.

The records of the 28 residents that were reviewed documented the residents had varied needs requiring extensive staff assistance. For example, 3 residents engaged in wandering behavior requiring increased supervision and no less than 3 residents required increased supervision and assistance related to falls. Additionally, of the 28 residents' records that were reviewed, 13 resident records did not include documentation the residents received care as specified in their care plans. Examples included, but were not limited to, the following:

- A resident's Care Plan, undated, documented the resident was dependent on staff for bathing. He was to be assisted with bathing twice per week and as needed.

The resident's ADL Reports for October, November, and December 2019 documented he did not receive a bath/shower from 10/5/19 to 10/11/19 (6 days), from 10/16/19 to 10/22/19 (6 days), from 10/23/19 to 11/4/19 (11 days), from 11/5/19 to 11/25/19 (20 days), and from 12/7/19 to 12/11/19 (5 days).

On 12/8/19 and on 12/12/19 at 10:25 AM and 8:57 AM respectively, the resident stated the time between showers/baths had gotten longer. He said his regular scheduled shower days were Wednesdays and Saturdays and he said the facility wanted to change his Saturday schedule to a different day and he told them no.

- A resident's Care Plan, dated 11/21/19, documented she was dependent on staff and directed staff to provide assistance with her bathing and personal hygiene.

The resident's ADL Reports for November and December 2019, documented her bathing days were Tuesday and Friday and as needed. The reports documented she was not bathed from 11/20/19 to 11/26/19 (7 days) and from 11/27/19 to 12/3/19 (7 days).

- A resident's Care Plan, revised on 11/18/19, documented he required extensive assistance of 1-2 staff for bathing. The facility's shower schedule documented the resident's shower schedule was Mondays and Thursdays in the morning.

The resident's ADL report for November 2019 and December 2019 documented there were no showers given or offered from 11/6/19 to 11/10/19 (5 days), from 11/12/19 to 11/17/19 (6 days) and from 12/6/19 to 12/10/19 (5 days).

On 12/10/19 at 2:15 PM, the resident stated his last shower was on 12/5/19.

- A resident's Care Plan, dated 11/26/19, directed staff to provide 1-person assistance with bathing.

The resident's ADL Reports for November and December 2019, documented her bathing days were Wednesday and Saturday and as needed. The reports documented she was not bathed from 11/28/19 to 12/2/19 (5 days) and from 12/5/19 to 12/9/19 (5 days).

On 12/8/19 at 11:33 AM, the resident said since she had been admitted to the facility, she had not received her showers as scheduled.

Further, the facility's policy for Nurse Aide Staffing, dated 11/28/17, stated nurse aides were to receive at least 12 hours of in-service training each employment year based on the outcome of the annual performance review and special needs of the resident population and Nurse aides were to demonstrate competency in areas such as communication and personal skills, basic nursing skills, personal care skills, mental health and social service needs, basic restorative services, and Resident Rights.

However, the facility's records did not include documentation that CNAs received the required competency evaluations and completed the required hours of yearly training for 5 of 5 CNAs whose records were reviewed.

On 12/12/19 at 4:38 PM, the DON stated the Staff Development Coordinator was responsible for overseeing nursing competencies. The DON stated nursing staff should be evaluated to assess their competencies, skills, and knowledge "Yearly or if there is a change."
It was determined the facility failed to ensure sufficient numbers of trained staff were provided to meet the residents' needs. Therefore, the allegation was substantiated, and deficient practice was cited at F725 related to the number of staff and F730 related to the lack of staff training and competency evaluations.

The facility was also cited at F550 related to the facility's failure to ensure residents were not left in soiled incontinent briefs for extended periods of time, F585 related to the facility's failure to resolve grievances, F677 related to the facility's failure to ensure bathing and/or grooming, incontinence care, and transfers were provided consistent with residents' needs, F688 related to the facility's failure to increase or prevent a decrease in the residents' range of motion, F804 related to the facility's failure to ensure palatable food was served and F805 related to the facility's failure to ensure residents were provided with a diet that was consistent with physician orders.

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

Allegation #2: Residents are not provided the care and services necessary to prevent the development of pressure ulcers.

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

Six resident records, including 2 closed records, were reviewed for care and services related to pressure ulcer prevention and treatment. The records included documentation of interventions taken for residents who were at risk of developing pressure ulcers. Concerns related to pressure ulcer prevention and treatment were not identified in 4 of the 6 resident records reviewed.

One closed record documented the resident was turned/repositioned as ordered, had a low air loss mattress, and did not have skin breakdown. Documentation of other positioning orders, such as the head of the resident's bed being elevated, was not included in the resident's record.

However, 2 residents' records included documentation that the residents had developed pressure ulcers while residing at the facility. One resident's record included a weekly skin report, dated 10/31/19 at 5:28 PM, which documented the resident had a new pressure ulcer on his right outer ankle which was unstageable and potentially caused by the resident's suprapubic catheter tubing.

On 12/10/19 at 3:30 PM, the DON stated the resident was at a higher risk for development of pressure ulcers with edema (swelling) in their bilateral lower extremities. The DON stated the development of the pressure ulcer on the resident's right outer ankle could have been avoided if the staff had monitored the position of the catheter tubing and the length of time the catheter tubing had been applying pressure to the skin.

Another resident's record included a wound clinic assessment note, dated 12/10/19, which documented a wound to the resident's right heel as an unhealed pressure ulcer. The assessment note stated "Deep Tissue Pressure Injury, persistent non-blanchable deep red, maroon or purple discoloration" measuring 4.2 cm x 1.7 cm x 0. The assessment note did not include information related to when the wound was acquired.

On 12/11/19 at 8:38 AM, the Wound Nurse stated the left ankle pressure ulcer and the deep tissue pressure injury to the resident's right heel developed in the facility.

The resident's record also documented treatment orders for multiple wounds, which were not implemented. The resident's 11/26/19 wound treatment orders, modified the dressing changes and included Santyl (an enzyme used to heal skin ulcers). The orders stated:

* Right and left ankles: Cleanse with normal saline or wound spray, apply skin protectant, apply debriding (removal of dead or infected skin) agent Santyl (an enzyme used to heal skin ulcers) and cover with slightly moist gauze, then cover with dry gauze securing with a cloth tape, change dressing daily and as needed for soiling, saturation, or accidental removal.

* Right buttock: cleanse the wound with normal saline or wound spray and apply skin protectant, it did not include applying a zinc oxide-based cream.

The resident's wound clinic assessment note, dated 12/3/19, documented their buttocks and right ankle wounds had decreased in size, but the left ankle wound had increased in size from 1.5 cm x 1.3 cm x 0.1 cm on 11/19/19 to 1.8 cm x 1.6 cm x 0 cm. The note also documented the left ankle wound had a scant amount of drainage.

The resident's wound clinic assessment note, dated 11/26/19, documented interventions which included repositioning the resident every 2 to 3 hours to alleviate pressure and wearing off-loading boots (Prevalon) to both lower extremities.

Wound clinic treatment orders for the resident, dated 12/3/19, stated to continue the previous wound care recommendations.

The resident's December 2019 TAR (Treatment Administration Record) did not include documentation the 11/26/19 orders were immediately implemented. The December 2019 TAR documented the Santyl start date for the left and right ankles was 12/5/19 (nine days after the 11/26/19 order). The December 2019 TAR documented the dressing changes, also started on 12/5/19, that the dressing were to be changed Monday through Friday, which was not consistent with the 11/26/19 order which stated the dressings were to be changed every day and as needed for soiling, saturation, or accidental removal. The December 2019 TAR did not include documentation that the wound dressings on the resident's left and right ankles were changed on 12/7/19 and 12/8/19. Further, the resident's December 2019 TAR did not include documentation the order for the resident to have bilateral heel protectors while in bed had been implemented until 12/8/19 (twelve days after the 11/26/19 order).

The resident was observed at various times throughout the survey. The resident's wound care orders were not observed to be consistently implemented. Examples included, but were not limited to, the following:

On 12/8/19 at 10:33 AM, the resident was observed lying in bed. The sheets were not covering the resident's legs. A pillow was positioned under each leg, he was not wearing Prevalon boots, and no dressings were observed on the resident's ankle wounds.

On 12/8/19 at 10:56 AM, 11:28 AM, 11:40 AM, and 12:02 PM, the resident's feet were touching the footboard of the bed, he was not wearing Prevalon boots, and there were no dressings observed on the resident's ankle wounds.

On 12/9/19 at 9:32 AM, the resident was lying in bed with his heels resting on pillows. He was not wearing Prevalon boots and there were no dressings observed on the resident's ankle wounds.

On 12/11/19 at 8:24 AM, a UM (Unit Manager) was asked about the resident not having any dressing on his pressure ulcers on 12/8/19 and 12/9/19. He stated if the dressings got wet they were changed and the resident was "very edematous" so the dressings may have slipped off.

It was determined the facility failed to ensure residents were provided with care and services necessary to prevent the development of pressure ulcers. The allegation was substantiated and deficient practice was cited at F686.

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

Allegation #3: The facility failed to notify the residents' family members or guardians of significant events, including injuries from falls, changes in the residents' conditions and significant medication errors.

Findings #3: The facility's Resident Change of Condition policy, dated 11/28/17, documented the facility was to immediately inform the resident, the physician, and the resident representative when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention; 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); or a need to alter treatment significantly.

Four residents' family members and/or representatives were asked about notification of significant events by the facility and three said they were notified of significant changes. Fifteen residents were also interviewed individually throughout the survey and they said if they wanted, their family members were notified of significant events.

Grievances and Resident Council minutes from 11/2018 to 12/2019 were reviewed. There were no concerns related to the facility not notifying the residents' representatives of significant events, such as a change in the residents' condition.

The facility's I&As from 11/2018 to 12/2019 were also reviewed. The I&As included documentation that the residents' representatives had been notified of various significant events. Examples included, but were not limited to, the following:

An I&A dated, 3/7/19, documented a resident had fallen out of bed at 1:30 AM and sustained a bruise to the forehead. An investigation of the fall documented the resident's family member had been notified of the incident at 7:00 AM.

An I&A, dated 3/23/19, documented a resident had fallen in the bathroom at 10:25 AM. An investigation of the fall included documentation that the resident's family member was notified of the fall.

An I&A, dated 6/4/19, documented a resident had fallen in the dining room at 1:00 PM. An investigation of the fall included documentation that the resident's family member was notified of the fall.

Twenty-eight residents' records, including 3 closed records (meaning the resident had been discharged from the facility) were reviewed. Twenty-three of the 28 records included documentation that the residents' family members and/or representatives had been notified of any change in condition or other significant event the residents had experienced.

However, 1 resident's record included a Medication/Treatment/Lab Error Report, dated 7/9/19 at 7:15 PM, which documented the resident received the wrong medications. The report documented the resident and the resident's physician were notified of the error but documentation that the resident's guardians were notified of the error could not be found. On 12/10/19 at 3:02 PM, one of the resident's guardians said neither of the resident's guardians were notified of the medication error that occurred on 7/9/19.

It was determined the facility failed to ensure residents were free from medication errors and that a resident's guardians were notified of the significant medication error. Therefore, the allegation was substantiated and deficient practice was cited at F580 and F760.

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

Allegation #4: Staff do not perform hand hygiene and follow professional standards of practices for infection prevention.

Findings #4: Twenty-eight residents' records, including 3 closed records (meaning the residents had been discharged from the facility) were reviewed. Concerns regarding a lack of appropriate infection control practices were not evident in the residents' records.

Observations of the provision of care were conducted throughout the facility. During the observations of care for 3 residents, staff failed to perform hand hygiene and follow professional standards of practices for infection prevention. Examples included, but were not limited to, the following:

a. On 12/11/19 at 8:00 AM, when entering the facility there were signs posted on the front door and at the lobby desk to warn visitors the facility was experiencing a gastrointestinal virus and requested visitors come back later to avoid exposure.

On 12/11/19 at 8:20 AM, the DON stated there were 5 residents who were identified as having gastrointestinal symptoms and they resided on 1 hall. The DON stated all the residents on the one hall were instructed to stay in their rooms for meals. The DON stated 1 staff member was identified as having the gastrointestinal symptoms and was not at work. The DON stated the 5 residents who were identified had an isolation caddy hung on their door to alert staff to follow the appropriate Personal Protective Equipment (PPE) precautions.

On 12/11/19 at 8:38 AM, an isolation caddy was observed hanging on the backside of a resident's open door. There was no sign or direction of what precautions were to be taken.

On 12/11/19 at 8:40 AM, the DON was observed entering the resident's room with a breakfast tray without applying a gown, gloves, or a mask. The DON exited the resident's room and applied hand sanitizer to both hands.

On 12/11/19 at 8:46 AM, the DON was observed re-entering Resident #57's room without applying a gown, gloves, or a mask. The DON exited the room applying hand sanitizer to both hands.
On 12/11/19 at 8:48 AM, the DON stated she did not see the isolation caddy on the back of the door. The DON stated there should have been a sign to warn the staff of isolation precautions and the isolation caddy should have been hung up on the front side of the door.

b. On 12/8/19 at 10:52 AM, an RN and a CNA were observed as they provided peri-care to a resident. The RN and the CNA were wearing gloves, the RN wiped the resident's genitalia and the CNA wiped the resident's buttocks. The RN then removed her gloves and applied new gloves without performing hand hygiene. The RN then used wipes to clean the resident's body and applied deodorant under his arms. The RN then removed her gloves and looked for the resident's socks in his drawer. The RN did not perform hand hygiene after removing her gloves. The RN applied new gloves and put nonskid socks on the resident. When the RN and the CNA finished performing cares for the resident, they assisted him to transfer to his power wheelchair using the ceiling Hoyer (a stationary lifting device mounted on a rail system that transfers patients between a bed and a chair or toilet). The RN and the CNA then removed their gloves then performed hand hygiene before leaving the resident's room.

c. On 12/9/19 from 1:08 to 1:23 PM, a resident was observed in the day room watching TV. An oven mitt, with a detachable strap, was on the floor next to the resident's wheelchair. An LPN picked the oven mitt up off of the floor with her gloved right hand and placed it in the resident's lap. The LPN did not remove her gloves or perform hand hygiene after picking up the mitt from the floor.

On 12/9/19 at 1:24 PM, the LPN said she should have placed the resident's dirty mitt into a bag to be washed and should have removed her gloves and sanitized her hands.

It was determined the facility failed to ensure staff performed hand hygiene and followed professional standards of practices for infection prevention. Therefore the allegatioon was substantiated and deficient practice was cited at F880.

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.

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/ac

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HEALTH & WELFARE

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March 24, 2020

Royal Jensen, Administrator
Cascadia of Boise
6000 W Denton St,
Boise, ID 83704

Provider #: 135146

Dear Mr. Jensen:

On **December 8, 2019** through **December 13, 2019**, an unannounced on-site complaint survey was conducted at Cascadia of Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008128

Allegation #1: The facility failed to ensure incidents were investigated and residents were free from abuse, neglect, and mistreatment.

Findings #1: An unannounced, onsite recertification and complaint survey was conducted from 12/8/19 to 12/13/19. During the survey, observations and interviews were conducted and resident records, Incident and Accident reports (I&A), reportable events, grievances, and Resident Council minutes were reviewed with the following results:

Eighteen residents were observed throughout the survey. Multiple staff were observed to interact with residents in a respectful manner and safety devices were observed throughout the facility. Examples included, but were not limited to, the following:

All resident bathrooms were equipped with grab bars. In addition, on 12/8/19 at 10:52 AM, one resident was observed being transferred by a Certified Nursing Assistant (CNA) and a Registered Nurse (RN) using a Hoyer lift (mechanical lift) that was secured to the ceiling. The resident was given instruction and was transferred safely from his bed to his wheelchair. There was no concern noted.

On 12/12/19 at 8:45 AM, a Shower Aide was observed providing a bed bath to a resident. The Shower Aide was talking to the resident as she gave the resident a bed bath and the resident was smiling and conversed with the Shower Aide. Concerns related to abuse were not identified during the observations.

On 12/10/19 at 2:35 PM, 8 residents attended a group interview and no concerns were voiced regarding abuse. Fifteen residents were also interviewed individually throughout the survey. No concerns were voiced regarding abuse.

On 12/11/19 at 10:25 AM, the Administrator was interviewed. The Administrator said if staff witnessed abuse, he/she should intervene, keep the resident safe and report it immediately. The Administrator said if staff suspected abuse, staff were to stop and report all incidents of potential abuse.

Throughout the survey, 6 Certified Nursing Assistants (CNAs), 3 Licensed Practical Nurses (LPNs), and 3 Registered Nurses (RNs) were interviewed. The staff said if they saw abuse or staff threatening residents, they would stop it immediately, make sure the resident was safe, and immediately report it to their supervisor, the Director of Nursing (DON), and/or the Administrator.

Grievances and Resident Council minutes from 11/2018 to 12/2019 were reviewed. Grievances related to abuse were investigated as a reportable event. The facility's I&A reports from 10/2018 to 12/2019 were also reviewed. The I&As included several allegations of abuse involving several residents. All of the allegations had been investigated including, but not limited to, the following:

An I&A, dated 3/4/19, documented an allegation that a staff member had thrown water in a resident's face because the resident did not swallow their medications quickly enough. The accused staff was suspended from working and an investigation was conducted. Upon completion of the investigation, the allegation of physical abuse was unsubstantiated.

An I&A, dated 5/25/19, documented a resident fell out of bed and was incontinent. The facility investigated the incident and added a 1:1 sitter for the resident's safety. No resident neglect related to the incident was identified.

An I&A, dated 10/12/18, alleged that a staff member had put feces in a resident's face, flicked her fingers on the resident's forehead and asked the resident what they were thinking. The I&A also alleged the staff belittled the resident and called the resident a trouble maker. The accused staff was suspended from working and an investigation was conducted. Upon completion of the investigation, the allegation was unsubstantiated and the staff member returned to work.

An I&A report documented a resident fell in September of 2019 after walking unobserved from his bed to the bathroom in his room to use the toilet. The report documented witnesses stated the resident had not pressed the call light to request help. The report documented when found in the bathroom the resident said, "I was told they wanted me to start walking more by myself."

Therapists said they worked with the resident, he was not one to walk to the bathroom, he had a history of asking CNAs to assist with his brief change in bed. No resident neglect related to the incident was identified.

An I&A report documented another resident fell in mid-November 2019. The investigation documented the resident rolled out of bed and fell onto the floor. The investigation documented the resident's bed was not in the low position as directed by his Bed Safety Evaluation. A second Post Fall Investigation documented the resident also had an unwitnessed fall in late November 2019. However, there were no new documented interventions on the resident's care plan to prevent further falls. A Post Fall Investigation documented the resident had a third unwitnessed fall in late November 2019, while transferring out of his wheelchair and into the bed. No new interventions were documented on the resident's care plan.

When asked, on 12/10/19 at 10:58 AM, the Unit Manager stated the resident's fall risk score indicated he was a high fall risk. The Unit Manager stated care plan interventions should be completed after each fall.

The resident's record was reviewed. The record included a physician's order, dated 11/25/19, which documented the resident was to have a fall mat to the right side of his bed and a physician's order, dated 12/2/19, documented the resident was to have his bed in the lowest position.

However, on 12/10/19 at 10:07 AM, the resident was observed lying in bed. There was no fall mat on the floor by his bed and the bed was not in the lowest position. On 12/10/19 at 10:56 AM, the Unit Manager stated there was no floor mat in the resident's room and he should have one.

Additionally, an I&A, dated 9/17/19, documented a resident had a bruise of unknown injury reported by facility staff. The injury was investigated and was found to be an underlying clinical condition unrelated to physical abuse. The I&A documented the injury was unsubstantiated for abuse. On 12/10/19 at 12:25 PM, a family member of the resident was interviewed. The family member stated the residents' bruises and skin tears had decreased since a Hoyer Lift was now used to transfer the resident.

However, an I&A, dated 1/27/19, documented a bruise had been found on another resident on 1/27/19. A corresponding nurse's note in the resident's closed record (meaning the resident had been discharged from the facility) documented on 1/27/19 at 5:30 PM, the nurse was called by a CNA to check on the bruise found on the resident's arm. The bruise measured 11 cm x 9 cm, extending down to her right breast measuring 8 cm x 5 cm. The resident denied pain and did not know how it happened.

The I&A report documented that during witness statement collection, the CNA went and looked at the resident's bruise and reported to the nurse she (the CNA) thought the resident's bruise could have happened during the resident's 1/26/19 therapy session with the Physical Therapy Assistant (PTA) when using the Sit to Stand (STS) lift. The I&A report documented the Administrator and the DON were notified and the PTA was suspended from working pending investigation.

The I&A report also documented the PTA was interviewed by the Director of Therapy on 1/28/19 and 2 more staff were interviewed on the same day. The I&A report also documented 5 residents who were under the care of the PTA were interviewed on 1/30/19 and there were no concerns noted.

The PTA's Time Card Report documented the PTA continued to work during the course of the investigation, as follows:

*1/27/19 - In at 9:59 PM and Out at 10:10 PM
*1/28/19 - In at 8:00 AM and Out at 4:00 PM
*1/29/19 - In at 9:15 AM and Out at 6:50 PM
*1/30/19 - In at 9:00 AM and Out at 5:49 PM

The Administrator was interviewed on 12/11/19 at 10:25 AM. The Administrator stated he was the Abuse Coordinator and he enlisted the assistance of the DON, Licensed Social Worker (LSW) and other departmental supervisors in investigating an abuse incident. The Administrator said the alleged perpetrator would be suspended immediately until the abuse was ruled out which could be from an hour to 24 hours or more and they could return to work after it was determined it was not abuse. The Administrator reviewed the PTA's Time Card Report and said PT staff could check in remotely to finish their documentation. The Administrator said the PTA was informed of the incident on Sunday, 1/27/19 and could have written her statement on 1/27/19 between 9:59 PM and 10:10 PM as shown on her Time Card Report. When asked why the PTA was allowed to come back to work on 1/28/19 through 1/30/19 while the investigation was still in progress, the Administrator said he had a conference call with the DON, LSW and the Director of Therapy on the night of 1/27/19 and they determined abuse did not occur based on staff and resident interviews, and the bruise was caused by the sling from the STS lift.

The facility did not ensure the PTA was not allowed to report for work while an investigation of alleged abuse was being conducted.

Additionally, the I&A report documented the staff were given education regarding customer service and abuse training, but there was no documentation that the PTA was evaluated for proper use of the STS lift or provided additional training related to its use.

On 12/10/19 at 9:31 AM, the Director of Therapy said the PTA had chosen to leave the facility about six weeks ago.

It could not be determined that the facility failed to ensure residents were free from abuse and mistreatment. Therefore, the allegation was unsubstantiated. However, it was determined the facility failed to ensure an alleged perpetrator of abuse was not allowed to report for work while an investigation was being conducted and deficient practice was cited at F610. The facility was also cited at F689 related to the facility's failure to ensure residents were protected from falls and that staff had used the STS lift correctly.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility failed to ensure sufficient numbers of trained staff were present to meet residents' needs.

Findings #2: The facility's policy titled Sufficient Qualified Nurse Staffing, dated 11/28/17, stated the facility provided licensed nurses and other nursing personnel to provide nursing care to all residents in accordance with resident care plans. The policy stated nursing and related services were provided to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by their assessments and individual plans of care. The policy also stated these services were provided with consideration to the number, acuity, and diagnoses of the facility's resident population in accordance with the required facility assessment.

The Facility Assessment Tool, dated 7/1/19, documented the facility's staffing plan for nursing care, which included Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs), Nursing Assistants (NAs), and hospitality aides (non-skilled care), was to be at 4.5 to 5.5 hours per resident per day.

The direct care nursing hours worked from 11/17/19 through 12/7/19 were reviewed. The staffing levels did not meet the 4.5 to 5.5 hours planned in the Facility Assessment Tool. The days for which the hours did not meet nursing care were as follows:

Sunday, 11/17/19 - 4.01
Saturday, 11/23/19 - 4.3
Sunday, 11/24/19 - 3.82
Saturday, 11/30/19 - 4.32
Sunday, 12/1/19 - 3.90
Saturday, 12/7/19 - 4.09

On 12/12/19 at 4:38 PM, the Director of Nursing (DON) and the Clinical Resource Nurse were asked if the Facility Assessment included a determination of the level and competency of staff needed to meet each residents' needs each day and during emergencies. The DON said "Yes." Both the DON and the Clinical Resource Nurse said the planned nursing hours per resident per day was 4.5 hours to 5.5 hours. The DON and the Clinical Resource Nurse stated they were not aware the staffing levels for the past three weekends did not meet the planned staffing levels according to the Facility Assessment.

Observations were conducted at various times during all shifts throughout the survey. The residents' need were not observed to be consistently met. Examples included, but were not limited to, the following:

a. On 12/8/19 at 11:52 AM, a resident was in her wheelchair in the unit day room watching television. Her hair was matted and appeared unkempt. She had a non-stained clothing protector around her neck and chest area. She had on a sweater that was stained with streaks of

food and excessive oral secretions underneath the clothing protector. The top left of her pants was soiled with food stains, near her hip.

On 12/8/19 at 11:59 AM, an RN assisted the resident to her room and changed her sweater with a new shirt and a new clothing protector. The RN said the stain to her shirt was probably pudding she had eaten earlier in the day. The RN then assisted the resident out of her room. The RN did not attempt to change the resident's pants or brush her matted hair.

b. On 12/8/19 at 1:01 PM, a resident was asked if he was cleaned up quickly when he became soiled (incontinent of stool). The resident shook his head from side to side indicating "no."

On 12/10/19 at 9:08 AM, the resident was in his room lying on his back in bed and there was a strong odor of stool. At 9:08 AM, an Activities Assistant went into the resident's room and delivered a paper for his roommate to read then left the room. At 9:14 AM, a CNA walked by the resident's room, looked in the room then walked away. At 9:18 AM, the CNA again walked by the resident's room, looked in the room then walked away. From 9:21 to 9:37 AM, a CNA and 2 RNs walked by the resident's room without entering although there was a distinct odor of stool in the hallway outside the resident's room.

An alarm sounded from the resident's roommate's ventilator. At 9:40 AM, an RN entered the room, the alarm was then quiet, and the RN exited the room. The odor was still present upon her exit. There continued to be the odor of stool in the hallway outside the resident's room. A CNA and an RN walked by the room without entering from 9:46 to 9:56 AM. At 10:24 AM, the resident was observed crying while lying in his bed. When asked if he had a soiled brief, he nodded his head up and down indicating "yes." When asked if he could reach the call light on his chest, the resident shook his head from side to side indicating "no."

Additionally, during observations on 12/8/19, it was noted an RN was completing tasks which were typically completed by a CNA. On 12/13/19 at 9:45 AM, an RN said there was a staffing problem in the facility that was why she worked as a CNA on 12/8/19. Further, on 12/10/19 at 9:10 AM, a Restorative Nursing Aide (RNA) said he was working as a CNA and said he would not be able to do the RNA program today. When asked who would be doing the RNA program for the residents. the RNA said "Nobody." The RNA said he was pulled to work as a CNA about 4 to 5 times since he started working as an RNA 6 months ago.

Twenty-eight residents' records, including 3 closed records (meaning the residents had been discharged from the facility) were reviewed. Nine of the records, including 1 closed record, documented the residents' required therapy services. Seven of the 9 records included documentation that therapy services had been provided in accordance with the residents' care plan. For example, one resident's closed record documented the resident had received physical therapy (PT) and occupational therapy (OT) during her stay at the facility from 2/7/19 to 3/3/19. Billing for the PT and OT was reviewed, and no irregularities were noted. The resident's record documented she had received range of motion as specified by the physical therapist.

However, the records of 2 residents, who were residing at the facility at the time of the survey, did not include documentation they were receiving restorative therapy as ordered. One resident's record included physician orders, dated 11/26/19, which documented an active order for the resident to receive restorative nursing care and the resident's care plan, dated 9/30/19, documented staff was to monitor the need for consultation, and provide or screen the resident as needed for physical therapy. However, the resident record documented he was removed from physical and occupational therapy on 8/16/19. When asked on 12/8/19 at 10:17 AM, the resident's family member stated the facility no longer offered physical or restorative therapy for him.

On 12/12/19 at 9:30 AM, an RNA stated the resident was not receiving restorative care. The RNA stated the resident was taken off restorative care because he was so stiff it hurt him too much to move. The RNA stated the resident's family member was not notified why the resident was removed from restorative therapy.

Another resident's record included physical therapy treatment encounter notes, dated 11/21/19, which documented an RNA was instructed on range of motion to include bilateral lower extremities, 10 to 15 times for each extremity to increase and maintain the resident's range of motion. When asked on 12/8/19 at 10:33 AM, the resident's family member stated the facility was cutting back on the resident's physical therapy and he (the resident) was declining. The resident's family member stated she saw a decline in the resident's ability to move.

On 12/12/19 at 9:33 AM, an RNA stated the resident was put into the restorative program on 12/9/19 but had not yet received a restorative therapy session, 21 days after the restorative therapy recommendation was made by physical therapy.

Additionally, grievances and Resident Council Meeting minutes from 11/2018 to 12/2019 were reviewed. A grievance dated 5/22/19 documented a water pitcher was not being changed and grievances dated 7/22/19 and 9/26/19 documented concerns regarding meals delivered late. Concerns regarding call lights not being answered in a timely manner and daily living needs not being met, including urinals (plastic urine containers) not being emptied, were found in grievances dated from 11/1/18 to 9/2019 and the Resident Council minutes dated 12/6/18, 8/7/19, 9/4/19, 10/2/19, 11/6/19 and 12/4/19, documented ongoing concerns regarding lengthy call light response times, showers, and dining which were not addressed by the facility.

A resident group interview was conducted with 8 residents on 12/10/19 at 2:35 PM. None of the residents expressed concerns regarding their water pitchers not being filled, but 3 residents said there were still issues with late delivery of meal trays, low food temperatures, slow call light response times and the facility not having enough staff. Five residents also said showers were not being completed, especially on Saturdays. The residents stated these concerns were not addressed by the facility.

Throughout the survey, 15 residents were interviewed individually. On 12/9/19 at 10:39 AM, one resident said he had missed his showers before but after his sister voiced his concern to the facility, he was now receiving his showers three times a week on Mondays, Wednesdays and

Fridays, which was consistent with the documentation in the resident's record. The resident and the resident's room were observed to be clean, his urinals were empty, and no unpleasant smell was noted. When asked, the resident said he did not have to wait a long time for his meal trays to be delivered and most of the time he ate his meals in the dining room. At various times throughout the survey, the resident was observed. The resident's 2 water pitchers were observed filled with water and urinals were observed to be empty.

However, during the individual interviews, 3 other residents stated there were not enough staff to meet the residents' toileting needs and showering needs, medications were not administered on time and call lights were not responded to in a timely manner.
Four resident representatives and family members were also interviewed throughout the survey. The representatives and family members expressed concerns related to a lack of staff being available to provide sufficient supervision to residents who wandered, to prevent residents from falling, to ensure residents were provided with meals in a timely manner and to assist residents with their meals, toileting, hygiene, grooming and skin care needs. For example, on 12/10/19 at 3:02 PM, the co-guardians for a resident stated when they went in to visit or take the resident to an appointment, he often had a wet adult brief and the staff were not changing him. One of the guardians stated they had taken the resident to an appointment and at the appointment, a wound was found on his leg. The guardian stated the nurse at the appointment stated the wound should have been identified by the facility and it had been there "for a while." The guardian stated the staff at the facility should have been performing weekly skin checks to identify these types of issues. Additionally, another resident's family member stated she had been concerned with the resident receiving an appropriate diet, assistance with meals, incontinence care, bathing and grooming. The resident's family member stated hospice services had been initiated for the resident and her concerns had decreased since then.

Six CNAs and 3 LPNs were interviewed throughout the survey. The staff stated there were not enough staff to provide the care required and to meet all of the residents' needs. Staff stated several residents required 2-person assistance with transfers, and showers and grooming activities were not completed. Staff also stated there was not enough staff to assist residents during meals.

The records of the 28 residents that were reviewed documented the residents had varied needs requiring extensive staff assistance. For example, 3 residents engaged in wandering behavior requiring increased supervision and no less than 3 residents required increased supervision and assistance related to falls. Additionally, of the 28 residents' records that were reviewed, 13 resident records did not include documentation the residents received care as specified in their care plans. Examples included, but were not limited to, the following:

- A resident's Care Plan, undated, documented the resident was dependent on staff for bathing. He was to be assisted with bathing twice per week and as needed.

The resident's ADL Reports for October, November, and December 2019 documented he did not receive a bath/shower from 10/5/19 to 10/11/19 (6 days), from 10/16/19 to 10/22/19 (6 days), from 10/23/19 to 11/4/19 (11 days), from 11/5/19 to 11/25/19 (20 days), and from 12/7/19 to 12/11/19 (5 days).

On 12/8/19 and on 12/12/19 at 10:25 AM and 8:57 AM respectively, the resident stated the time between showers/baths had gotten longer. He said his regular scheduled shower days were Wednesdays and Saturdays and he said the facility wanted to change his Saturday schedule to a different day and he told them no.

- A resident's Care Plan, dated 11/21/19, documented she was dependent on staff and directed staff to provide assistance with her bathing and personal hygiene.

The resident's ADL Reports for November and December 2019, documented her bathing days were Tuesday and Friday and as needed. The reports documented she was not bathed from 11/20/19 to 11/26/19 (7 days) and from 11/27/19 to 12/3/19 (7 days).

- A resident's Care Plan, revised on 11/18/19, documented he required extensive assistance of 1-2 staff for bathing. The facility's shower schedule documented the resident's shower schedule was Mondays and Thursdays in the morning.

The resident's ADL report for November 2019 and December 2019 documented there were no showers given or offered from 11/6/19 to 11/10/19 (5 days), from 11/12/19 to 11/17/19 (6 days) and from 12/6/19 to 12/10/19 (5 days).

On 12/10/19 at 2:15 PM, the resident stated his last shower was on 12/5/19.

- A resident's Care Plan, dated 11/26/19, directed staff to provide 1-person assistance with bathing.

The resident's ADL Reports for November and December 2019, documented her bathing days were Wednesday and Saturday and as needed. The reports documented she was not bathed from 11/28/19 to 12/2/19 (5 days) and from 12/5/19 to 12/9/19 (5 days).

On 12/8/19 at 11:33 AM, the resident said since she had been admitted to the facility, she had not received her showers as scheduled.

Further, the facility's policy for Nurse Aide Staffing, dated 11/28/17, stated nurse aides were to receive at least 12 hours of in-service training each employment year based on the outcome of the annual performance review and special needs of the resident population and Nurse aides were to demonstrate competency in areas such as communication and personal skills, basic nursing skills, personal care skills, mental health and social service needs, basic restorative services, and Resident Rights.

However, the facility's records did not include documentation that CNAs received the required competency evaluations and completed the required hours of yearly training for 5 of 5 CNAs whose records were reviewed.

On 12/12/19 at 4:38 PM, the DON stated the Staff Development Coordinator was responsible for overseeing nursing competencies. The DON stated nursing staff should be evaluated to assess their competencies, skills, and knowledge "Yearly or if there is a change."

It was determined the facility failed to ensure sufficient numbers of trained staff were provided to meet the residents' needs. Therefore, the allegation was substantiated, and deficient practice was cited at F725 related to the number of staff and F730 related to the lack of staff training and competency evaluations. The facility was also cited at F550 related to the facility's failure to ensure residents were not left in soiled incontinent briefs for extended periods of time, F585 related to the facility's failure to resolve grievances, F677 related to the facility's failure to ensure bathing and/or grooming, incontinence care, and transfers were provided consistent with residents' needs, F688 related to the facility's failure to increase or prevent a decrease in the residents' range of motion, F804 related to the facility's failure to ensure palatable food was served and F805 related to the facility's failure to ensure residents were provided with a diet that was consistent with physician orders.

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

Allegation #3: The facility did not provide discharge notices.

Findings #3: Five resident records were reviewed for discharge notices. One of the 5 records reviewed documented a written discharge summary had been given to the resident's family during a meeting in the facility in the first part of August 2019. The resident had been admitted for therapy services and not for a long term stay. The summary included a 30 day notice and detailed multiple reasons the facility was not able to provide the care the resident required. The Resident Services person had provided helpful information in the summary to benefit the resident's family in finding a facility that could provide the care required by the resident.

Four of the records did not include documentation that a written notice had been provided to the residents and the residents' representatives prior to the residents being transferred to the hospital and that a copy of the written transfer/discharge notice was sent to the State Ombudsman. Examples included, but were not limited to, the following:

A resident's record documented he was discharged to a hospital on 12/9/19. His record did not include documentation that a written transfer/discharge notice had been provided to the resident and his family representative.

On 12/11/19 at 3:31 PM, the DON stated the resident's record did not include documentation a written notice was provided to the resident and his family representative at the time of his transfer to the hospital.

A resident's record documented he was discharged to a hospital on 9/1/19. His record did not include documentation that a written transfer/discharge notice was sent to the Ombudsman.

On 12/13/19 at 9:46 AM, the Admission/Discharge Nurse said she was made aware she needed to send a list of their discharges to the Ombudsman about two days ago.

It was determined the facility failed to ensure written notice had been provided to the residents and the residents' representatives prior to the residents being transferred to the hospital and that a copy of the written transfer/discharge notice was sent to the State Ombudsman. Therefore, the allegation was substantiated and deficient practice was cited at F623.

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

Allegation #4: The facility does not protect the residents' rights to privacy.

Findings #4: Twenty-eight residents' records, including 3 closed records (meaning the residents had been discharged from the facility) were reviewed. Concerns related to resident privacy or confidentiality of records were not identified.

Eighteen residents were observed throughout the survey. Multiple staff were observed to interact with residents in a respectful manner and the residents' private information was not noted to be discussed in the presence of others. However, during the observations on 12/8/19 at 12:35 PM and on 12/10/19 at 8:33 AM, one resident, was observed in the dining room in her wheelchair. The resident had a yellow bracelet on her right wrist which had the words "FALL RISK" imprinted on it.

On 12/10/19 at 9:39 AM, the resident said she did not know why she had the "FALL RISK" bracelet on.

On 12/10/19 at 1:39 PM, a nurse said the resident had a history of falling and she had the bracelet on her wrist for at least three or four weeks. The nurse said she (the nurse) was not sure where the bracelet came from since the facility did not use them.

On 12/11/19 at 3:35 PM, the resident was in her bed with the yellow bracelet on her wrist.

On 12/11/19 at 3:39 PM, a hospice nurse said the resident was at risk for falling. She said the hospice provider did not use fall risk bracelets and said she thought the facility had placed the bracelet on the resident's wrist.

On 12/11/19 at 3:42 PM, the DON said the facility did not use fall risk bracelets and expected staff to remove them if residents had them on.

It was determined the facility failed to ensure the resident's right to privacy was upheld. Therefore, the allegation was substantiated and deficient practice was cited at F583.

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

Allegation #5: The facility failed to obtain consent for treatment from the legally authorized person.

Findings #5: Twenty-eight residents' records, including 3 closed records (meaning the residents had been discharged from the facility) were reviewed. One resident's record included a "Letter of Co-Guarding" which documented two people were duly appointed and qualified as Co-Guardians for the resident on 6/14/18. The letter documented the resident was an incapacitated and protected person.

The resident's Care Plan, revised on 8/5/19, documented the resident had impaired cognitive function with impaired thought processes related to impaired decision making due to traumatic brain injury. The goals included communicating with family regarding his capabilities and needs. The care plan interventions included the resident communicating his basic needs, remaining oriented to person, place, situation, and time, and maintaining his current level of cognitive function.

The resident's record included a behavior progress note, dated 7/31/19 at 10:40 AM, which stated on 7/29/19 the resident was observed acting out of the ordinary from his baseline. A CNA asked the resident what was wrong, and he informed the CNA that his caregiver, hired by his family for socialization, had given him a marijuana brownie. The physician was informed, and an order was written for a urine drug screen. The note documented the resident's family was informed of the situation also.

A physician's order, dated 7/31/19 at 4:30 PM, documented "Urine drug/tox (###) screen. One time only for Urine lab for 1 Day."

A progress note, dated 8/2/19 at 8:26 PM, documented urine needed to be collected for a drug/toxicity screen on 7/31/19. The note stated the resident was refusing to use his urinal and was incontinent of urine and this was reported to the nurse practitioner on call and an order was received to use a straight catheter to obtain the urine sample if the resident allowed. The note documented the resident refused the straight catheter and the nurse practitioner was informed.

A nurse's progress note, dated 8/3/19 at 5:56 AM, documented two nurses and a CNA approached the resident and asked him if he would consent to a urine laboratory test ordered by a physician. They told him they would obtain the urine by a straight catheter. The resident agreed to obtaining the urine for the laboratory test. Two nurses and two CNAs obtained the urine sample using a straight catheter.

On 12/10/19 at 9:50 AM, on of the resident's co-guardians stated after telling the facility not to do a laboratory test for the resident, the facility went ahead and did the laboratory test anyway without permission from the guardian. The family member stated there was no need for the test and he had told them that.

On 12/12/19 at 3:21 PM, the DON was interviewed regarding the urinalysis obtained without the guardian's permission. The DON said one guardian had returned after the other guardian had left and said it was okay to do the urinalysis. The DON was asked where it was documented that the one guardian had given permission. The DON looked in the notes and stated, "I guess no one documented it."

On 12/12/19 at 3:25 PM, the Administrator was interviewed regarding the court appointed co-guardians of the resident. The Administrator was asked if the co-guardians were to decide on the resident's medical care and treatments. The Administrator said the guardians had been appointed by the court to oversee the resident in everything but his housing. The housing where the resident was placed was the only thing they both had to agree upon.

It was determined the facility failed to ensure consent was obtained from both legally authorized parties prior to the urine sample being collected and tested. Therefore, the allegation was substantiated and deficient practice was cited at F552.

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.

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/ac

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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March 19, 2020

Royal Jensen, Administrator
Cascadia of Boise
6000 W Denton St
Boise, ID 83704

Provider #: 135146

Dear Mr. Jensen:

On **December 8, 2019,** through **December 13, 2019**, an unannounced on-site complaint survey was conducted at Cascadia of Boise. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00008162

Allegation #1: The facility failed to ensure sufficient numbers of trained staff were present to meet residents' needs.

Findings #1: During the survey, observations and interviews were conducted, and resident records, policies, facility grievances, Incident and Accident reports, and staffing schedules and staff training records were reviewed.

The facility's policy titled Sufficient Qualified Nurse Staffing, dated 11/28/17, stated the facility provided licensed nurses and other nursing personnel to provide nursing care to all residents in accordance with resident care plans. The policy stated nursing and related services were provided to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by their assessments and individual plans of care. The policy also stated these services were provided with consideration to the number, acuity, and diagnoses of the facility's resident population in accordance with the required facility assessment.

The Facility Assessment Tool, dated 7/1/19, documented the facility's staffing plan for nursing care, which included Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs), Nursing Assistants (NAs), and hospitality aides (non-skilled care), was to be at 4.5 to 5.5 hours per resident per day.

The direct care nursing hours worked from 11/17/19 through 12/7/19 were reviewed. The staffing levels did not meet the 4.5 to 5.5 hours planned in the Facility Assessment Tool. The days for which the hours did not meet nursing care were as follows:

Sunday, 11/17/19 - 4.01
Saturday, 11/23/19 - 4.3
Sunday, 11/24/19 - 3.82
Saturday, 11/30/19 - 4.32
Sunday, 12/1/19 - 3.90
Saturday, 12/7/19 - 4.09

On 12/12/19 at 4:38 PM, the Director of Nursing (DON) and the Clinical Resource Nurse were asked if the Facility Assessment included a determination of the level and competency of staff needed to meet each residents' needs each day and during emergencies. The DON said "Yes." Both the DON and the Clinical Resource Nurse said the planned nursing hours per resident per day was 4.5 hours to 5.5 hours. The DON and the Clinical Resource Nurse stated they were not aware the staffing levels for the past three weekends did not meet the planned staffing levels according to the Facility Assessment.

Observations were conducted at various times during all shifts throughout the survey. The residents' need were not observed to be consistently met. Examples included, but were not limited to, the following:

a. On 12/8/19 at 11:52 AM, a resident was in her wheelchair in the unit day room watching television. Her hair was matted and appeared unkempt. She had a non-stained clothing protector around her neck and chest area. She had on a sweater that was stained with streaks of food and excessive oral secretions underneath the clothing protector. The top left of her pants was soiled with food stains, near her hip.

On 12/8/19 at 11:59 AM, an RN assisted the resident to her room and changed her sweater with a new shirt and a new clothing protector. The RN said the stain to her shirt was probably pudding she had eaten earlier in the day. The RN then assisted the resident out of her room. The RN did not attempt to change the resident's pants or brush her matted hair.

b. On 12/8/19 at 1:01 PM, a resident was asked if he was cleaned up quickly when he became soiled (incontinent of stool). The resident shook his head from side to side

indicating "no."
On 12/10/19 at 9:08 AM, the resident was in his room lying on his back in bed and there was a strong odor of stool. At 9:08 AM, an Activities Assistant went into the resident's room and delivered a paper for his roommate to read then left the room. At 9:14 AM, a CNA walked by the resident's room, looked in the room then walked away. At 9:18 AM, the CNA again walked by the resident's room, looked in the room then walked away. From 9:21 to 9:37 AM, a CNA and 2 RNs walked by the resident's room without entering although there was a distinct odor of stool in the hallway outside the resident's room.

An alarm sounded from the resident's roommate's ventilator. At 9:40 AM, an RN entered the room, the alarm was then quiet, and the RN exited the room. The odor was still present upon her exit. There continued to be the odor of stool in the hallway outside the resident's room. A CNA and an RN walked by the room without entering from 9:46 to 9:56 AM. At 10:24 AM, the resident was observed crying while lying in his bed. When asked if he had a soiled brief, he nodded his head up and down indicating "yes." When asked if he could reach the call light on his chest, the resident shook his head from side to side indicating "no."

Additionally, during observations on 12/8/19, it was noted an RN was completing tasks which were typically completed by a CNA. On 12/13/19 at 9:45 AM, an RN said there was a staffing problem in the facility that was why she worked as a CNA on 12/8/19. Further, on 12/10/19 at 9:10 AM, a Restorative Nursing Aide (RNA) said he was working as a CNA and said he would not be able to do the RNA program today. When asked who would be doing the RNA program for the residents. the RNA said "Nobody." The RNA said he was pulled to work as a CNA about 4 to 5 times since he started working as an RNA 6 months ago.

Twenty-eight residents' records, including 3 closed records (meaning the residents had been discharged from the facility) were reviewed. Nine of the records, including 1 closed record, documented the residents' required therapy services. Seven of the 9 records included documentation that therapy services had been provided in accordance with the residents' care plan. For example, one resident's closed record documented the resident had received physical therapy (PT) and occupational therapy (OT) during her stay at the facility from 2/7/19 to 3/3/19. Billing for the PT and OT was reviewed, and no irregularities were noted. The resident's record documented she had received range of motion as specified by the physical therapist.

However, the records of 2 residents, who were residing at the facility at the time of the survey, did not include documentation they were receiving restorative therapy as ordered. One resident's record included physician orders, dated 11/26/19, which documented an active order for the resident to receive restorative nursing care and the resident's care plan, dated 9/30/19, documented staff was to monitor the need for consultation, and provide or screen the resident as needed for physical therapy.

However, the resident record documented he was removed from physical and occupational therapy on 8/16/19. When asked on 12/8/19 at 10:17 AM, the resident's family member stated the facility no longer offered physical or restorative therapy for him.

On 12/12/19 at 9:30 AM, an RNA stated the resident was not receiving restorative care. The RNA stated the resident was taken off restorative care because he was so stiff it hurt him too much to move. The RNA stated the resident's family member was not notified why the resident was removed from restorative therapy.

Another resident's record included physical therapy treatment encounter notes, dated 11/21/19, which documented an RNA was instructed on range of motion to include bilateral lower extremities, 10 to 15 times for each extremity to increase and maintain the resident's range of motion. When asked on 12/8/19 at 10:33 AM, the resident's family member stated the facility was cutting back on the resident's physical therapy and he (the resident) was declining. The resident's family member stated she saw a decline in the resident's ability to move.

On 12/12/19 at 9:33 AM, an RNA stated the resident was put into the restorative program on 12/9/19 but had not yet received a restorative therapy session, 21 days after the restorative therapy recommendation was made by physical therapy.

Additionally, grievances and Resident Council Meeting minutes from 11/2018 to 12/2019 were reviewed. A grievance dated 5/22/19 documented a water pitcher was not being changed and grievances dated 7/22/19 and 9/26/19 documented concerns regarding meals delivered late. Concerns regarding call lights not being answered in a timely manner and daily living needs not being met, including urinals (plastic urine containers) not being emptied, were found in grievances dated from 11/1/18 to 9/2019 and the Resident Council minutes dated 12/6/18, 8/7/19, 9/4/19, 10/2/19, 11/6/19 and 12/4/19, documented ongoing concerns regarding lengthy call light response times, showers, and dining which were not addressed by the facility.

A resident group interview was conducted with 8 residents on 12/10/19 at 2:35 PM. None of the residents expressed concerns regarding their water pitchers not being filled, but 3 residents said there were still issues with late delivery of meal trays, low food temperatures, slow call light response times and the facility not having enough staff. Five residents also said showers were not being completed, especially on Saturdays. The residents stated these concerns were not addressed by the facility.

Throughout the survey, 15 residents were interviewed individually. On 12/9/19 at 10:39 AM, one resident said he had missed his showers before but after his sister voiced his concern to the facility, he was now receiving his showers three times a week on

Mondays, Wednesdays and Fridays, which was consistent with the documentation in the resident's record.
The resident and the resident's room were observed to be clean, his urinals were empty, and no unpleasant smell was noted. When asked, the resident said he did not have to wait a long time for his meal trays to be delivered and most of the time he ate his meals in the dining room. At various times throughout the survey, the resident was observed. The resident's 2 water pitchers were observed filled with water and urinals were observed to be empty.

However, during the individual interviews, 3 other residents stated there were not enough staff to meet the residents' toileting needs and showering needs, medications were not administered on time and call lights were not responded to in a timely manner.

Four resident representatives and family members were also interviewed throughout the survey. The representatives and family members expressed concerns related to a lack of staff being available to provide sufficient supervision to residents who wandered, to prevent residents from falling, to ensure residents were provided with meals in a timely manner and to assist residents with their meals, toileting, hygiene, grooming and skin care needs. For example, on 12/10/19 at 3:02 PM, the co-guardians for a resident stated when they went in to visit or take the resident to an appointment, he often had a wet adult brief and the staff were not changing him. One of the guardians stated they had taken the resident to an appointment and at the appointment, a wound was found on his leg. The guardian stated the nurse at the appointment stated the wound should have been identified by the facility and it had been there "for a while." The guardian stated the staff at the facility should have been performing weekly skin checks to identify these types of issues. Additionally, another resident's family member stated she had been concerned with the resident receiving an appropriate diet, assistance with meals, incontinence care, bathing and grooming. The resident's family member stated hospice services had been initiated for the resident and her concerns had decreased since then.

Six CNAs and 3 LPNs were interviewed throughout the survey. The staff stated there were not enough staff to provide the care required and to meet all of the residents' needs. Staff stated several residents required 2-person assistance with transfers, and showers and grooming activities were not completed. Staff also stated there was not enough staff to assist residents during meals.

The records of the 28 residents that were reviewed documented the residents had varied needs requiring extensive staff assistance. For example, 3 residents engaged in wandering behavior requiring increased supervision and no less than 3 residents required increased supervision and assistance related to falls. Additionally, of the 28 residents' records that were reviewed, 13 resident records did not include documentation the residents received care as specified in their care plans. Examples included, but were not limited to, the following:

- A resident's Care Plan, undated, documented the resident was dependent on staff for bathing. He was to be assisted with bathing twice per week and as needed.
The resident's ADL Reports for October, November, and December 2019 documented he did not receive a bath/shower from 10/5/19 to 10/11/19 (6 days), from 10/16/19 to 10/22/19 (6 days), from 10/23/19 to 11/4/19 (11 days), from 11/5/19 to 11/25/19 (20 days), and from 12/7/19 to 12/11/19 (5 days).

On 12/8/19 and on 12/12/19 at 10:25 AM and 8:57 AM respectively, the resident stated the time between showers/baths had gotten longer. He said his regular scheduled shower days were Wednesdays and Saturdays and he said the facility wanted to change his Saturday schedule to a different day and he told them no.

- A resident's Care Plan, dated 11/21/19, documented she was dependent on staff and directed staff to provide assistance with her bathing and personal hygiene.

The resident's ADL Reports for November and December 2019, documented her bathing days were Tuesday and Friday and as needed. The reports documented she was not bathed from 11/20/19 to 11/26/19 (7 days) and from 11/27/19 to 12/3/19 (7 days).

- A resident's Care Plan, revised on 11/18/19, documented he required extensive assistance of 1-2 staff for bathing. The facility's shower schedule documented the resident's shower schedule was Mondays and Thursdays in the morning.

The resident's ADL report for November 2019 and December 2019 documented there were no showers given or offered from 11/6/19 to 11/10/19 (5 days), from 11/12/19 to 11/17/19 (6 days) and from 12/6/19 to 12/10/19 (5 days).

On 12/10/19 at 2:15 PM, the resident stated his last shower was on 12/5/19.

- A resident's Care Plan, dated 11/26/19, directed staff to provide 1-person assistance with bathing.

The resident's ADL Reports for November and December 2019, documented her bathing days were Wednesday and Saturday and as needed. The reports documented she was not bathed from 11/28/19 to 12/2/19 (5 days) and from 12/5/19 to 12/9/19 (5 days).

On 12/8/19 at 11:33 AM, the resident said since she had been admitted to the facility, she had not received her showers as scheduled.

Further, the facility's policy for Nurse Aide Staffing, dated 11/28/17, stated nurse aides were to receive at least 12 hours of in-service training each employment year based on the outcome of the annual performance review and special needs of the resident

population and Nurse aides were to demonstrate competency in areas such as communication and personal skills, basic nursing skills, personal care skills, mental health and social service needs, basic restorative services, and Resident Rights. However, the facility's records did not include documentation that CNAs received the required competency evaluations and completed the required hours of yearly training for 5 of 5 CNAs whose records were reviewed.

On 12/12/19 at 4:38 PM, the DON stated the Staff Development Coordinator was responsible for overseeing nursing competencies. The DON stated nursing staff should be evaluated to assess their competencies, skills, and knowledge "Yearly or if there is a change."

It was determined the facility failed to ensure sufficient numbers of trained staff were provided to meet the residents' needs. Therefore, the allegation was substantiated, and deficient practice was cited at F725 related to the number of staff and F730 related to the lack of staff training and competency evaluations. The facility was also cited at F550 related to the facility's failure to ensure residents were not left in soiled incontinent briefs for extended periods of time, F585 related to the facility's failure to resolve grievances, F677 related to the facility's failure to ensure bathing and/or grooming, incontinence care, and transfers were provided consistent with residents' needs, F688 related to the facility's failure to increase or prevent a decrease in the residents' range of motion, F804 related to the facility's failure to ensure palatable food was served and F805 related to the facility's failure to ensure residents were provided with a diet that was consistent with physician orders.

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

Allegation #2: The facility failed to ensure incidents were investigated and residents were free from abuse, neglect, and mistreatment.

Findings #2: Eighteen residents were observed throughout the survey. Multiple staff were observed to interact with residents in a respectful manner and safety devices were observed throughout the facility. Examples included, but were not limited to, the following:

All resident bathrooms were equipped with grab bars. In addition, on 12/8/19 at 10:52 AM, one resident was observed being transferred by a Certified Nursing Assistant (CNA) and a Registered Nurse (RN) using a Hoyer lift (mechanical lift) that was secured to the ceiling. The resident was given instruction and was transferred safely from his bed to his wheelchair. There was no concern noted.

On 12/12/19 at 8:45 AM, a Shower Aide was observed providing a bed bath to a resident. The Shower Aide was talking to the resident as she gave the resident a bed bath and the

resident was smiling and conversed with the Shower Aide. Concerns related to abuse were not identified during the observations.

On 12/10/19 at 2:35 PM, 8 residents attended a group interview and no concerns were voiced regarding abuse. Fifteen residents were also interviewed individually throughout the survey. No concerns were voiced regarding abuse.

On 12/11/19 at 10:25 AM, the Administrator was interviewed. The Administrator said if staff witnessed abuse, he/she should intervene, keep the resident safe and report it immediately. The Administrator said if staff suspected abuse, staff were to stop and report all incidents of potential abuse.

Throughout the survey, 6 Certified Nursing Assistants (CNAs), 3 Licensed Practical Nurses (LPNs), and 3 Registered Nurses (RNs) were interviewed. The staff said if they saw abuse or staff threatening residents, they would stop it immediately, make sure the resident was safe, and immediately report it to their supervisor, the Director of Nursing (DON), and/or the Administrator.

Grievances and Resident Council minutes from 11/2018 to 12/2019 were reviewed. Grievances related to abuse were investigated as a reportable event. The facility's I&A reports from 10/2018 to 12/2019 were also reviewed. The I&As included several allegations of abuse involving several residents. All of the allegations had been investigated including, but not limited to, the following:

An I&A, dated 3/4/19, documented an allegation that a staff member had thrown water in a resident's face because the resident did not swallow their medications quickly enough. The accused staff was suspended from working and an investigation was conducted. Upon completion of the investigation, the allegation of physical abuse was unsubstantiated.

An I&A, dated 5/25/19, documented a resident fell out of bed and was incontinent. The facility investigated the incident and added a 1:1 sitter for the resident's safety. No resident neglect related to the incident was identified.

An I&A, dated 10/12/18, alleged that a staff member had put feces in a resident's face, flicked her fingers on the resident's forehead and asked the resident what they were thinking. The I&A also alleged the staff belittled the resident and called the resident a trouble maker. The accused staff was suspended from working and an investigation was conducted. Upon completion of the investigation, the allegation was unsubstantiated and the staff member returned to work.

An I&A report documented a resident fell in September of 2019 after walking unobserved from his bed to the bathroom in his room to use the toilet. The report

documented witnesses stated the resident had not pressed the call light to request help.

The report documented when found in the bathroom the resident said, "I was told they wanted me to start walking more by myself." Therapists said they worked with the resident, he was not one to walk to the bathroom, he had a history of asking CNAs to assist with his brief change in bed. No resident neglect related to the incident was identified.

An I&A report documented another resident fell in mid-November 2019. The investigation documented the resident rolled out of bed and fell onto the floor. The investigation documented the resident's bed was not in the low position as directed by his Bed Safety Evaluation. A second Post Fall Investigation documented the resident also had an unwitnessed fall in late November 2019. However, there were no new documented interventions on the resident's care plan to prevent further falls. A Post Fall Investigation documented the resident had a third unwitnessed fall in late November 2019, while transferring out of his wheelchair and into the bed. No new interventions were documented on the resident's care plan.

When asked, on 12/10/19 at 10:58 AM, the Unit Manager stated the resident's fall risk score indicated he was a high fall risk. The Unit Manager stated care plan interventions should be completed after each fall.

The resident's record was reviewed. The record included a physician's order, dated 11/25/19, which documented the resident was to have a fall mat to the right side of his bed and a physician's order, dated 12/2/19, documented the resident was to have his bed in the lowest position.

However, on 12/10/19 at 10:07 AM, the resident was observed lying in bed. There was no fall mat on the floor by his bed and the bed was not in the lowest position. On 12/10/19 at 10:56 AM, the Unit Manager stated there was no floor mat in the resident's room and he should have one.

Additionally, an I&A, dated 9/17/19, documented a resident had a bruise of unknown injury reported by facility staff. The injury was investigated and was found to be an underlying clinical condition unrelated to physical abuse. The I&A documented the injury was unsubstantiated for abuse. On 12/10/19 at 12:25 PM, a family member of the resident was interviewed. The family member stated the residents' bruises and skin tears had decreased since a Hoyer Lift was now used to transfer the resident.

However, an I&A, dated 1/27/19, documented a bruise had been found on another resident on 1/27/19. A corresponding nurse's note in the resident's closed record (meaning the resident had been discharged from the facility) documented on 1/27/19 at

5:30 PM, the nurse was called by a CNA to check on the bruise found on the resident's arm. The bruise measured 11 cm x 9 cm, extending down to her right breast measuring 8 cm x 5 cm. The resident denied pain and did not know how it happened.
The I&A report documented that during witness statement collection, the CNA went and looked at the resident's bruise and reported to the nurse she (the CNA) thought the resident's bruise could have happened during the resident's 1/26/19 therapy session with the Physical Therapy Assistant (PTA) when using the Sit to Stand (STS) lift. The I&A report documented the Administrator and the DON were notified and the PTA was suspended from working pending investigation.

The I&A report also documented the PTA was interviewed by the Director of Therapy on 1/28/19 and 2 more staff were interviewed on the same day. The I&A report also documented 5 residents who were under the care of the PTA were interviewed on 1/30/19 and there were no concerns noted.

The PTA's Time Card Report documented the PTA continued to work during the course of the investigation, as follows:

*1/27/19 - In at 9:59 PM and Out at 10:10 PM
*1/28/19 - In at 8:00 AM and Out at 4:00 PM
*1/29/19 - In at 9:15 AM and Out at 6:50 PM
*1/30/19 - In at 9:00 AM and Out at 5:49 PM

The Administrator was interviewed on 12/11/19 at 10:25 AM. The Administrator stated he was the Abuse Coordinator and he enlisted the assistance of the DON, Licensed Social Worker (LSW) and other departmental supervisors in investigating an abuse incident. The Administrator said the alleged perpetrator would be suspended immediately until the abuse was ruled out which could be from an hour to 24 hours or more and they could return to work after it was determined it was not abuse. The Administrator reviewed the PTA's Time Card Report and said PT staff could check in remotely to finish their documentation. The Administrator said the PTA was informed of the incident on Sunday, 1/27/19 and could have written her statement on 1/27/19 between 9:59 PM and 10:10 PM as shown on her Time Card Report. When asked why the PTA was allowed to come back to work on 1/28/19 through 1/30/19 while the investigation was still in progress, the Administrator said he had a conference call with the DON, LSW and the Director of Therapy on the night of 1/27/19 and they determined abuse did not occur based on staff and resident interviews, and the bruise was caused by the sling from the STS lift.

The facility did not ensure the PTA was not allowed to report for work while an investigation of alleged abuse was being conducted.

Additionally, the I&A report documented the staff were given education regarding

customer service and abuse training, but there was no documentation that the PTA was evaluated for proper use of the STS lift or provided additional training related to its use.

On 12/10/19 at 9:31 AM, the Director of Therapy said the PTA had chosen to leave the facility about six weeks ago.

It could not be determined that the facility failed to ensure residents were free from abuse and mistreatment. Therefore, the allegation was unsubstantiated. However, it was determined the facility failed to ensure an alleged perpetrator of abuse was not allowed to report for work while an investigation was being conducted and deficient practice was cited at F610. The facility was also cited at F689 related to the facility's failure to ensure residents were protected from falls and that staff had used the STS lift correctly.

Conclusion: 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,

LAURA THOMPSON, RN, Supervisor
Long Term Care Program

LT/ac

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HEALTH & WELFARE

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March 24, 2020

Royal Jensen, Administrator
Cascadia of Boise
6000 W Denton St,
Boise, ID 83704

Provider #: 135146

Dear Mr. Jensen:

On **December 8, 2019** through **December 13, 2019**, an unannounced on-site complaint survey was conducted at Cascadia of Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008206

Allegation #1: The facility failed to ensure sufficient numbers of trained staff were present to meet residents' needs.

Findings #1: During the survey, observations and interviews were conducted, and resident records, policies, facility grievances, Incident and Accident reports, staffing schedules, and staff training records were reviewed.

The facility's policy titled Sufficient Qualified Nurse Staffing, dated 11/28/17, stated the facility provided licensed nurses and other nursing personnel to provide nursing care to all residents in accordance with resident care plans. The policy stated nursing and related services were provided to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by their assessments and individual plans of care. The policy also stated these services were provided with consideration to the number, acuity, and diagnoses of the facility's resident population in accordance with the required facility assessment.

The Facility Assessment Tool, dated 7/1/19, documented the facility's staffing plan for nursing care, which included Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs), Nursing Assistants (NAs), and hospitality aides (non-skilled care), was to be at 4.5 to 5.5 hours per resident per day.

The direct care nursing hours worked from 11/17/19 through 12/7/19 were reviewed. The staffing levels did not meet the 4.5 to 5.5 hours planned in the Facility Assessment Tool. The days for which the hours did not meet nursing care were as follows:

Sunday, 11/17/19 - 4.01
Saturday, 11/23/19 - 4.3
Sunday, 11/24/19 - 3.82
Saturday, 11/30/19 - 4.32
Sunday, 12/1/19 - 3.90
Saturday, 12/7/19 - 4.09

On 12/12/19 at 4:38 PM, the Director of Nursing (DON) and the Clinical Resource Nurse were asked if the Facility Assessment included a determination of the level and competency of staff needed to meet each residents' needs each day and during emergencies. The DON said "Yes." Both the DON and the Clinical Resource Nurse said the planned nursing hours per resident per day was 4.5 hours to 5.5 hours. The DON and the Clinical Resource Nurse stated they were not aware the staffing levels for the past three weekends did not meet the planned staffing levels according to the Facility Assessment.

Observations were conducted at various times during all shifts throughout the survey. The residents' need were not observed to be consistently met. Examples included, but were not limited to, the following:

a. On 12/8/19 at 11:52 AM, a resident was in her wheelchair in the unit day room watching television. Her hair was matted and appeared unkempt. She had a non-stained clothing protector around her neck and chest area. She had on a sweater that was stained with streaks of food and excessive oral secretions underneath the clothing protector. The top left of her pants was soiled with food stains, near her hip.

On 12/8/19 at 11:59 AM, an RN assisted the resident to her room and changed her sweater with a new shirt and a new clothing protector. The RN said the stain to her shirt was probably pudding she had eaten earlier in the day. The RN then assisted the resident out of her room. The RN did not attempt to change the resident's pants or brush her matted hair.

b. On 12/8/19 at 1:01 PM, a resident was asked if he was cleaned up quickly when he became soiled (incontinent of stool). The resident shook his head from side to side indicating "no."

On 12/10/19 at 9:08 AM, the resident was in his room lying on his back in bed and there was a strong odor of stool. At 9:08 AM, an Activities Assistant went into the resident's room and delivered a paper for his roommate to read then left the room. At 9:14 AM, a CNA walked by the resident's room, looked in the room then walked away. At 9:18 AM, the CNA again walked by the resident's room, looked in the room then walked away. From 9:21 to 9:37 AM, a CNA and 2 RNs walked by the resident's room without entering although there was a distinct odor of stool in the hallway outside the resident's room.

An alarm sounded from the resident's roommate's ventilator. At 9:40 AM, an RN entered the room, the alarm was then quiet, and the RN exited the room. The odor was still present upon her exit. There continued to be the odor of stool in the hallway outside the resident's room. A CNA and an RN walked by the room without entering from 9:46 to 9:56 AM. At 10:24 AM, the resident was observed crying while lying in his bed. When asked if he had a soiled brief, he nodded his head up and down indicating "yes." When asked if he could reach the call light on his chest, the resident shook his head from side to side indicating "no."

Additionally, during observations on 12/8/19, it was noted an RN was completing tasks which were typically completed by a CNA. On 12/13/19 at 9:45 AM, an RN said there was a staffing problem in the facility that was why she worked as a CNA on 12/8/19. Further, on 12/10/19 at 9:10 AM, a Restorative Nursing Aide (RNA) said he was working as a CNA and said he would not be able to do the RNA program today. When asked who would be doing the RNA program for the residents. the RNA said "Nobody." The RNA said he was pulled to work as a CNA about 4 to 5 times since he started working as an RNA 6 months ago.

Twenty-eight residents' records, including 3 closed records (meaning the residents had been discharged from the facility) were reviewed. Nine of the records, including 1 closed record, documented the residents' required therapy services. Seven of the 9 records included documentation that therapy services had been provided in accordance with the residents' care plan. For example, one resident's closed record documented the resident had received physical therapy (PT) and occupational therapy (OT) during her stay at the facility from 2/7/19 to 3/3/19. Billing for the PT and OT was reviewed, and no irregularities were noted. The resident's record documented she had received range of motion as specified by the physical therapist.

However, the records of 2 residents, who were residing at the facility at the time of the survey, did not include documentation they were receiving restorative therapy as ordered. One resident's record included physician orders, dated 11/26/19, which documented an active order for the resident to receive restorative nursing care and the resident's care plan, dated 9/30/19, documented staff was to monitor the need for consultation, and provide or screen the resident as needed for physical therapy. However, the resident record documented he was removed from physical and occupational therapy on 8/16/19. When asked on 12/8/19 at 10:17 AM, the resident's family member stated the facility no longer offered physical or restorative therapy for him.

On 12/12/19 at 9:30 AM, an RNA stated the resident was not receiving restorative care. The RNA stated the resident was taken off restorative care because he was so stiff it hurt him too much to move. The RNA stated the resident's family member was not notified why the resident was removed from restorative therapy.

Another resident's record included physical therapy treatment encounter notes, dated 11/21/19, which documented an RNA was instructed on range of motion to include bilateral lower extremities, 10 to 15 times for each extremity to increase and maintain the resident's range of motion. When asked on 12/8/19 at 10:33 AM, the resident's family member stated the facility was cutting back on the resident's physical therapy and he (the resident) was declining. The resident's family member stated she saw a decline in the resident's ability to move.

On 12/12/19 at 9:33 AM, an RNA stated the resident was put into the restorative program on 12/9/19 but had not yet received a restorative therapy session, 21 days after the restorative therapy recommendation was made by physical therapy.

Additionally, grievances and Resident Council Meeting minutes from 11/2018 to 12/2019 were reviewed. A grievance dated 5/22/19 documented a water pitcher was not being changed and grievances dated 7/22/19 and 9/26/19 documented concerns regarding meals delivered late. Concerns regarding call lights not being answered in a timely manner and daily living needs not being met, including urinals (plastic urine containers) not being emptied, were found in grievances dated from 11/1/18 to 9/2019 and the Resident Council minutes dated 12/6/18, 8/7/19, 9/4/19, 10/2/19, 11/6/19 and 12/4/19, documented ongoing concerns regarding lengthy call light response times, showers, and dining which were not addressed by the facility.

A resident group interview was conducted with 8 residents on 12/10/19 at 2:35 PM. None of the residents expressed concerns regarding their water pitchers not being filled, but 3 residents said there were still issues with late delivery of meal trays, low food temperatures, slow call light response times and the facility not having enough staff. Five residents also said showers were not being completed, especially on Saturdays. The residents stated these concerns were not addressed by the facility.

Throughout the survey, 15 residents were interviewed individually. On 12/9/19 at 10:39 AM, one resident said he had missed his showers before but after his sister voiced his concern to the facility, he was now receiving his showers three times a week on Mondays, Wednesdays and Fridays, which was consistent with the documentation in the resident's record. The resident and the resident's room were observed to be clean, his urinals were empty, and no unpleasant smell was noted. When asked, the resident said he did not have to wait a long time for his meal trays to be delivered and most of the time he ate his meals in the dining room. At various times throughout the survey, the resident was observed. The resident's 2 water pitchers were observed filled with water and urinals were observed to be empty.

However, during the individual interviews, 3 other residents stated there were not enough staff to meet the residents' toileting needs and showering needs, medications were not administered on time and call lights were not responded to in a timely manner.
Four resident representatives and family members were also interviewed throughout the survey. The representatives and family members expressed concerns related to a lack of staff being available to provide sufficient supervision to residents who wandered, to prevent residents from falling, to ensure residents were provided with meals in a timely manner and to assist residents with their meals, toileting, hygiene, grooming and skin care needs. For example, on 12/10/19 at 3:02 PM, the co-guardians for a resident stated when they went in to visit or take the resident to an appointment, he often had a wet adult brief and the staff were not changing him. One of the guardians stated they had taken the resident to an appointment and at the appointment, a wound was found on his leg. The guardian stated the nurse at the appointment stated the wound should have been identified by the facility and it had been there "for a while." The guardian stated the staff at the facility should have been performing weekly skin checks to identify these types of issues. Additionally, another resident's family member stated she had been concerned with the resident receiving an appropriate diet, assistance with meals, incontinence care, bathing and grooming. The resident's family member stated hospice services had been initiated for the resident and her concerns had decreased since then.

Six CNAs and 3 LPNs were interviewed throughout the survey. The staff stated there were not enough staff to provide the care required and to meet all of the residents' needs. Staff stated several residents required 2-person assistance with transfers, and showers and grooming activities were not completed. Staff also stated there was not enough staff to assist residents during meals.

The records of the 28 residents that were reviewed documented the residents had varied needs requiring extensive staff assistance. For example, 3 residents engaged in wandering behavior requiring increased supervision and no less than 3 residents required increased supervision and assistance related to falls. Additionally, of the 28 residents' records that were reviewed, 13 resident records did not include documentation the residents received care as specified in their care plans. Examples included, but were not limited to, the following:

- A resident's Care Plan, undated, documented the resident was dependent on staff for bathing. He was to be assisted with bathing twice per week and as needed.

The resident's ADL Reports for October, November, and December 2019 documented he did not receive a bath/shower from 10/5/19 to 10/11/19 (6 days), from 10/16/19 to 10/22/19 (6 days), from 10/23/19 to 11/4/19 (11 days), from 11/5/19 to 11/25/19 (20 days), and from 12/7/19 to 12/11/19 (5 days).

On 12/8/19 and on 12/12/19 at 10:25 AM and 8:57 AM respectively, the resident stated the time between showers/baths had gotten longer. He said his regular scheduled shower days were Wednesdays and Saturdays and he said the facility wanted to change his Saturday schedule to a different day and he told them no.

- A resident's Care Plan, dated 11/21/19, documented she was dependent on staff and directed staff to provide assistance with her bathing and personal hygiene.

The resident's ADL Reports for November and December 2019, documented her bathing days were Tuesday and Friday and as needed. The reports documented she was not bathed from 11/20/19 to 11/26/19 (7 days) and from 11/27/19 to 12/3/19 (7 days).

- A resident's Care Plan, revised on 11/18/19, documented he required extensive assistance of 1-2 staff for bathing. The facility's shower schedule documented the resident's shower schedule was Mondays and Thursdays in the morning.

The resident's ADL report for November 2019 and December 2019 documented there were no showers given or offered from 11/6/19 to 11/10/19 (5 days), from 11/12/19 to 11/17/19 (6 days) and from 12/6/19 to 12/10/19 (5 days).

On 12/10/19 at 2:15 PM, the resident stated his last shower was on 12/5/19.

- A resident's Care Plan, dated 11/26/19, directed staff to provide 1-person assistance with bathing.

The resident's ADL Reports for November and December 2019, documented her bathing days were Wednesday and Saturday and as needed. The reports documented she was not bathed from 11/28/19 to 12/2/19 (5 days) and from 12/5/19 to 12/9/19 (5 days).

On 12/8/19 at 11:33 AM, the resident said since she had been admitted to the facility, she had not received her showers as scheduled.

Further, the facility's policy for Nurse Aide Staffing, dated 11/28/17, stated nurse aides were to receive at least 12 hours of in-service training each employment year based on the outcome of the annual performance review and special needs of the resident population and Nurse aides were to demonstrate competency in areas such as communication and personal skills, basic nursing skills, personal care skills, mental health and social service needs, basic restorative services, and Resident Rights.

However, the facility's records did not include documentation that CNAs received the required competency evaluations and completed the required hours of yearly training for 5 of 5 CNAs whose records were reviewed.

On 12/12/19 at 4:38 PM, the DON stated the Staff Development Coordinator was responsible for overseeing nursing competencies. The DON stated nursing staff should be evaluated to assess their competencies, skills, and knowledge "Yearly or if there is a change."

It was determined the facility failed to ensure sufficient numbers of trained staff were provided to meet the residents' needs. Therefore, the allegation was substantiated, and deficient practice was cited at F725 related to the number of staff and F730 related to the lack of staff training and competency evaluations. The facility was also cited at F550 related to the facility's failure to ensure residents were not left in soiled incontinent briefs for extended periods of time, F585 related to the facility's failure to resolve grievances, F677 related to the facility's failure to ensure bathing and/or grooming, incontinence care, and transfers were provided consistent with residents' needs, F688 related to the facility's failure to increase or prevent a decrease in the residents' range of motion, F804 related to the facility's failure to ensure palatable food was served and F805 related to the facility's failure to ensure residents were provided with a diet that was consistent with physician orders.

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

Findings #2: Grievances and Resident Council minutes from 11/2018 to 12/2019 were reviewed. No concerns related to Continuous Positive Airway Pressure (CPAP) or oxygen use were noted in the grievances or Resident Council minutes.

Five residents were interviewed regarding oxygen use. On 12/10/19 at 10:32 AM, 1 resident stated he used his CPAP every night. The resident said the staff filled his CPAP chamber with water and set it up for him. No concerns related to CPAP or oxygen use were expressed. Four residents' representatives were also interviewed regarding CPAP and oxygen usage and no concerns were itdentified.

The records of 6 residents with respiratory needs were reviewed. Concerns related to CPAP or oxygen use were not identified. However, during an observation on 12/8/19 at 11:17 AM, a resident was observed sitting at the table in his power wheelchair in the dining room. He had oxygen in place by nasal cannula connected to a portable oxygen tank. At 12:34 PM, the resident said his portable oxygen tank was filled by a CNA before he went to the dining room. The resident said while he was in the dining room waiting for his lunch he felt dizzy and the Unit Manager (UM) found his oxygen tank was empty. The resident said this was not the first time he found his portable oxygen tank empty.

On 12/8/19 at 12:35 PM, the UM came back with the portable oxygen tank. The UM said the resident complained of feeling dizzy and when he checked the portable oxygen tank it was empty. The UM then checked the resident's oxygen saturation and it was 88 to 90 percent. The UM said the resident was on continuous oxygen at 2 liters per minute and staff should make sure his portable oxygen tank was not empty whenever he was out of his room.

It was determined the facility failed to ensure the resident's respiratory needs were met. Therefore, the allegation was substantiated and deficient practice was cited at F695.

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.

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/ac

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March 24, 2020

Royal Jensen, Administrator
Cascadia of Boise
6000 W Denton St,
Boise, ID 83704

Provider #: 135146

Dear Mr. Jensen:

On **December 8, 2019** through **December 13, 2019**, an unannounced on-site complaint survey was conducted at Cascadia of Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008264

Allegation #1: The facility failed to ensure incidents were investigated and residents were free from abuse, neglect, and mistreatment.

Findings #1: During the survey, observations and interviews were conducted and resident records, Incident and Accident reports (I&A), reportable events, grievances, and Resident Council minutes were reviewed with the following results:

Eighteen residents were observed throughout the survey. Multiple staff were observed to interact with residents in a respectful manner and safety devices were observed throughout the facility. Examples included, but were not limited to, the following:

All resident bathrooms were equipped with grab bars. In addition, on 12/8/19 at 10:52 AM, one resident was observed being transferred by a Certified Nursing Assistant (CNA) and a Registered Nurse (RN) using a Hoyer lift (mechanical lift) that was secured to the ceiling. The resident was given instruction and was transferred safely from his bed to his wheelchair. There was no concern noted.

On 12/12/19 at 8:45 AM, a Shower Aide was observed providing a bed bath to a resident. The Shower Aide was talking to the resident as she gave the resident a bed bath and the resident was smiling and conversed with the Shower Aide. Concerns related to abuse were not identified during the observations.

On 12/10/19 at 2:35 PM, 8 residents attended a group interview and no concerns were voiced regarding abuse. Fifteen residents were also interviewed individually throughout the survey. No concerns were voiced regarding abuse.

On 12/11/19 at 10:25 AM, the Administrator was interviewed. The Administrator said if staff witnessed abuse, he/she should intervene, keep the resident safe and report it immediately. The Administrator said if staff suspected abuse, staff were to stop and report all incidents of potential abuse.

Throughout the survey, 6 Certified Nursing Assistants (CNAs), 3 Licensed Practical Nurses (LPNs), and 3 Registered Nurses (RNs) were interviewed. The staff said if they saw abuse or staff threatening residents, they would stop it immediately, make sure the resident was safe, and immediately report it to their supervisor, the Director of Nursing (DON), and/or the Administrator.

Grievances and Resident Council minutes from 11/2018 to 12/2019 were reviewed. Grievances related to abuse were investigated as a reportable event. The facility's I&A reports from 10/2018 to 12/2019 were also reviewed. The I&As included several allegations of abuse involving several residents. All of the allegations had been investigated including, but not limited to, the following:

An I&A, dated 3/4/19, documented an allegation that a staff member had thrown water in a resident's face because the resident did not swallow their medications quickly enough. The accused staff was suspended from working and an investigation was conducted. Upon completion of the investigation, the allegation of physical abuse was unsubstantiated.

An I&A, dated 5/25/19, documented a resident fell out of bed and was incontinent. The facility investigated the incident and added a 1:1 sitter for the resident's safety. No resident neglect related to the incident was identified.

An I&A, dated 10/12/18, alleged that a staff member had put feces in a resident's face, flicked her fingers on the resident's forehead and asked the resident what they were thinking. The I&A also alleged the staff belittled the resident and called the resident a trouble maker. The accused staff was suspended from working and an investigation was conducted. Upon completion of the investigation, the allegation was unsubstantiated and the staff member returned to work.

An I&A report documented a resident fell in September of 2019 after walking

unobserved from his bed to the bathroom in his room to use the toilet. The report documented witnesses stated the resident had not pressed the call light to request help. The report documented when found in the bathroom the resident said, "I was told they wanted me to start walking more by myself." Therapists said they worked with the resident, he was not one to walk to the bathroom, he had a history of asking CNAs to assist with his brief change in bed. No resident neglect related to the incident was identified.

An I&A report documented another resident fell in mid-November 2019. The investigation documented the resident rolled out of bed and fell onto the floor. The investigation documented the resident's bed was not in the low position as directed by his Bed Safety Evaluation. A second Post Fall Investigation documented the resident also had an unwitnessed fall in late November 2019. However, there were no new documented interventions on the resident's care plan to prevent further falls. A Post Fall Investigation documented the resident had a third unwitnessed fall in late November 2019, while transferring out of his wheelchair and into the bed. No new interventions were documented on the resident's care plan.

When asked, on 12/10/19 at 10:58 AM, the Unit Manager stated the resident's fall risk score indicated he was a high fall risk. The Unit Manager stated care plan interventions should be completed after each fall.

The resident's record was reviewed. The record included a physician's order, dated 11/25/19, which documented the resident was to have a fall mat to the right side of his bed and a physician's order, dated 12/2/19, documented the resident was to have his bed in the lowest position.

However, on 12/10/19 at 10:07 AM, the resident was observed lying in bed. There was no fall mat on the floor by his bed and the bed was not in the lowest position. On 12/10/19 at 10:56 AM, the Unit Manager stated there was no floor mat in the resident's room and he should have one.

Additionally, an I&A, dated 9/17/19, documented a resident had a bruise of unknown injury reported by facility staff. The injury was investigated and was found to be an underlying clinical condition unrelated to physical abuse. The I&A documented the injury was unsubstantiated for abuse. On 12/10/19 at 12:25 PM, a family member of the resident was interviewed. The family member stated the residents' bruises and skin tears had decreased since a Hoyer Lift was now used to transfer the resident.

However, an I&A, dated 1/27/19, documented a bruise had been found on another resident on 1/27/19. A corresponding nurse's note in the resident's closed record (meaning the resident had been discharged from the facility) documented on 1/27/19 at 5:30 PM, the nurse was called by a CNA to check on the bruise found on the resident's arm. The bruise measured 11 cm x 9 cm, extending down to her right breast measuring 8 cm x 5 cm. The resident denied pain and did not know how it happened.

The I&A report documented that during witness statement collection, the CNA went and looked at the resident's bruise and reported to the nurse she (the CNA) thought the resident's bruise could have happened during the resident's 1/26/19 therapy session with the Physical Therapy Assistant (PTA) when using the Sit to Stand (STS) lift. The I&A report documented the Administrator and the DON were notified and the PTA was suspended from working pending investigation. The I&A report also documented the PTA was interviewed by the Director of Therapy on 1/28/19 and 2 more staff were interviewed on the same day. The I&A report also documented 5 residents who were under the care of the PTA were interviewed on 1/30/19 and there were no concerns noted.

The PTA's Time Card Report documented the PTA continued to work during the course of the investigation, as follows:

*1/27/19 - In at 9:59 PM and Out at 10:10 PM
*1/28/19 - In at 8:00 AM and Out at 4:00 PM
*1/29/19 - In at 9:15 AM and Out at 6:50 PM
*1/30/19 - In at 9:00 AM and Out at 5:49 PM

The Administrator was interviewed on 12/11/19 at 10:25 AM. The Administrator stated he was the Abuse Coordinator and he enlisted the assistance of the DON, Licensed Social Worker (LSW) and other departmental supervisors in investigating an abuse incident. The Administrator said the alleged perpetrator would be suspended immediately until the abuse was ruled out which could be from an hour to 24 hours or more and they could return to work after it was determined it was not abuse. The Administrator reviewed the PTA's Time Card Report and said PT staff could check in remotely to finish their documentation. The Administrator said the PTA was informed of the incident on Sunday, 1/27/19 and could have written her statement on 1/27/19 between 9:59 PM and 10:10 PM as shown on her Time Card Report. When asked why the PTA was allowed to come back to work on 1/28/19 through 1/30/19 while the investigation was still in progress, the Administrator said he had a conference call with the DON, LSW and the Director of Therapy on the night of 1/27/19 and they determined abuse did not occur based on staff and resident interviews, and the bruise was caused by the sling from the STS lift.

The facility did not ensure the PTA was not allowed to report for work while an investigation of alleged abuse was being conducted.

Additionally, the I&A report documented the staff were given education regarding customer service and abuse training, but there was no documentation that the PTA was evaluated for proper use of the STS lift or provided additional training related to its use.

On 12/10/19 at 9:31 AM, the Director of Therapy said the PTA had chosen to leave the facility about six weeks ago.

It could not be determined that the facility failed to ensure residents were free from abuse and mistreatment. Therefore, the allegation was unsubstantiated. However, it was determined the facility failed to ensure an alleged perpetrator of abuse was not allowed to report for work while an investigation was being conducted and deficient practice was cited at F610. The facility was also cited at F689 related to the facility's failure to ensure residents were protected from falls and that staff had used the STS lift correctly.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The facility failed to ensure sufficient numbers of trained staff were present to meet residents' needs.

Findings #2: The facility's policy titled Sufficient Qualified Nurse Staffing, dated 11/28/17, stated the facility provided licensed nurses and other nursing personnel to provide nursing care to all residents in accordance with resident care plans. The policy stated nursing and related services were provided to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by their assessments and individual plans of care. The policy also stated these services were provided with consideration to the number, acuity, and diagnoses of the facility's resident population in accordance with the required facility assessment.

The Facility Assessment Tool, dated 7/1/19, documented the facility's staffing plan for nursing care, which included Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs), Nursing Assistants (NAs), and hospitality aides (non-skilled care), was to be at 4.5 to 5.5 hours per resident per day.

The direct care nursing hours worked from 11/17/19 through 12/7/19 were reviewed. The staffing levels did not meet the 4.5 to 5.5 hours planned in the Facility Assessment Tool. The days for which the hours did not meet nursing care were as follows:

Sunday, 11/17/19 - 4.01
Saturday, 11/23/19 - 4.3
Sunday, 11/24/19 - 3.82
Saturday, 11/30/19 - 4.32
Sunday, 12/1/19 - 3.90
Saturday, 12/7/19 - 4.09

On 12/12/19 at 4:38 PM, the Director of Nursing (DON) and the Clinical Resource Nurse were asked if the Facility Assessment included a determination of the level and competency of staff needed to meet each residents' needs each day and during emergencies. The DON said "Yes." Both the DON and the Clinical Resource Nurse said the planned nursing hours per resident per day was 4.5 hours to 5.5 hours. The DON and the Clinical Resource Nurse stated they were not aware the staffing levels for the

past three weekends did not meet the planned staffing levels according to the Facility Assessment.

Observations were conducted at various times during all shifts throughout the survey. The residents' need were not observed to be consistently met. Examples included, but were not limited to, the following:

a. On 12/8/19 at 11:52 AM, a resident was in her wheelchair in the unit day room watching television. Her hair was matted and appeared unkempt. She had a non-stained clothing protector around her neck and chest area. She had on a sweater that was stained with streaks of food and excessive oral secretions underneath the clothing protector. The top left of her pants was soiled with food stains, near her hip.
On 12/8/19 at 11:59 AM, an RN assisted the resident to her room and changed her sweater with a new shirt and a new clothing protector. The RN said the stain to her shirt was probably pudding she had eaten earlier in the day. The RN then assisted the resident out of her room. The RN did not attempt to change the resident's pants or brush her matted hair.

b. On 12/8/19 at 1:01 PM, a resident was asked if he was cleaned up quickly when he became soiled (incontinent of stool). The resident shook his head from side to side indicating "no."

On 12/10/19 at 9:08 AM, the resident was in his room lying on his back in bed and there was a strong odor of stool. At 9:08 AM, an Activities Assistant went into the resident's room and delivered a paper for his roommate to read then left the room. At 9:14 AM, a CNA walked by the resident's room, looked in the room then walked away. At 9:18 AM, the CNA again walked by the resident's room, looked in the room then walked away. From 9:21 to 9:37 AM, a CNA and 2 RNs walked by the resident's room without entering although there was a distinct odor of stool in the hallway outside the resident's room.

An alarm sounded from the resident's roommate's ventilator. At 9:40 AM, an RN entered the room, the alarm was then quiet, and the RN exited the room. The odor was still present upon her exit. There continued to be the odor of stool in the hallway outside the resident's room. A CNA and an RN walked by the room without entering from 9:46 to 9:56 AM. At 10:24 AM, the resident was observed crying while lying in his bed. When asked if he had a soiled brief, he nodded his head up and down indicating "yes." When asked if he could reach the call light on his chest, the resident shook his head from side to side indicating "no."

Additionally, during observations on 12/8/19, it was noted an RN was completing tasks which were typically completed by a CNA. On 12/13/19 at 9:45 AM, an RN said there was a staffing problem in the facility that was why she worked as a CNA on 12/8/19. Further, on 12/10/19 at 9:10 AM, a Restorative Nursing Aide (RNA) said he was working as a CNA and said he would not be able to do the RNA program today. When asked who

would be doing the RNA program for the residents. the RNA said "Nobody." The RNA said he was pulled to work as a CNA about 4 to 5 times since he started working as an RNA 6 months ago.

Twenty-eight residents' records, including 3 closed records (meaning the residents had been discharged from the facility) were reviewed. Nine of the records, including 1 closed record, documented the residents' required therapy services. Seven of the 9 records included documentation that therapy services had been provided in accordance with the residents' care plan. For example, one resident's closed record documented the resident had received physical therapy (PT) and occupational therapy (OT) during her stay at the facility from 2/7/19 to 3/3/19. Billing for the PT and OT was reviewed, and no irregularities were noted. The resident's record documented she had received range of motion as specified by the physical therapist.

However, the records of 2 residents, who were residing at the facility at the time of the survey, did not include documentation they were receiving restorative therapy as ordered. One resident's record included physician orders, dated 11/26/19, which documented an active order for the resident to receive restorative nursing care and the resident's care plan, dated 9/30/19, documented staff was to monitor the need for consultation, and provide or screen the resident as needed for physical therapy. However, the resident record documented he was removed from physical and occupational therapy on 8/16/19. When asked on 12/8/19 at 10:17 AM, the resident's family member stated the facility no longer offered physical or restorative therapy for him.

On 12/12/19 at 9:30 AM, an RNA stated the resident was not receiving restorative care. The RNA stated the resident was taken off restorative care because he was so stiff it hurt him too much to move. The RNA stated the resident's family member was not notified why the resident was removed from restorative therapy.

Another resident's record included physical therapy treatment encounter notes, dated 11/21/19, which documented an RNA was instructed on range of motion to include bilateral lower extremities, 10 to 15 times for each extremity to increase and maintain the resident's range of motion. When asked on 12/8/19 at 10:33 AM, the resident's family member stated the facility was cutting back on the resident's physical therapy and he (the resident) was declining. The resident's family member stated she saw a decline in the resident's ability to move.

On 12/12/19 at 9:33 AM, an RNA stated the resident was put into the restorative program on 12/9/19 but had not yet received a restorative therapy session, 21 days after the restorative therapy recommendation was made by physical therapy.

Additionally, grievances and Resident Council Meeting minutes from 11/2018 to 12/2019 were reviewed. A grievance dated 5/22/19 documented a water pitcher was not

being changed and grievances dated 7/22/19 and 9/26/19 documented concerns regarding meals delivered late. Concerns regarding call lights not being answered in a timely manner and daily living needs not being met, including urinals (plastic urine containers) not being emptied, were found in grievances dated from 11/1/18 to 9/2019 and the Resident Council minutes dated 12/6/18, 8/7/19, 9/4/19, 10/2/19, 11/6/19 and 12/4/19, documented ongoing concerns regarding lengthy call light response times, showers, and dining which were not addressed by the facility.

A resident group interview was conducted with 8 residents on 12/10/19 at 2:35 PM. None of the residents expressed concerns regarding their water pitchers not being filled, but 3 residents said there were still issues with late delivery of meal trays, low food temperatures, slow call light response times and the facility not having enough staff. Five residents also said showers were not being completed, especially on Saturdays. The residents stated these concerns were not addressed by the facility.

Throughout the survey, 15 residents were interviewed individually. On 12/9/19 at 10:39 AM, one resident said he had missed his showers before but after his sister voiced his concern to the facility, he was now receiving his showers three times a week on Mondays, Wednesdays and Fridays, which was consistent with the documentation in the resident's record. The resident and the resident's room were observed to be clean, his urinals were empty, and no unpleasant smell was noted. When asked, the resident said he did not have to wait a long time for his meal trays to be delivered and most of the time he ate his meals in the dining room. At various times throughout the survey, the resident was observed. The resident's 2 water pitchers were observed filled with water and urinals were observed to be empty.

However, during the individual interviews, 3 other residents stated there were not enough staff to meet the residents' toileting needs and showering needs, medications were not administered on time and call lights were not responded to in a timely manner.

Four resident representatives and family members were also interviewed throughout the survey. The representatives and family members expressed concerns related to a lack of staff being available to provide sufficient supervision to residents who wandered, to prevent residents from falling, to ensure residents were provided with meals in a timely manner and to assist residents with their meals, toileting, hygiene, grooming and skin care needs. For example, on 12/10/19 at 3:02 PM, the co-guardians for a resident stated when they went in to visit or take the resident to an appointment, he often had a wet adult brief and the staff were not changing him. One of the guardians stated they had taken the resident to an appointment and at the appointment, a wound was found on his leg. The guardian stated the nurse at the appointment stated the wound should have been identified by the facility and it had been there "for a while." The guardian stated the staff at the facility should have been performing weekly skin checks to identify these types of issues. Additionally, another resident's family member stated she had been concerned with the resident receiving an appropriate diet, assistance with meals,

incontinence care, bathing and grooming. The resident's family member stated hospice services had been initiated for the resident and her concerns had decreased since then.

Six CNAs and 3 LPNs were interviewed throughout the survey. The staff stated there were not enough staff to provide the care required and to meet all of the residents' needs. Staff stated several residents required 2-person assistance with transfers, and showers and grooming activities were not completed. Staff also stated there was not enough staff to assist residents during meals.

The records of the 28 residents that were reviewed documented the residents had varied needs requiring extensive staff assistance. For example, 3 residents engaged in wandering behavior requiring increased supervision and no less than 3 residents required increased supervision and assistance related to falls. Additionally, of the 28 residents' records that were reviewed, 13 resident records did not include documentation the residents received care as specified in their care plans. Examples included, but were not limited to, the following:

- A resident's Care Plan, undated, documented the resident was dependent on staff for bathing. He was to be assisted with bathing twice per week and as needed.
The resident's ADL Reports for October, November, and December 2019 documented he did not receive a bath/shower from 10/5/19 to 10/11/19 (6 days), from 10/16/19 to 10/22/19 (6 days), from 10/23/19 to 11/4/19 (11 days), from 11/5/19 to 11/25/19 (20 days), and from 12/7/19 to 12/11/19 (5 days).

On 12/8/19 and on 12/12/19 at 10:25 AM and 8:57 AM respectively, the resident stated the time between showers/baths had gotten longer. He said his regular scheduled shower days were Wednesdays and Saturdays and he said the facility wanted to change his Saturday schedule to a different day and he told them no.

- A resident's Care Plan, dated 11/21/19, documented she was dependent on staff and directed staff to provide assistance with her bathing and personal hygiene.

The resident's ADL Reports for November and December 2019, documented her bathing days were Tuesday and Friday and as needed. The reports documented she was not bathed from 11/20/19 to 11/26/19 (7 days) and from 11/27/19 to 12/3/19 (7 days).

- A resident's Care Plan, revised on 11/18/19, documented he required extensive assistance of 1-2 staff for bathing. The facility's shower schedule documented the resident's shower schedule was Mondays and Thursdays in the morning.

The resident's ADL report for November 2019 and December 2019 documented there were no showers given or offered from 11/6/19 to 11/10/19 (5 days), from 11/12/19 to 11/17/19 (6 days) and from 12/6/19 to 12/10/19 (5 days).

On 12/10/19 at 2:15 PM, the resident stated his last shower was on 12/5/19.

- A resident's Care Plan, dated 11/26/19, directed staff to provide 1-person assistance with bathing.

The resident's ADL Reports for November and December 2019, documented her bathing days were Wednesday and Saturday and as needed. The reports documented she was not bathed from 11/28/19 to 12/2/19 (5 days) and from 12/5/19 to 12/9/19 (5 days).

On 12/8/19 at 11:33 AM, the resident said since she had been admitted to the facility, she had not received her showers as scheduled.

Further, the facility's policy for Nurse Aide Staffing, dated 11/28/17, stated nurse aides were to receive at least 12 hours of in-service training each employment year based on the outcome of the annual performance review and special needs of the resident population and Nurse aides were to demonstrate competency in areas such as communication and personal skills, basic nursing skills, personal care skills, mental health and social service needs, basic restorative services, and Resident Rights.

However, the facility's records did not include documentation that CNAs received the required competency evaluations and completed the required hours of yearly training for 5 of 5 CNAs whose records were reviewed.

On 12/12/19 at 4:38 PM, the DON stated the Staff Development Coordinator was responsible for overseeing nursing competencies. The DON stated nursing staff should be evaluated to assess their competencies, skills, and knowledge "Yearly or if there is a change."

It was determined the facility failed to ensure sufficient numbers of trained staff were provided to meet the residents' needs. Therefore, the allegation was substantiated, and deficient practice was cited at F725 related to the number of staff and F730 related to the lack of staff training and competency evaluations. The facility was also cited at F550 related to the facility's failure to ensure residents were not left in soiled incontinent briefs for extended periods of time, F585 related to the facility's failure to resolve grievances, F677 related to the facility's failure to ensure bathing and/or grooming, incontinence care, and transfers were provided consistent with residents' needs, F688 related to the facility's failure to increase or prevent a decrease in the residents' range of motion, F804 related to the facility's failure to ensure palatable food was served and F805 related to the facility's failure to ensure residents were provided with a diet that was consistent with physician orders.

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

Allegation #3: Residents are not provided the care and services necessary to prevent the development of pressure ulcers.

Findings #3: During the survey, resident records were reviewed, staff were interviewed, and observations were conducted.

Six resident records, including 2 closed records, were reviewed for care and services related to pressure ulcer prevention and treatment. The records included documentation of interventions taken for residents who were at risk of developing pressure ulcers. Concerns related to pressure ulcer prevention and treatment were not identified in 4 of the 6 resident records reviewed.

One closed record documented the resident was turned/repositioned as ordered, had a low air loss mattress, and did not have skin breakdown. Documentation of other positioning orders, such as the head of the resident's bed being elevated, was not included in the resident's record.

However, 2 residents' records included documentation that the residents had developed pressure ulcers while residing at the facility. One resident's record included a weekly skin report, dated 10/31/19 at 5:28 PM, which documented the resident had a new pressure ulcer on his right outer ankle which was unstageable and potentially caused by the resident's suprapubic catheter tubing.

On 12/10/19 at 3:30 PM, the DON stated the resident was at a higher risk for development of pressure ulcers with edema (swelling) in their bilateral lower extremities. The DON stated the development of the pressure ulcer on the resident's right outer ankle could have been avoided if the staff had monitored the position of the catheter tubing and the length of time the catheter tubing had been applying pressure to the skin.

Another resident's record included a wound clinic assessment note, dated 12/10/19, which documented a wound to the resident's right heel as an unhealed pressure ulcer. The assessment note stated "Deep Tissue Pressure Injury, persistent non-blanchable deep red, maroon or purple discoloration" measuring 4.2 cm x 1.7 cm x 0. The assessment note did not include information related to when the wound was acquired.

On 12/11/19 at 8:38 AM, the Wound Nurse stated the left ankle pressure ulcer and the deep tissue pressure injury to the resident's right heel developed in the facility.

The resident's record also documented treatment orders for multiple wounds, which were not implemented. The resident's 11/26/19 wound treatment orders, modified the dressing changes and included Santyl (an enzyme used to heal skin ulcers). The orders stated:

* Right and left ankles: Cleanse with normal saline or wound spray, apply skin protectant, apply debriding (removal of dead or infected skin) agent Santyl (an enzyme used to heal skin ulcers) and cover with slightly moist gauze, then cover with dry gauze securing with a cloth tape, change dressing daily and as needed for soiling, saturation, or accidental removal.

* Right buttock: cleanse the wound with normal saline or wound spray and apply skin protectant, it did not include applying a zinc oxide-based cream.

The resident's wound clinic assessment note, dated 12/3/19, documented their buttocks and right ankle wounds had decreased in size, but the left ankle wound had increased in size from 1.5 cm x 1.3 cm x 0.1 cm on 11/19/19 to 1.8 cm x 1.6 cm x 0 cm. The note also documented the left ankle wound had a scant amount of drainage.

The resident's wound clinic assessment note, dated 11/26/19, documented interventions which included repositioning the resident every 2 to 3 hours to alleviate pressure and wearing off-loading boots (Prevalon) to both lower extremities.

Wound clinic treatment orders for the resident, dated 12/3/19, stated to continue the previous wound care recommendations.

The resident's December 2019 TAR (Treatment Administration Record) did not include documentation the 11/26/19 orders were immediately implemented. The December 2019 TAR documented the Santyl start date for the left and right ankles was 12/5/19 (nine days after the 11/26/19 order). The December 2019 TAR documented the dressing changes, also started on 12/5/19, that the dressing were to be changed Monday through Friday, which was not consistent with the 11/26/19 order which stated the dressings were to be changed every day and as needed for soiling, saturation, or accidental removal. The December 2019 TAR did not include documentation that the wound dressings on the resident's left and right ankles were changed on 12/7/19 and 12/8/19. Further, the resident's December 2019 TAR did not include documentation the order for the resident to have bilateral heel protectors while in bed had been implemented until 12/8/19 (twelve days after the 11/26/19 order).

The resident was observed at various times throughout the survey. The resident's wound care orders were not observed to be consistently implemented. Examples included, but were not limited to, the following:
On 12/8/19 at 10:33 AM, the resident was observed lying in bed. The sheets were not covering the resident's legs. A pillow was positioned under each leg, he was not wearing Prevalon boots, and no dressings were observed on the resident's ankle wounds.

On 12/8/19 at 10:56 AM, 11:28 AM, 11:40 AM, and 12:02 PM, the resident's feet were touching the footboard of the bed, he was not wearing Prevalon boots, and there were no dressings observed on the resident's ankle wounds.

On 12/9/19 at 9:32 AM, the resident was lying in bed with his heels resting on pillows. He was not wearing Prevalon boots and there were no dressings observed on the resident's ankle wounds.

On 12/11/19 at 8:24 AM, a UM (Unit Manager) was asked about the resident not having any dressing on his pressure ulcers on 12/8/19 and 12/9/19. He stated if the dressings got wet they were changed and the resident was "very edematous" so the dressings may have slipped off.

It was determined the facility failed to ensure residents were provided with care and services necessary to prevent the development of pressure ulcers. The allegation was substantiated and deficient practice was cited at F686.

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.

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/ac

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HEALTH & WELFARE

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DAVE JEPPESEN – Director

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April 8, 2020

Royal Jensen, Administrator
Cascadia of Boise
6000 W. Denton St.
Boise, ID 83704

Provider #: 135146

Dear Mr. Jensen:

On **December 8, 2019** through **December 13, 2019**, an unannounced on-site complaint survey was conducted at Cascadia of Boise. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008282

ALLEGATION #1:

The facility failed to ensure incidents were investigated and residents were free from abuse, neglect, and mistreatment.

FINDINGS #1:

During the survey, observations and interviews were conducted and resident records, Incident and Accident reports (I&A), reportable events, grievances, and Resident Council minutes were reviewed with the following results:

Eighteen residents were observed throughout the survey. Multiple staff were observed to interact with residents in a respectful manner and safety devices were observed throughout the facility. Examples included, but were not limited to, the following:

All resident bathrooms were equipped with grab bars. In addition, on 12/8/19 at 10:52 AM, one resident was observed being transferred by a Certified Nursing Assistant (CNA) and a Registered Nurse (RN) using a Hoyer lift (mechanical lift) that was secured to the ceiling. The resident was given instruction and was transferred safely from his bed to his wheelchair. There was no concern noted.

On 12/12/19 at 8:45 AM, a Shower Aide was observed providing a bed bath to a resident. The Shower Aide was talking to the resident as she gave the resident a bed bath and the resident was smiling and conversed with the Shower Aide. Concerns related to abuse were not identified during the observations.

On 12/10/19 at 2:35 PM, 8 residents attended a group interview and no concerns were voiced regarding abuse. Fifteen residents were also interviewed individually throughout the survey. No concerns were voiced regarding abuse.

On 12/11/19 at 10:25 AM, the Administrator was interviewed. The Administrator said if staff witnessed abuse, he/she should intervene, keep the resident safe and report it immediately. The Administrator said if staff suspected abuse, staff were to stop and report all incidents of potential abuse.

Throughout the survey, 6 Certified Nursing Assistants (CNAs), 3 Licensed Practical Nurses (LPNs), and 3 Registered Nurses (RNs) were interviewed. The staff said if they saw abuse or staff threatening residents, they would stop it immediately, make sure the resident was safe, and immediately report it to their supervisor, the Director of Nursing (DON), and/or the Administrator.

Grievances and Resident Council minutes from 11/2018 to 12/2019 were reviewed. Grievances related to abuse were investigated as a reportable event. The facility's I&A reports from 10/2018 to 12/2019 were also reviewed. The I&As included several allegations of abuse involving several residents. All of the allegations had been investigated including, but not limited to, the following:

An I&A, dated 3/4/19, documented an allegation that a staff member had thrown water in a resident's face because the resident did not swallow their medications quickly enough. The accused staff was suspended from working and an investigation was conducted. Upon completion of the investigation, the allegation of physical abuse was unsubstantiated.

An I&A, dated 5/25/19, documented a resident fell out of bed and was incontinent. The facility investigated the incident and added a 1:1 sitter for the resident's safety. No resident neglect related to the incident was identified.

An I&A, dated 10/12/18, alleged that a staff member had put feces in a resident's face, flicked her fingers on the resident's forehead and asked the resident what they were thinking. The I&A also alleged the staff belittled the resident and called the resident a trouble maker. The accused staff was suspended from working and an investigation was conducted. Upon completion of the investigation, the allegation was unsubstantiated and the staff member returned to work.

An I&A report documented a resident fell in September of 2019 after walking unobserved from his bed to the bathroom in his room to use the toilet. The report documented witnesses stated the resident had not pressed the call light to request help. The report documented when found in the bathroom the resident said, "I was told they wanted me to start walking more by myself." Therapists said they worked with the resident, he was not one to walk to the bathroom, he had a history of asking CNAs to assist with his brief change in bed. No resident neglect related to the incident was identified.

An I&A report documented another resident fell in mid-November 2019. The investigation documented the resident rolled out of bed and fell onto the floor. The investigation documented the resident's bed was not in the low position as directed by his Bed Safety Evaluation. A second Post Fall Investigation documented the resident also had an unwitnessed fall in late November 2019. However, there were no new documented interventions on the resident's care plan to prevent further falls. A Post Fall Investigation documented the resident had a third unwitnessed fall in late November 2019, while transferring out of his wheelchair and into the bed. No new interventions were documented on the resident's care plan.

When asked, on 12/10/19 at 10:58 AM, the Unit Manager stated the resident's fall risk score indicated he was a high fall risk. The Unit Manager stated care plan interventions should be completed after each fall.

The resident's record was reviewed. The record included a physician's order, dated 11/25/19, which documented the resident was to have a fall mat to the right side of his bed and a physician's order, dated 12/2/19, documented the resident was to have his bed in the lowest position.

However, on 12/10/19 at 10:07 AM, the resident was observed lying in bed. There was no fall mat on the floor by his bed and the bed was not in the lowest position. On 12/10/19 at 10:56 AM, the Unit Manager stated there was no floor mat in the resident's room and he should have one.

Additionally, an I&A, dated 9/17/19, documented a resident had a bruise of unknown injury reported by facility staff. The injury was investigated and was found to be an underlying clinical condition unrelated to physical abuse.

The I&A documented the injury was unsubstantiated for abuse. On 12/10/19 at 12:25 PM, a family member of the resident was interviewed. The family member stated the residents' bruises and skin tears had decreased since a Hoyer Lift was now used to transfer the resident.

However, an I&A, dated 1/27/19, documented a bruise had been found on another resident on 1/27/19. A corresponding nurse's note in the resident's closed record (meaning the resident had been discharged from the facility) documented on 1/27/19 at 5:30 PM, the nurse was called by a CNA to check on the bruise found on the resident's arm. The bruise measured 11 cm x 9 cm, extending down to her right breast measuring 8 cm x 5 cm. The resident denied pain and did not know how it happened.

The I&A report documented that during witness statement collection, the CNA went and looked at the resident's bruise and reported to the nurse she (the CNA) thought the resident's bruise could have happened during the resident's 1/26/19 therapy session with the Physical Therapy Assistant (PTA) when using the Sit to Stand (STS) lift. The I&A report documented the Administrator and the DON were notified and the PTA was suspended from working pending investigation.

The I&A report also documented the PTA was interviewed by the Director of Therapy on 1/28/19 and 2 more staff were interviewed on the same day. The I&A report also documented 5 residents who were under the care of the PTA were interviewed on 1/30/19 and there were no concerns noted.

The PTA's Time Card Report documented the PTA continued to work during the course of the investigation, as follows:

- 1/27/19 - In at 9:59 PM and Out at 10:10 PM
- 1/28/19 - In at 8:00 AM and Out at 4:00 PM
- 1/29/19 - In at 9:15 AM and Out at 6:50 PM
- 1/30/19 - In at 9:00 AM and Out at 5:49 PM

The Administrator was interviewed on 12/11/19 at 10:25 AM. The Administrator stated he was the Abuse Coordinator and he enlisted the assistance of the DON, Licensed Social Worker (LSW) and other departmental supervisors in investigating an abuse incident. The Administrator said the alleged perpetrator would be suspended immediately until the abuse was ruled out which could be from an hour to 24 hours or more and they could return to work after it was determined it was not abuse. The Administrator reviewed the PTA's Time Card Report and said PT staff could check in remotely to finish their documentation. The Administrator said the PTA was informed of the incident on Sunday, 1/27/19 and could have written her statement on 1/27/19 between 9:59 PM and 10:10 PM as shown on her Time Card Report.

When asked why the PTA was allowed to come back to work on 1/28/19 through 1/30/19 while the investigation was still in progress, the Administrator said he had a conference call with the DON, LSW and the Director of Therapy on the night of 1/27/19 and they determined abuse did not occur based on staff and resident interviews, and the bruise was caused by the sling from the STS lift.

The facility did not ensure the PTA was not allowed to report for work while an investigation of alleged abuse was being conducted.

Additionally, the I&A report documented the staff were given education regarding customer service and abuse training, but there was no documentation that the PTA was evaluated for proper use of the STS lift or provided additional training related to its use.

On 12/10/19 at 9:31 AM, the Director of Therapy said the PTA had chosen to leave the facility about six weeks ago.

It could not be determined that the facility failed to ensure residents were free from abuse and mistreatment. Therefore, the allegation was unsubstantiated. However, it was determined the facility failed to ensure an alleged perpetrator of abuse was not allowed to report for work while an investigation was being conducted and deficient practice was cited at F610. The facility was also cited at F689 related to the facility's failure to ensure residents were protected from falls and that staff had used the STS lift correctly.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

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

FINDINGS #2:

The facility's policy titled Sufficient Qualified Nurse Staffing, dated 11/28/17, stated the facility provided licensed nurses and other nursing personnel to provide nursing care to all residents in accordance with resident care plans. The policy stated nursing and related services were provided to ensure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by their assessments and individual plans of care. The policy also stated these services were provided with consideration to the number, acuity, and diagnoses of the facility's resident population in accordance with the required facility assessment.

The Facility Assessment Tool, dated 7/1/19, documented the facility's staffing plan for nursing care, which included Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs), Nursing Assistants (NAs), and hospitality aides (non-skilled care), was to be at 4.5 to 5.5 hours per resident per day.

The direct care nursing hours worked from 11/17/19 through 12/7/19 were reviewed. The staffing levels did not meet the 4.5 to 5.5 hours planned in the Facility Assessment Tool. The days for which the hours did not meet nursing care were as follows:

Sunday, 11/17/19 - 4.01
Saturday, 11/23/19 - 4.3
Sunday, 11/24/19 - 3.82
Saturday, 11/30/19 - 4.32
Sunday, 12/1/19 - 3.90
Saturday, 12/7/19 - 4.09

On 12/12/19 at 4:38 PM, the Director of Nursing (DON) and the Clinical Resource Nurse were asked if the Facility Assessment included a determination of the level and competency of staff needed to meet each residents' needs each day and during emergencies. The DON said "Yes." Both the DON and the Clinical Resource Nurse said the planned nursing hours per resident per day was 4.5 hours to 5.5 hours. The DON and the Clinical Resource Nurse stated they were not aware the staffing levels for the past three weekends did not meet the planned staffing levels according to the Facility Assessment.

Observations were conducted at various times during all shifts throughout the survey. The residents' need were not observed to be consistently met. Examples included, but were not limited to, the following:

a. On 12/8/19 at 11:52 AM, a resident was in her wheelchair in the unit day room watching television. Her hair was matted and appeared unkempt. She had a non-stained clothing protector around her neck and chest area. She had on a sweater that was stained with streaks of food and excessive oral secretions underneath the clothing protector. The top left of her pants was soiled with food stains, near her hip.

On 12/8/19 at 11:59 AM, an RN assisted the resident to her room and changed her sweater with a new shirt and a new clothing protector. The RN said the stain to her shirt was probably pudding she had eaten earlier in the day. The RN then assisted the resident out of her room. The RN did not attempt to change the resident's pants or brush her matted hair.

b. On 12/8/19 at 1:01 PM, a resident was asked if he was cleaned up quickly when he became soiled (incontinent of stool). The resident shook his head from side to side indicating "no."

On 12/10/19 at 9:08 AM, the resident was in his room lying on his back in bed and there was a strong odor of stool. At 9:08 AM, an Activities Assistant went into the resident's room and delivered a paper for his roommate to read then left the room. At 9:14 AM, a CNA walked by the resident's room, looked in the room then walked away. At 9:18 AM, the CNA again walked by the resident's room, looked in the room then walked away. From 9:21 to 9:37 AM, a CNA and 2 RNs walked by the resident's room without entering although there was a distinct odor of stool in the hallway outside the resident's room.

An alarm sounded from the resident's roommate's ventilator. At 9:40 AM, an RN entered the room, the alarm was then quiet, and the RN exited the room. The odor was still present upon her exit. There continued to be the odor of stool in the hallway outside the resident's room. A CNA and an RN walked by the room without entering from 9:46 to 9:56 AM. At 10:24 AM, the resident was observed crying while lying in his bed. When asked if he had a soiled brief, he nodded his head up and down indicating "yes." When asked if he could reach the call light on his chest, the resident shook his head from side to side indicating "no."

During observations on 12/8/19, it was noted an RN was completing tasks which were typically completed by a CNA. On 12/13/19 at 9:45 AM, an RN said there was a staffing problem in the facility that was why she worked as a CNA on 12/8/19. Further, on 12/10/19 at 9:10 AM, a Restorative Nursing Aide (RNA) said he was working as a CNA and said he would not be able to do the RNA program today. When asked who would be doing the RNA program for the residents. the RNA said "Nobody." The RNA said he was pulled to work as a CNA about 4 to 5 times since he started working as an RNA 6 months ago.

Twenty-eight residents' records, including 3 closed records (meaning the residents had been discharged from the facility) were reviewed. Nine of the records, including 1 closed record, documented the residents' required therapy services. Seven of the 9 records included documentation that therapy services were provided in accordance with the residents' care plan. For example, one resident's closed record documented the resident had received physical therapy (PT) and occupational therapy (OT) during her stay at the facility from 2/7/19 to 3/3/19. Billing for the PT and OT was reviewed, and no irregularities were noted. The resident's record documented she had received range of motion as specified by the physical therapist.

However, the records of 2 residents, who were residing at the facility at the time of the survey, did not include documentation they were receiving restorative therapy as ordered.

One resident's record included physician orders, dated 11/26/19, which documented an active order for the resident to receive restorative nursing care and the resident's care plan, dated 9/30/19, documented staff was to monitor the need for consultation, and provide or screen the resident as needed for physical therapy. However, the resident record documented he was removed from physical and occupational therapy on 8/16/19. When asked on 12/8/19 at 10:17 AM, the resident's family member stated the facility no longer offered physical or restorative therapy for him.

On 12/12/19 at 9:30 AM, an RNA stated the resident was not receiving restorative care. The RNA stated the resident was taken off restorative care because he was so stiff it hurt him too much to move. The RNA stated the resident's family member was not notified why the resident was removed from restorative therapy.

Another resident's record included physical therapy treatment encounter notes, dated 11/21/19, which documented an RNA was instructed on range of motion to include bilateral lower extremities, 10 to 15 times for each extremity to increase and maintain the resident's range of motion. When asked on 12/8/19 at 10:33 AM, the resident's family member stated the facility was cutting back on the resident's physical therapy and he (the resident) was declining. The resident's family member stated she saw a decline in the resident's ability to move.

On 12/12/19 at 9:33 AM, an RNA stated the resident was put into the restorative program on 12/9/19 but had not yet received a restorative therapy session, 21 days after the restorative therapy recommendation was made by physical therapy.

Grievances and Resident Council Meeting minutes from 11/2018 to 12/2019 were also reviewed. A grievance dated 5/22/19 documented a water pitcher was not being changed and grievances dated 7/22/19 and 9/26/19 documented concerns regarding meals delivered late. Concerns regarding call lights not being answered in a timely manner and daily living needs not being met, including urinals (plastic urine containers) not being emptied, were found in grievances dated from 11/1/18 to 9/2019 and the Resident Council minutes dated 12/6/18, 8/7/19, 9/4/19, 10/2/19, 11/6/19 and 12/4/19, documented ongoing concerns regarding lengthy call light response times, showers, and dining which were not addressed by the facility.

A resident group interview was conducted with 8 residents on 12/10/19 at 2:35 PM. None of the residents expressed concerns regarding their water pitchers not being filled, but 3 residents said there were still issues with late delivery of meal trays, low food temperatures, slow call light response times and the facility not having enough staff. Five residents also said showers were not being completed, especially on Saturdays. The residents stated these concerns were not addressed by the facility.

Throughout the survey, 15 residents were interviewed individually. On 12/9/19 at 10:39 AM, one resident said he had missed his showers before but after his sister voiced his concern to the facility, he was now receiving his showers three times a week on Mondays, Wednesdays and Fridays, which was consistent with the documentation in the resident's record. The resident and the resident's room were observed to be clean, his urinals were empty, and no unpleasant smell was noted. When asked, the resident said he did not have to wait a long time for his meal trays to be delivered and most of the time he ate his meals in the dining room. At various times throughout the survey, the resident was observed. The resident's 2 water pitchers were observed filled with water and urinals were observed to be empty.

However, during the individual interviews, 3 other residents stated there were not enough staff to meet the residents' toileting needs and showering needs, medications were not administered on time and call lights were not responded to in a timely manner.

Four resident representatives and family members were also interviewed throughout the survey. The representatives and family members expressed concerns related to a lack of staff being available to provide sufficient supervision to residents who wandered, to prevent residents from falling, to ensure residents were provided with meals in a timely manner and to assist residents with their meals, toileting, hygiene, grooming and skin care needs. For example, on 12/10/19 at 3:02 PM, the co-guardians for a resident stated when they went in to visit or take the resident to an appointment, he often had a wet adult brief and the staff were not changing him. One of the guardians stated they had taken the resident to an appointment and at the appointment, a wound was found on his leg. The guardian stated the nurse at the appointment stated the wound should have been identified by the facility and it had been there "for a while." The guardian stated the staff at the facility should have been performing weekly skin checks to identify these types of issues. Additionally, another resident's family member stated she had been concerned with the resident receiving an appropriate diet, assistance with meals, incontinence care, bathing and grooming. The resident's family member stated hospice services had been initiated for the resident and her concerns had decreased since then.

Six CNAs and 3 LPNs were interviewed throughout the survey. The staff stated there were not enough staff to provide the care required and to meet all of the residents' needs. Staff stated several residents required 2-person assistance with transfers, and showers and grooming activities were not completed. Staff also stated there was not enough staff to assist residents during meals.

The records of the 28 residents that were reviewed documented the residents had varied needs requiring extensive staff assistance. For example, 3 residents engaged in wandering behavior requiring increased supervision and no less than 3 residents required increased supervision and assistance related to falls.

Additionally, of the 28 residents' records that were reviewed, 13 resident records did not include documentation the residents received care as specified in their care plans. Examples included, but were not limited to, the following:

- A resident's Care Plan, undated, documented the resident was dependent on staff for bathing. He was to be assisted with bathing twice per week and as needed.

The resident's ADL Reports for October, November, and December 2019 documented he did not receive a bath/shower from 10/5/19 to 10/11/19 (6 days), from 10/16/19 to 10/22/19 (6 days), from 10/23/19 to 11/4/19 (11 days), from 11/5/19 to 11/25/19 (20 days), and from 12/7/19 to 12/11/19 (5 days).

On 12/8/19 and on 12/12/19 at 10:25 AM and 8:57 AM respectively, the resident stated the time between showers/baths had gotten longer. He said his regular scheduled shower days were Wednesdays and Saturdays and he said the facility wanted to change his Saturday schedule to a different day and he told them no.

- A resident's Care Plan, dated 11/21/19, documented she was dependent on staff and directed staff to provide assistance with her bathing and personal hygiene.

The resident's ADL Reports for November and December 2019, documented her bathing days were Tuesday and Friday and as needed. The reports documented she was not bathed from 11/20/19 to 11/26/19 (7 days) and from 11/27/19 to 12/3/19 (7 days).

- A resident's Care Plan, revised on 11/18/19, documented he required extensive assistance of 1-2 staff for bathing. The facility's shower schedule documented the resident's shower schedule was Mondays and Thursdays in the morning.

The resident's ADL report for November 2019 and December 2019 documented there were no showers given or offered from 11/6/19 to 11/10/19 (5 days), from 11/12/19 to 11/17/19 (6 days) and from 12/6/19 to 12/10/19 (5 days).

On 12/10/19 at 2:15 PM, the resident stated his last shower was on 12/5/19.

- A resident's Care Plan, dated 11/26/19, directed staff to provide 1-person assistance with bathing.

The resident's ADL Reports for November and December 2019, documented her bathing days were Wednesday and Saturday and as needed. The reports documented she was not bathed from 11/28/19 to 12/2/19 (5 days) and from 12/5/19 to 12/9/19 (5 days).

On 12/8/19 at 11:33 AM, the resident said since she had been admitted to the facility, she had not received her showers as scheduled.

Further, the facility's policy for Nurse Aide Staffing, dated 11/28/17, stated nurse aides were to receive at least 12 hours of in-service training each employment year based on the outcome of the annual performance review and special needs of the resident population and Nurse aides were to demonstrate competency in areas such as communication and personal skills, basic nursing skills, personal care skills, mental health and social service needs, basic restorative services, and Resident Rights.

However, the facility's records did not include documentation that CNAs received the required competency evaluations and completed the required hours of yearly training for 5 of 5 CNAs whose records were reviewed.

On 12/12/19 at 4:38 PM, the DON stated the Staff Development Coordinator was responsible for overseeing nursing competencies. The DON stated nursing staff should be evaluated to assess their competencies, skills, and knowledge "Yearly or if there is a change."

It was determined the facility failed to ensure sufficient numbers of trained staff were provided to meet the residents' needs. Therefore, the allegation was substantiated, and deficient practice was cited at F725 related to the number of staff and F730 related to the lack of staff training and competency evaluations. The facility was also cited at F550 related to the facility's failure to ensure residents were not left in soiled incontinent briefs for extended periods of time, F585 related to the facility's failure to resolve grievances, F677 related to the facility's failure to ensure bathing and/or grooming, incontinence care, and transfers were provided consistent with residents' needs, F688 related to the facility's failure to increase or prevent a decrease in the residents' range of motion, F804 related to the facility's failure to ensure palatable food was served and F805 related to the facility's failure to ensure residents were provided with a diet that was consistent with physician orders.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

Residents are not provided the care and services necessary to prevent the development of pressure ulcers.

FINDINGS #3:

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

Six resident records, including 2 closed records, were reviewed for care and services related to pressure ulcer prevention and treatment. The records included documentation of interventions taken for residents who were at risk of developing pressure ulcers. Concerns related to pressure ulcer prevention and treatment were not identified in 4 of the 6 resident records reviewed.

One closed record documented the resident was turned/repositioned as ordered, had a low air loss mattress, and did not have skin breakdown. Documentation of other positioning orders, such as the head of the resident's bed being elevated, was not included in the resident's record.

However, 2 residents' records included documentation that the residents had developed pressure ulcers while residing at the facility. One resident's record included a weekly skin report, dated 10/31/19 at 5:28 PM, which documented the resident had a new pressure ulcer on his right outer ankle which was unstageable and potentially caused by the resident's suprapubic catheter tubing.

On 12/10/19 at 3:30 PM, the DON stated the resident was at a higher risk for development of pressure ulcers with edema (swelling) in their bilateral lower extremities. The DON stated the development of the pressure ulcer on the resident's right outer ankle could have been avoided if the staff had monitored the position of the catheter tubing and the length of time the catheter tubing had been applying pressure to the skin.

Another resident's record included a wound clinic assessment note, dated 12/10/19, which documented a wound to the resident's right heel as an unhealed pressure ulcer. The assessment note stated "Deep Tissue Pressure Injury, persistent non-blanchable deep red, maroon or purple discoloration" measuring 4.2 cm x 1.7 cm x 0. The assessment note did not include information related to when the wound was acquired.

On 12/11/19 at 8:38 AM, the Wound Nurse stated the left ankle pressure ulcer and the deep tissue pressure injury to the resident's right heel developed in the facility.

The resident's record also documented treatment orders for multiple wounds, which were not implemented. The resident's 11/26/19 wound treatment orders, modified the dressing changes and included Santyl (an enzyme used to heal skin ulcers). The orders stated:

* Right and left ankles: Cleanse with normal saline or wound spray, apply skin protectant, apply debriding (removal of dead or infected skin) agent Santyl (an enzyme used to heal skin ulcers) and cover with slightly moist gauze, then cover with dry gauze securing with a cloth tape, change dressing daily and as needed for soiling, saturation, or accidental removal.

* Right buttock: cleanse the wound with normal saline or wound spray and apply skin protectant, it did not include applying a zinc oxide-based cream.

The resident's wound clinic assessment note, dated 12/3/19, documented their buttocks and right ankle wounds had decreased in size, but the left ankle wound had increased in size from 1.5 cm x 1.3 cm x 0.1 cm on 11/19/19 to 1.8 cm x 1.6 cm x 0 cm. The note also documented the left ankle wound had a scant amount of drainage.

The resident's wound clinic assessment note, dated 11/26/19, documented interventions which included repositioning the resident every 2 to 3 hours to alleviate pressure and wearing off-loading boots (Prevalon) to both lower extremities.

Wound clinic treatment orders for the resident, dated 12/3/19, stated to continue the previous wound care recommendations.

The resident's December 2019 TAR (Treatment Administration Record) did not include documentation the 11/26/19 orders were immediately implemented. The December 2019 TAR documented the Santyl start date for the left and right ankles was 12/5/19 (nine days after the 11/26/19 order). The December 2019 TAR documented the dressing changes, also started on 12/5/19, that the dressing were to be changed Monday through Friday, which was not consistent with the 11/26/19 order which stated the dressings were to be changed every day and as needed for soiling, saturation, or accidental removal. The December 2019 TAR did not include documentation that the wound dressings on the resident's left and right ankles were changed on 12/7/19 and 12/8/19. Further, the resident's December 2019 TAR did not include documentation the order for the resident to have bilateral heel protectors while in bed had been implemented until 12/8/19 (twelve days after the 11/26/19 order).

The resident was observed at various times throughout the survey. The resident's wound care orders were not observed to be consistently implemented. Examples included, but were not limited to, the following:

On 12/8/19 at 10:33 AM, the resident was observed lying in bed. The sheets were not covering the resident's legs. A pillow was positioned under each leg, he was not wearing Prevalon boots, and no dressings were observed on the resident's ankle wounds.

On 12/8/19 at 10:56 AM, 11:28 AM, 11:40 AM, and 12:02 PM, the resident's feet were touching the footboard of the bed, he was not wearing Prevalon boots, and there were no dressings observed on the resident's ankle wounds.

On 12/9/19 at 9:32 AM, the resident was lying in bed with his heels resting on pillows. He was not wearing Prevalon boots and there were no dressings observed on the resident's ankle wounds.

On 12/11/19 at 8:24 AM, a UM (Unit Manager) was asked about the resident not having any dressing on his pressure ulcers on 12/8/19 and 12/9/19. He stated if the dressings got wet they were changed and the resident was "very edematous" so the dressings may have slipped off.

It was determined the facility failed to ensure residents were provided with care and services necessary to prevent the development of pressure ulcers. The allegation was substantiated and deficient practice was cited at F686.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

Residents' personal possessions are missing.

FINDINGS #4:

Grievances and Resident Council minutes from 11/2018 to 12/2019 were reviewed. Grievances, dated 3/26/19 and 6/13/19, documented 1 resident was missing clothing. The grievance was investigated and the missing clothing was not found. The facility replaced the resident's missing items

On 12/10/19 at 2:35 PM, 8 residents attended a group interview. Throughout the survey, 15 residents were interviewed individually and they did not have a concern regarding missing personal possessions.

Additionally, 4 residents' representatives were interviewed and they did not have a concern regarding missing personal possessions.

It was determined that a resident's personal possessions were missing. Therefore, the allegation was substantiated. However, the facility replaced the missing items. Therefore, no deficient practice was cited.

CONCLUSIONS:

Substantiated. No 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

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj