



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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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

Kurt Holm, Administrator
McCall Rehabilitation And Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

Dear Mr. Holm:

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

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed.

NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back

in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **January 21, 2020**. Failure to submit an acceptable PoC by **January 21, 2020**, may result in the imposition of penalties by **February 10, 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **January 22, 2020 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **March 18, 2020**. A change in the seriousness of the

deficiencies on **February 1, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

March 18, 2020 includes the following:

Denial of payment for new admissions effective **March 18, 2020**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **June 18, 2020**, if substantial compliance is not achieved by that time.

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

If you believe these deficiencies have been corrected, you may contact Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 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.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **March 18, 2020** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information

Kurt Holm, Administrator
January 8, 2020
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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:

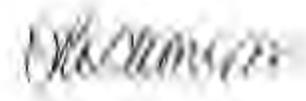
- BFS Letters (06/30/11)

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,



Laura Thompson, RN, Supervisor
Long Term Care Program

lt/lj

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

PRINTED: 02/19/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/18/2019
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MCCALL, ID 83638		
(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 a complaint survey conducted from 12/16/19 - 12/18/19. The survey was conducted by: Belinda Day, RN, Team Coordinator Monica Meister, M.Ed., QIDP Jim Troutfetter, M.Ed., QIDP Abbreviations used in this report: BIMS - Brief Interview for Mental Status CNA - Certified Nursing Assistant CMA - Certified Medical Assistant DNS - Director of Nursing Services ICHU - Idaho Criminal History Unit LN - Licensed Nurse LPN - Licensed Practical Nurse LSW - Licensed Social Worker RN - Registered Nurse	F 000			
F 550 SS=D	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	F 550		1/21/20	

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

TITLE

(X6) DATE

Electronically Signed

01/17/2020

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 550	<p>Continued From page 1 promote the rights of the resident.</p> <p>§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.</p> <p>§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.</p> <p>§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.</p> <p>§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 policy review, record review, resident interview, and staff interview, it was determined the facility failed to ensure each resident had the right to exercise his or her rights as a resident of the facility and as a citizen of the United States for 1 of 9 residents (Resident #3) whose records were reviewed. This resulted in the potential for psychosocial harm when a resident was denied the envelope from a personal letter which was addressed to the resident. Findings include:</p>	F 550	<p>F550: Resident rights/exercise of rights</p> <p>Corrective action for residents found to have been affected by this deficiency: On 12/16/19 Resident #3 was offered the envelope with her daughters address on it and declined it. Resident #3 then signed a statement allowing the facility to retain the envelope. Corrective action for residents that may</p>		

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F 550	Continued From page 2 The facility's Rights policy, dated 5/2017, stated residents had a right "To be encouraged and assisted throughout his or her stay in the Center to exercise these Resident Rights as well as those which Residents are entitled as a U.S. [United States] citizen." Resident #3's record documented as of 10/7/19, her BIMS score was 13 (indicating little to no cognitive impairment). Resident #3 was interviewed on 12/16/19 from 1:00 PM to 1:42 PM. During the interview, Resident #3 stated she received a letter from her estranged daughter. Resident #3 stated she requested the LSW read the letter to her as she was shaking. Resident #3 stated the LSW left the letter with her but took the envelope. Resident #3 stated she asked for the envelope, which contained her daughter's address, and the LSW refused to give it to her. When asked, the LSW stated during an interview on 12/16/19 from 4:20 PM to 4:30 PM, Resident #3's daughter called and emailed the LSW and requested her address not be given to Resident #3. The LSW stated Resident #3 did ask for the envelope and the LSW told Resident #3 she could not have it due to the daughter's request. The facility failed to ensure Resident #3 had the right to exercise her rights as a resident of the facility and as a citizen of the United States.	F 550	be affect by this deficiency: All residents have the potential to be affected by this deficient practice. The facility conducted an audit of current residents to ensure that they are receiving mail in accordance with resident rights. Measures that will be put into place to ensure that this deficiency does not recur: DON or designee will educate staff regarding resident's rights. Education will be completed by 01/21/2020. Staff members delivering mail will ensure that envelopes are included with all delivered mail. Licensed Social Worker counseled regarding resident rights and that an envelope is part of a letter. Staff will receive continuing education regarding resident rights annually and PRN. Measures that will be put into place to ensure that this deficiency does not recur: Residents will be interviewed by LSW or designee weekly x 4 weeks and then monthly x 2 months on resident rights to ensure that resident rights are being honored. Audits will begin the week of 01/21/2020. The DON or ED will review the interviews and report the results of the interviews in QA committee meeting. Corrective action completed by: 01/21/2020		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600		1/21/20	

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F 600	<p>Continued From page 3</p> <p>Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-</p> <p>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on policy review, review of grievance reports, and staff interview, it was determined the facility failed to ensure residents were free from abuse, neglect, and misappropriation of resident property for 2 of 5 residents (Residents #2 and #3) whose grievance reports were reviewed. This resulted in the potential for residents to be subjected to ongoing abuse, neglect, and misappropriation of resident property. Findings include:</p> <p>The facility's Abuse policy, updated 4/2019, stated "It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation...All allegations of abuse, neglect,</p>	F 600	<p>F600: Free From abuse and neglect</p> <p>Corrective action for residents found to have been affected by this deficiency: Grievances were investigated and allegations were considered to be unsubstantiated. Corrective action for residents that may be affect by this deficiency: All residents have the potential to be affected by this deficient practice. All current residents have been interviewed to determine that they are free from abuse and neglect. Measures that will be put into place to ensure that this deficiency does not recur: Clinical Resource, Operational Resource or designee will educate all IDT regarding differences between a grievance and state reportable events. Staff will receive continued education regarding abuse and neglect quarterly at</p>		

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F 600	<p>Continued From page 4</p> <p>misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee...The investigation, and the results of the investigation, will be documented."</p> <p>The policy included the following definitions:</p> <ul style="list-style-type: none"> - Abuse: "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in the definition of abuse, means the individual must have acted deliberately..." - Mistreatment: "inappropriate treatment or exploitation of a resident." - Misappropriation of resident property: "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent." - Neglect: "the failure of the facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." 	F 600	<p>All Staff meetings. Guardian Angel rounds have been updated with increased frequency of visits to detect concerns of alleged abuse or neglect. Department heads have been reeducated regarding the purpose of Guardian Angel rounds. All grievance will be reviewed when they occur to determine if there has been alleged abuse or neglect. Education will be completed by 01/21/2020</p> <p>Measures that will be put into place to ensure that this deficiency does not recur: Random audits will be conducted by ED, DON or designee to determine that residents are free from potential abuse and neglect. Results of the audits will be reviewed in monthly QAPI meeting for three months and adjustments will be made as needed.</p> <p>Corrective action completed by: 01/21/2020</p>		

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F 600	<p>Continued From page 5</p> <p>- Verbal Abuse: "includes the use of oral written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representatives, or within their hearing distance, regardless of their age, ability to comprehend, or disability."</p> <p>The policy also documented investigations would include the following "an interview with the person(s) reporting the incident; an interview with the resident(s); interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; a review of the resident's medical records; an interview with staff members (on all shifts) who may have information regarding the alleged incident; interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident; an interview with staff members (on all shifts) having contact with the accused employee; and a review of all circumstances surrounding the incident."</p> <p>The facility's Grievance Reports, dated 8/28/19 to 12/2/19, included allegations of abuse and neglect, as follows:</p> <p>a. A Grievance Report, dated 9/12/19, stated Resident #3 "...saw [CNA #8] & resident 11B [sic]. She believes that there was inappropriate sexual activity going on between them... [Resident #3] reports seeing some of the young, pretty CNAs flirting with resident [sic] 23B. She says they sit in his lap, hug and kiss him..."</p> <p>b. A Grievance Report, dated 10/25/19, stated on 10/24/19 during the evening shift, RN #3 went</p>	F 600			

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F 600	<p>Continued From page 6</p> <p>into Resident #3's room with Resident #3's medication. The report stated "My drawer was open, and she saw my white box with metronidazole gel. She said I couldn't keep it. I told her that [the DNS] said I could keep it in my drawer. I was also told I could keep my prescription shampoo. [RN #3] threw the box back into my drawer and then slammed my pills onto my bedside table. Some of the pills bounced off the table onto the floor. She turned and left the room...I don't want to deal with [RN #3]. She is just nasty..." The report stated the Administrator talked with Resident #3's roommate who witnessed the event and verified the incident.</p> <p>c. A Grievance Report, dated 11/18/19, stated Resident #2 reported "They went to move her up in bed and used her arms rather than [sic] turn sheet...Resident with some discomfort to her right shoulder...Then she went on to say that [CNA #7] wasn't friendly and threw her gloves..." The report documented 5 additional residents were interviewed and Resident #9 stated "...new gal is a bit rough..." and Resident #3 "...says tall female aid is rough. She needs some skills. She does not want her to bathe her."</p> <p>d. A Grievance Report, dated 11/26/19, stated Resident #2 reported "[LPN #2] has been nasty to every [sic] since I came here...She said she was mad because I rang the bell [call light] all the time."</p> <p>When asked about the reports and the facility's abuse policy, the LSW stated during an interview on 12/18/19 from 8:55 AM to 10:15 AM, the incidents were viewed as grievances and not</p>	F 600			

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F 600	Continued From page 7 allegations of potential abuse or neglect.	F 600			
F 607 SS=E	<p>The facility failed to ensure residents were free from potential abuse and neglect.</p> <p>Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)</p> <p>§483.12(b) The facility must develop and implement written policies and procedures that:</p> <p>§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,</p> <p>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and</p> <p>§483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on policy review, review of grievance reports, employee record review, and staff interview, it was determined the facility failed to ensure its policies were implemented to protect residents from potential physical and/or psychosocial harm. This was true for 2 of 5 residents (#2 and #3) whose grievance reports were reviewed, and for 1 of 8 staff (RN #1) whose personnel files were reviewed for pre-employment background checks. This had the potential to place each of the 26 residents residing in the facility at increased risk for physical and/or psychosocial harm. Findings include:</p> <p>1. The facility's Abuse policy, updated 4/2019, stated "It is the policy of this facility that each</p>	F 607	<p>F607: Develop/Implement Abuse/Neglect Policies</p> <p>Corrective action for residents found to have been affected by this deficiency: A thorough investigation with documentation was completed and all allegations of abuse & neglect were considered to be unsubstantiated. Pre-employment background check of RN #1 in the process. Corrective action for residents that may be affect by this deficiency: All residents have the potential to be affected by this deficient practice. All ongoing allegations of abuse or neglect are being investigated and documented</p>	1/21/20	

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F 607	<p>Continued From page 8</p> <p>resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation...All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee...The investigation, and the results of the investigation, will be documented."</p> <p>The policy also documented investigations would include the following "an interview with the person(s) reporting the incident; an interview with the resident(s); interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; a review of the resident's medical records; an interview with staff members (on all shifts) who may have information regarding the alleged incident; interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident; an interview with staff members (on all shifts) having contact with the accused employee; and a review of all circumstances surrounding the incident."</p> <p>This policy was not followed.</p> <p>The facility's Grievance Reports, dated 8/28/19 to 12/2/19, included allegations of potential abuse and neglect, as follows:</p> <p>a. A Grievance Report, dated 9/12/19, stated</p>	F 607	<p>per policies and procedures.</p> <p>All employee files have been audited and discrepancies have been corrected. Measures that will be put into place to ensure that this deficiency does not recur: ED, DON and LSW, which comprises the Grievance committee, were educated regarding proper investigation and documentation of any allegations of abuse and neglect on. On 01/16/2020 an investigation checklist was created to assist in investigation and documentation of all allegations of abuse and neglect. On 01/16/2020 Human Recourse was educated regarding following policy for pre-employment background checks. Measures that will be put into place to ensure that this deficiency does not recur: Investigation checklist will be used for auditing weekly x 4 weeks and then monthly x 2 months. Results of the audits will be reviewed in monthly QAPI meeting for three months and adjustments will be made as needed.</p> <p>ED or designee will audit all new employee files for pre-employment background checks. Results of the audits will be reviewed in monthly QAPI meeting for three months and adjustments will be made as needed.</p> <p>Corrective action completed by: 01/21/2020</p>		

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F 607	<p>Continued From page 9</p> <p>Resident #3 "...saw [CNA #8] & resident 11B [sic]. She believes that there was inappropriate sexual activity going on between them... [Resident #3] reports seeing some of the young, pretty CNAs flirting with resident [sic] 23B. She says they sit in his lap, hug and kiss him..."</p> <p>b. A Grievance Report, dated 10/25/19, stated on 10/24/19 during the evening shift, RN #3 went into Resident #3's room with Resident #3's medication. The report stated "My drawer was open, and she saw my white box with metronidazole gel. She said I couldn't keep it. I told her that [the DNS] said I could keep it in my drawer. I was also told I could keep my prescription shampoo. [RN #3] threw the box back into my drawer and then slammed my pills onto my bedside table. Some of the pills bounced off the table onto the floor. She turned and left the room...I don't want to deal with [RN #3]. She is just nasty..." The report stated the Administrator talked with Resident #3's roommate who witnessed the event and verified the incident.</p> <p>c. A Grievance Report, dated 11/18/19, stated Resident #2 reported "They went to move her up in bed and used her arms rather than [sic] turn sheet...Resident with some discomfort to her right shoulder...Then she went on to say that [CNA #7] wasn't friendly and threw her gloves..." The report documented 5 additional residents were interviewed and Resident #9 stated "...new gal is a bit rough..." and Resident #3 "...says tall female aid is rough. She needs some skills. She does not want her to bathe her."</p> <p>d. A Grievance Report, dated 11/26/19, stated</p>	F 607			

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F 607	<p>Continued From page 10</p> <p>Resident #2 reported "[LPN #2] has been nasty to every [sic] since I came here...She said she was mad because I rang the bell [call light] all the time."</p> <p>When asked about the reports and the facility's abuse policy, the LSW stated during an interview on 12/18/19 from 8:55 AM to 10:15 AM, the incidents were viewed as grievances and not allegations of potential abuse or neglect.</p> <p>The facility failed to implement their policy to thoroughly investigate and document all allegations of abuse and neglect.</p> <p>2. The facility's Pre-Employment Investigations policy, revised 5/2014, stated "If the applicant/employee receives approval through ICHU to be employed in a skilled nursing facility, those results shall be maintained in his/her confidential personnel file."</p> <p>The personnel files of 8 staff were reviewed for background checks. Seven records included evidence of ICHU background checks. However, documentation of a ICHU background check for RN#1 could not be found.</p> <p>RN #1's personnel record documented her date of hire was 10/15/19.</p> <p>When asked during an interview on 12/18/19 at 10:45 AM, the DNS stated she could not find documentation of a background check with fingerprints for RN #1.</p> <p>The facility failed to ensure their policy for pre-employment background checks was</p>	F 607			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 607	Continued From page 11 implemented for RN #1.	F 607			
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on policy review, review of grievance reports, and staff interview, it was determined the facility failed to ensure allegations of abuse, neglect, and misappropriation of resident	F 609	F609: Reporting of Alleged Violations Corrective action for residents found to have been affected by this deficiency: Facility will ensure that all policies and	1/21/20	

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F 609	<p>Continued From page 12</p> <p>property, were reported to the State Survey Agency within 24 hours for 5 of 5 residents (Residents #2, #3, #4, #7, and #8) whose grievance reports were reviewed. This resulted in the potential for adverse outcomes to residents whose abuse, neglect and misappropriation of resident property was not reported and investigated throughly. Findings include:</p> <p>The facility's Abuse policy, updated 4/2019, stated "It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation..."</p> <p>The policy included the following definitions:</p> <p>- Abuse: "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in the definition of abuse, means the individual must have acted deliberately..."</p>	F 609	<p>procedures for reporting allegations of abuse, neglect and misappropriation of property are followed.</p> <p>Corrective action for residents that may be affect by this deficiency: All residents have the potential to be affected by this deficient practice. All allegations of abuse, neglect and misappropriation of resident property will be reported to the state survey agency per guidelines.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur: ED, DON or designee will educate staff regarding reporting of abuse, neglect and misappropriation of resident property. Clinical Resource, Operational Resource or designee will educate ED, DON and LSW regarding the reporting of abuse, neglect and misappropriation of property. ED and DON will provide continuing education at All Staff meetings quarterly, regarding reporting of abuse, neglect and misappropriation of property. An investigation checklist has been created to assure that reporting is completed. Education to be complete by 01/21/2020. Measures that will be put into place to ensure that this deficiency does not recur: Investigation checklist will be used for auditing weekly x 4 weeks and then monthly x 2 months. Results of the audits will be reviewed in monthly QAPI meeting for three months and adjustments will be made as needed.</p> <p>Corrective action completed by: 01/21/2020</p>		

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F 609	<p>Continued From page 13</p> <ul style="list-style-type: none"> - Mistreatment: "inappropriate treatment or exploitation of a resident." - Misappropriation of resident property: "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent." - Neglect: "the failure of the facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." - Verbal Abuse: "includes the use of oral written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representatives, or within their hearing distance, regardless of their age, ability to comprehend, or disability." <p>The facility's Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment policy, revised 11/28/17, stated the facility would ensure all alleged violations were reported to the State Survey Agency.</p> <p>The facility's Grievance Reports, dated 8/28/19 to 12/2/19, included allegations of abuse, neglect, misappropriation of funds, and exploitation.</p> <p>The facility's Grievance Reports which included allegation of abuse, mistreatment, neglect and misappropriation of resident property did not include evidence the allegations were reported to the State Survey Agency, as follows:</p>	F 609			

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F 609	Continued From page 14 a. A Grievance Report, dated 8/28/19 at 4:45 PM, stated Resident #4 was "...visibly upset...feeling very scared because she could not breath. She stated she was poorly positioned and her air was being cut off...[CNA #9] came in and repositioned her...She noted nurse, [LN #1] had been in the room as well, but was in a hurry. She did not seem to understand how frightened and upset [Resident #4] was. [Resident #4] told her she couldn't breathe. [LN #1] checked the oxygen and said it was working fine. She didn't understand that it was [Resident #4's] position that was restricting her breathing. The LSW reported to nurse [LN #1] and she requested [CNA #9] and another CNA go back to reposition [Resident #4] again." b. A Grievance Report, dated 9/12/19, stated Resident #3 "...saw [CNA #8] & resident 11B [sic]. She believes that there was inappropriate sexual activity going on between them... [Resident #3] reports seeing some of the young, pretty CNAs flirting with resident [sic] 23B. She says they sit in his lap, hug and kiss him..." c. A Grievance Report, dated 10/1/19, stated Resident #8 stated "About 3 weeks ago, I noticed that I had \$300 missing out of my room...I reported it to [the Administrator]. I did not file a police report because I thought I knew who was doing it. I thought it was a guy that visits residents [sic] in 21. This time...\$100 was taken from my bedside table...I want to file a police report. [The Administrator] said he would call them for me." d. A Grievance Report, dated 10/25/19, stated on	F 609			

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F 609	<p>Continued From page 15</p> <p>10/24/19 during the evening shift, RN #3 went into Resident #3's room with Resident #3's medication. The report stated "My drawer was open and she saw my white box with metronidazole gel. She said I couldn't keep it. I told her that [the DNS] said I could keep it in my drawer. I was also told I could keep my prescription shampoo. [RN #3] threw the box back into my drawer and then slammed my pills onto my bedside table. Some of the pills bounced off the table onto the floor. She turned and left the room...I don't want to deal with [RN #3]. She is just nasty..." The report stated the Administrator talked with Resident #3's roommate who witnessed the event and verified the incident and RN #3 was educated about her approach with residents.</p> <p>e. A Grievance Report, dated 11/26/19, stated Resident #2 had \$40.00 in her pants pocket and suspected CNA #3 had taken it. The report stated "money not found. Resident has been reimbursed by facility. Investigation completed + staff interviewed [CNA #3 and CNA #10]."</p> <p>f. A Grievance Report, dated 11/26/19, stated Resident #2 reported "[LPN #2] has been nasty to every [sic] since I came here...She said she was mad because I rang the bell [call light] all the time." The report stated "She [LPN #2] has been counseled to work on customer service. She realized she needs to improve + will work on it."</p> <p>g. A Grievance Report, dated 11/18/19, stated Resident #2 reported "They went to move her up in bed and used her arms rather than [sic] turn sheet...Resident with some discomfort to her right shoulder...Then she went on to say that</p>	F 609			

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F 609	Continued From page 16 [CNA #7] wasn't friendly and threw her gloves..." The report documented 5 additional residents were interviewed and Resident #9 stated "...new gal is a bit rough..." and Resident #3 "...says tall female aid is rough. She needs some skills. She does not want her to bathe her." h. A Grievance Report, dated 12/2/19, stated Resident #7 "...saw an employee coming out of her room with some of her special diabetic lotions given to her by her daughter...The unidentified employee stated she was instructed to go through residents' rooms and remove excess toiletries...She [Resident #7] felt violated and that her privacy had been invaded." When asked about the reports and the facility's abuse policy, the LSW stated during an interview on 12/18/19 from 8:55 AM to 10:15 AM, the incidents were viewed as grievances and not allegations of potential abuse, neglect, or misappropriation of funds. When asked, the Administrator stated during an interview on 12/18/19 from 8:55 AM to 10:15 AM, the incident was not reported to the State Survey Agency. The facility failed to ensure allegations of abuse, neglect, and misappropriation of resident property were reported to the State Survey Agency.	F 609			
F 610 SS=E	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:	F 610		1/21/20	

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F 610	Continued From page 17 §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 policy review, review of grievance reports, and staff interview, it was determined the facility failed to ensure allegations of abuse, neglect, and misappropriation of resident property were thoroughly investigated, and corrective action was taken to prevent reoccurrence for 5 of 5 residents (Residents #2, #3, #4, #7, and #8) whose grievance reports were reviewed. This resulted in the potential for residents to be subjected to ongoing abuse, neglect, and misappropriation of resident property. Findings include: The facility's Abuse policy, updated 4/2019, stated "It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the	F 610	F610: Resident rights/exercise of rights Corrective action for residents found to have been affected by this deficiency: Facility will ensure that all policies and procedures for investigating and taking corrective actions regarding allegations of abuse, neglect and misappropriation of property are followed. Corrective action for residents that may be affect by this deficiency: All residents have the potential to be affected by this deficient practice. Facility is ensuring that policies and procedures for allegations of abuse, neglect, misappropriation of resident property and exploitation are being followed and that corrective action to prevent reoccurrence is taken. Measures that will be put into place to ensure that this deficiency does not recur: On 01/14/2020 Clinical Resources and		

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F 610	<p>Continued From page 18</p> <p>rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation...All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee...The investigation, and the results of the investigation, will be documented."</p> <p>The policy included the following definitions:</p> <ul style="list-style-type: none"> - Abuse: "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in the definition of abuse, means the individual must have acted deliberately..." - Mistreatment: "inappropriate treatment or exploitation of a resident." - Misappropriation of resident property: "the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent." - Neglect: "the failure of the facility, its employees or services providers to provide goods and 	F 610	<p>Operational Resource provided education to the IDT in regards to proper investigation of incidents of allegations of abuse, neglect, misappropriation of resident property and exploitation and corrective actions to prevent reoccurrences. An investigation checklist has been created to assist in investigation and corrective action to prevent reoccurrences.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur: Investigation checklist will be used for auditing weekly x 4 weeks and then monthly x 2 months. Results of the audits will be reviewed in monthly QAPI meeting for three months and adjustments will be made as needed.</p> <p>Corrective action completed by: 01/21/2020</p>		

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F 610	<p>Continued From page 19</p> <p>services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress."</p> <p>- Verbal Abuse: "includes the use of oral written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representatives, or within their hearing distance, regardless of their age, ability to comprehend, or disability."</p> <p>The policy also stated investigations would include the following "an interview with the person(s) reporting the incident; an interview with the resident(s); interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; a review of the resident's medical records; an interview with staff members (on all shifts) who may have information regarding the alleged incident; interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident; an interview with staff members (on all shifts) having contact with the accused employee; and a review of all circumstances surrounding the incident."</p> <p>The facility's Grievance Reports, dated 8/28/19 to 12/2/19, were reviewed and included allegations of abuse, neglect, and misappropriation of funds.</p> <p>When asked about the reports and the facility's abuse policy, the LSW stated during an interview on 12/18/19 from 8:55 AM to 10:15 AM, the incidents were viewed as grievances and not allegations of potential abuse, neglect, mistreatment, or misappropriation of funds.</p>	F 610			

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F 610	<p>Continued From page 20</p> <p>The facility's Grievance Reports did not include documentation incidents were thoroughly investigated, and corrective action taken to prevent reoccurrence, as follows:</p> <p>a. A Grievance Report, dated 8/28/19 at 4:45 PM, stated Resident #4 was "...visibly upset...feeling very scared because she could not breath. She stated she was poorly positioned and her air was being cut off...[CNA #9] came in and repositioned her...She noted nurse, [LN #1] had been in the room as well, but was in a hurry. She did not seem to understand how frightened and upset [Resident #4] was. Resident #4 told her she couldn't breathe. [LN #1] checked the oxygen and said it was working fine. She didn't understand that it was [Resident #4's] position that was restricting her breathing. The LSW reported to nurse [LN #1] and she requested [CNA #9] and another CNA go back to reposition [Resident #4] again."</p> <p>The report did not include documentation of staff statements or information related to the employee who originally positioned Resident #4. The report also did not include documentation corrective action was taken to prevent reoccurrence.</p> <p>When asked who originally positioned Resident #4, the DNS stated during an interview on 12/18/19 from 8:55 AM to 10:15 AM, they did not know. The Administrator, who was present, stated the facility did not obtain staff statements and no corrective action was taken other than suggesting physical therapy work with Resident #4.</p>	F 610			

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F 610	<p>Continued From page 21</p> <p>b. A Grievance Report, dated 9/12/19, stated Resident #3 "...saw [CNA #8] & resident 11B [sic]. She believes that there was inappropriate sexual activity going on between them... [Resident #3] reports seeing some of the young, pretty CNAs flirting with resident [sic] 23B. She says they sit in his lap, hug and kiss him..."</p> <p>The report did not include documentation of additional resident interviews and staff statements, or information related to the corrective action taken to prevent reoccurrence.</p> <p>When asked, the Administrator stated during an interview on 12/18/19 from 8:55 AM to 10:15 AM, the facility did not obtain resident interviews and staff statement, and there was no documentation corrective action was taken to prevent reoccurrence.</p> <p>c. A Grievance Report, dated 10/1/19, stated Resident #8 stated "About 3 weeks ago, I noticed that I had \$300 missing out of my room...I reported it to [the Administrator]. I did not file a police report because I thought I knew who was doing it. I thought it was a guy that visits residents [sic] in 21. This time...\$100 was taken from my bedside table...I want to file a police report. [The Administrator] said he would call them for me."</p> <p>The report did not include additional resident interviews, statements from staff including housekeeping and laundry staff, evidence of a room search, or corrective action taken to prevent reoccurrence.</p> <p>When asked, the Administrator stated during an</p>	F 610			

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F 610	<p>Continued From page 22</p> <p>interview on 12/18/19 from 8:55 AM to 10:15 AM, he talked with other staff including housekeeping and laundry staff, but it was not documented. The Administrator stated a room search was conducted but it was not documented. The Administrator stated no additional residents were interviewed, and no corrective action was taken to prevent reoccurrence other than talking to Resident #8 about keeping his money in a lock box.</p> <p>d. A Grievance Report, dated 10/25/19, stated on 10/24/19 during the evening shift, RN #3 went into Resident #3's room with Resident #3's medication. The report stated "My drawer was open and she saw my white box with metronidazole gel. She said I couldn't keep it. I told her that [the DNS] said I could keep it in my drawer. I was also told I could keep my prescription shampoo. [RN #3] threw the box back into my drawer and then slammed my pills onto my bedside table. Some of the pills bounced off the table onto the floor. She turned and left the room...I don't want to deal with [RN #3]. She is just nasty..." The report stated the Administrator talked with Resident #3's roommate who witnessed the event and verified the incident and RN #3 was educated about her approach with residents.</p> <p>The report did not include documentation of additional resident interviews and staff statements, or information related to the corrective action taken to prevent reoccurrence.</p> <p>When asked, DNS stated during an interview on 12/18/19 from 8:55 AM to 10:15 AM, only the nurse [RN #3] was interviewed. The</p>	F 610			

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F 610	<p>Continued From page 23</p> <p>Administrator, who was present, stated no resident interviews or additional corrective action was taken to prevent reoccurrence.</p> <p>e. A Grievance Report, dated 11/26/19, stated Resident #2 had \$40.00 in her pants pocket and suspected CNA #3 had taken it. The report stated "money not found. Resident has been reimbursed by facility. Investigation completed + staff interviewed [CNA #3 and CNA #10]."</p> <p>The report did not include statements from CNA #3 and CNA #10, additional resident interviews, additional staff statements, or statements from housekeeping staff. There was no documentation a room search was conducted. There was no documentation corrective action was taken to prevent reoccurrence.</p> <p>When asked, the Administrator stated during an interview on 12/18/19 from 8:55 AM to 10:15 AM, no other residents were interviewed. The Administrator stated a room search was conducted but it was not documented, staff and housekeeping were interviewed but it was not documented, and only Resident #2 was educated about securing her money in a lock box.</p> <p>f. A Grievance Report, dated 11/26/19, stated Resident #2 reported "[LPN #2] has been nasty to every [sic] since I came here...She said she was mad because I rang the bell [call light] all the time." The report stated "She [LPN #2] has been counseled to work on customer service. She realized she needs to improve + will work on it."</p> <p>The report did not include a statement from LPN #2, additional resident interviews, or additional</p>	F 610			

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F 610	<p>Continued From page 24</p> <p>staff statements. There was no documentation of additional corrective action to prevent reoccurrence. LPN #2's personnel record was reviewed and did not include documentation she was counseled.</p> <p>When asked, the DNS stated during an interview on 12/18/19 from 8:55 AM to 10:15 AM, LPN #2 was not interviewed and a statement from her was not obtained. The Administrator, who was present, stated the facility did not obtain additional resident interviews and staff statements, and there was no documentation corrective action was taken to prevent reoccurrence.</p> <p>g. A Grievance Report, dated 11/18/19, stated Resident #2 reported "They went to move her up in bed and used her arms rather than [sic] turn sheet...Resident with some discomfort to her right shoulder...Then she went on to say that [CNA #7] wasn't friendly and threw her gloves..." The report documented 5 additional residents were interviewed and Resident #9 stated "...new gal is a bit rough..." and Resident #3 "...says tall female aid is rough. She needs some skills. She does not want her to bathe her."</p> <p>The report did not include a statement from CNA #7, or documentation Resident #3's and Resident #9's concerns were addressed. There was no documentation corrective action was taken to prevent reoccurrence.</p> <p>When asked, the DNS stated during an interview on 12/18/19 from 8:55 AM to 10:15 AM, she talked with CNA #7 but a statement from CNA #7 was not obtained. The Administrator, who was</p>	F 610			

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F 610	Continued From page 25 present, stated Resident #3 and Resident #9's concerns were not addressed, and there was no documented evidence of corrective action taken to prevent reoccurrence. h. A Grievance Report, dated 12/2/19, stated Resident #7 "...saw an employee coming out of her room with some of her special diabetic lotions given to her by her daughter...The unidentified employee stated she was instructed to go through residents' rooms and remove excess toiletries...She [Resident #7] felt violated and that her privacy had been invaded." The report did not include additional resident interviews, or additional staff statements including housekeeping, dietary and laundry staff. There was no documentation additional corrective action was taken to prevent reoccurrence. When asked about the unidentified employee, the Administrator stated during an interview on 12/18/19 from 8:55 AM to 10:15 AM, they were not able to identify the person. The Administrator stated no other residents were interviewed, and dietary, laundry, and additional staff statements were not obtained. The Administrator stated housekeeping staff were interviewed but it was not documented, and no corrective action was taken to prevent reoccurrence. The facility failed to ensure allegations of abuse, neglect, misappropriation of resident property, and exploitation were thoroughly investigated, and corrective action was taken to prevent reoccurrence.	F 610			
F 676	Activities Daily Living (ADLs)/Mntn Abilities	F 676		1/21/20	

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F 676 SS=D	Continued From page 26 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 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.	F 676			

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F 676	<p>Continued From page 27</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, resident interview, and staff interview, it was determined the facility failed to implement comprehensive resident-centered care plans related to oral/denture care. This was true for 1 of 6 residents (Resident #2) whose care plans were reviewed. This resulted in the potential for a resident to experience adverse outcomes if they did not receive adequate oral care. Findings include:</p> <p>The facility's policy, titled Oral Hygiene - Brushing Teeth and Care of Dentures, revised 5/2007, stated "If the resident has dentures, ask resident to remove them for cleaning...Put dentures in denture cup and take to appropriate area for cleaning...Clean with tap water and denture cleaning product. Brush up and down rather than across dentures. Check for broken pieces...Check the resident's mouth for unusual sores. Report any unusual observations to the charge nurse...Chart oral care and appropriate observations."</p> <p>Resident #2 was admitted to the facility on 10/1/19, and readmitted on 10/4/19, with diagnoses which included polyneuropathy (disease affecting nerves including weakness, numbness, and burning pain), obesity, oropharyngeal dysphagia (problems when preparing to swallow food or fluids, accompanied by aspiration and a sensation of residual food remaining in the pharynx which is the cavity behind the nose and mouth), and congestive heart failure (a chronic progressive condition that affects the pumping power of the heart muscles).</p>	F 676	<p>F676: Activities of Daily Living (ADL)/Mntn Abilities Corrective action for residents found to have been affected by this deficiency: For resident #2, assessment of oral hygiene and dentures completed 01/16/2020 and care plan was updated as indicated. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by this deficient practice. All current residents were assessed for oral/denture care and care plans were updated as indicated. Measures that will be put into place to ensure that this deficiency does not recur: DON or Designee will educate nursing staff by 01/21/2020 on oral/denture care. Measures that will be put into place to ensure that this deficiency does not recur: Radom oral/denture care rounds will be performed by DNS or designee weekly x 4 weeks and then monthly x 2 months. Results of the audits will reviewed in monthly QAPI meeting for three months and adjustments will be made as needed. Corrective action completed by: 01/21/2020</p>		

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F 676	<p>Continued From page 28</p> <p>Resident #2's care plan, dated 10/4/19, documented she had upper and lower dentures and staff were to assist her to care for them.</p> <p>On 12/16/19 at 4:11 PM, Resident #2's dentures were observed on her bedside table, not in a cup. The upper dentures had dark brown speckles embedded on the palate. The teeth on the dentures were dull (not shiny) and had many green food particles on and between the teeth. When asked by the surveyor how often the facility cleaned her dentures, Resident #2 said she did not know, but sometimes they put them in a cup with liquid, but she didn't know if it was water or something else. She did not recall if anyone brushed them. Resident #2 said she had a sore area on her lower left gum and it was really bothering her. She said she thought it was because her dentures did not fit right. Resident #2 did not recall anyone asking to look in her mouth or offering her mouthwash or other oral care.</p> <p>Resident #2's record did not include documentation specific to her oral care, how often it was offered, or documentation of oral inspection.</p> <p>On 12/17/19 at 7:10 AM, when asked about the sore area on Resident #2's lower left gum, RN #1, who was caring for Resident #2, stated, "this is the first I've heard about it." When asked how often residents received oral care, RN #1 stated the CNAs provided oral care and she believed it was offered once a shift.</p> <p>During an interview on 12/19/19 at 10:09 A.M.,</p>	F 676			

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F 676	Continued From page 29 the DNS said she expected residents to receive oral care at a minimum of twice a day, in the morning, in the evening, and as needed. The DNS stated residents' records did not have an area under the personal care section specific to document oral care.	F 676			
F 684 SS=D	The facility failed to ensure Resident #2 received oral care in accordance with their policy. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and provider interview, it was determined the facility failed to ensure outside providers received current medical information for residents who went outside the facility for medical appointments. This was true for 1 of 6 residents (Resident #2) whose records were reviewed. This resulted in the potential for a resident to experience adverse outcomes if they did not receive appropriate medication and treatment due to lack of information when the resident met with their physician. Findings include: The official journal website for the American Nurses Association, "American Nurse Today,"	F 684	F684: Quality of Care Corrective action for residents found to have been affected by this deficiency: Resident #2 has gone to all subsequent appointments with her appropriate paper work. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by this deficient practice. All current residents are being sent to appointments with appropriate paper work. Measures that will be put into place to	1/21/20	

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F 684	<p>Continued From page 30</p> <p>accessed on 12/19/19, included an article about transport teams and patient handoff reports, dated 10/2/19. The article documented:</p> <p>"Transport teams understand that written handoffs won't [sic] always be available; however, some forms (for example, medical necessity and demographic forms) are required for patient transport. Verbal report at a minimum (preferably accompanied by printed or electronic written documentation) should include:</p> <ul style="list-style-type: none"> * name * gender * age * code status * chief complaint * diagnosis * pertinent medical history * current illness/injury history * pertinent laboratory and imaging results and significant laboratory trends * allergies * medications and interventions administered within the last 24 hours and patient response * treatment plan * reason for transfer * likelihood of significant negative or positive change in patient condition" <p>Resident #2 was admitted to the facility on 10/1/19, and readmitted on 10/4/19, with diagnoses which included polyneuropathy (disease affecting nerves including weakness, numbness, and burning pain), obesity, oropharyngeal dysphagia (problems when preparing to swallow food or fluids, accompanied by aspiration and a sensation of residual food remaining in the pharynx which is the cavity</p>	F 684	<p>ensure that this deficiency does not recur: All staff involved in transportation will be educated by DNS or designee on appropriate paper work to be taken to appointments, by 01/21/2020. Transportation policy was updated on 01/17/2020.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur: Random audits of paper work prior to transport will be performed by DNS of designee weekly x 4 weeks and then monthly x 2 months. Results of the audits will reviewed in monthly QAPI meeting for three months and adjustments will be made as needed.</p> <p>Corrective action completed by: 01/21/2020</p>		

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F 684	Continued From page 31 behind the nose and mouth), and congestive heart failure (a chronic progressive condition that affects the pumping power of the heart muscles). A progress note from the a wound center, dated 12/9/19, documented Resident #2 arrived by wheelchair for an appointment. Resident #2's record did not include documentation a verbal report prior to her transfer to the wound clinic was given or documentation paperwork was sent with her for her provider to review. During a phone interview on 12/17/19 at 9:30 AM, the CMA from Resident #2's wound clinic stated, Resident #2 arrived for her appointment on 12/9/19 without paperwork about her current medical status, and the clinic did not receive a verbal report from the facility. She stated this made it difficult to provide needed care and treatment for residents when they did not receive information on their current medical status and medications. During an interview with the DNS on 12/18/19 at 10:09 AM, she stated she expected the nurse or medical records personnel from the facility to print out the medication sheet, vital signs, daily weights, blood sugar reports, and progress notes and transport those records with the resident to outside clinic appointments.	F 684			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		1/21/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/18/2019
NAME OF PROVIDER OR SUPPLIER MCCALL REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 418 FLOYDE STREET MCCALL, ID 83638		
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F 695	<p>Continued From page 32</p> <p>care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, resident interview, staff interview, and provider interview, it was determined the facility failed to ensure each resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. This was true for 1 of 6 residents (Resident #2) whose records were reviewed. This resulted in the potential for a resident to experience adverse outcomes if they did not receive oxygen as ordered. Findings include:</p> <p>Resident #2 was admitted to the facility on 10/1/19, and readmitted on 10/4/19, with diagnoses which included polyneuropathy (disease affecting nerves including weakness, numbness, and burning pain), obesity, oropharyngeal dysphagia (problems when preparing to swallow food or fluids, accompanied by aspiration and a sensation of residual food remaining in the pharynx which is the cavity behind the nose and mouth), and congestive heart failure (a chronic progressive condition that affects the pumping power of the heart muscles).</p> <p>Resident #2's physician's order, dated 10/4/19, documented she was to receive oxygen at 1-2 liters via nasal cannula.</p> <p>Resident #2's care plan, dated 10/7/19, documented she was to be provided with oxygen as ordered.</p>	F 695	<p>F695: Respiration/Tracheostomy Care and Suctioning</p> <p>Corrective action for residents found to have been affected by this deficiency: Resident #2 has gone to all subsequent appointments with her oxygen as ordered. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by this deficient practice. All residents are being sent to appointments with appropriate respiratory equipment. All resident on oxygen have been interview and no adverse findings were found.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur: By 01/21/20, DON or designee will educate all staff involved in transportation and assuring residents with ordered oxygen have their oxygen during transport.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur: DON or designee will perform random audits on residents with oxygen going to appointments weekly x 4 weeks and then monthly x 2 months. Results of the audits will reviewed in monthly QAPI meeting for three months and adjustments will be made as needed.</p>		

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

PRINTED: 02/19/2020
FORM APPROVED
OMB NO. 0938-0391

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F 695	Continued From page 33 A progress note from the a wound center, dated 12/9/19, documented Resident #2 arrived by wheelchair for an appointment. The note did not include documentation that she had her oxygen. During an interview on 12/16/19 at 2:12 PM, CNA #1 said she oversaw medical records and resident transport for the facility. CNA #1 said when residents were taken to appointments outside of the facility, she brought needed equipment with residents to keep them safe, such as wheelchairs, walkers, and oxygen. During an interview on 12/16/19 at 4:11 PM, Resident #2 stated she went to see her doctor at the clinic last Monday [12/9/19]. Resident #2 said CNA #1 drove her to the appointment and she arrived without her oxygen. Resident #2 said when she went into the building, it was discovered she did not have her oxygen. She stated CNA #1 went outside to the vehicle and brought back a small oxygen tank that was used for emergencies. During a phone interview on 12/17/19 at 9:30 AM, the CMA from the wound clinic stated Resident #2 arrived for her appointment on 12/9/19 without oxygen or a nasal cannula to connect to oxygen. The CMA stated CNA #1, who accompanied Resident #2 to her appointment, went outside to the vehicle Resident #2 was transported in and brought a small emergency oxygen canister and cannula for Resident #2. On 12/18/19 at 10:09 AM, the DNS said when residents were taken to outside appointments,	F 695	Corrective action completed by: 01/21/2020		

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F 695	Continued From page 34 she expected residents were assessed for their physical function and all needed equipment was transported to the appointment with them such us a wheelchair, walker, and oxygen. Resident #2 did not have her oxygen on as ordered by the physician during her transport to the wound clinic.	F 695			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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March 27, 2020

Kurt Holm, Administrator
McCall Rehabilitation and Care Center
418 Floyde Street
McCall, ID 83638-4508

Provider #: 135082

Dear Mr. Holm:

On **December 16, 2019** through **December 18, 2019**, an unannounced on-site complaint survey was conducted at McCall Rehabilitation and Care Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008324

ALLEGATION #1:

The facility is not ensuring residents are free from abuse.

FINDINGS #1:

During the investigation, observations were conducted, nine resident records were reviewed, grievance reports from August 2019 to December 2019 were reviewed, 12 staff were interviewed, and 12 residents were interviewed; including residents who attended a resident council meeting.

Review of grievance reports included five allegations of potential abuse toward residents from staff. The reports did not include a thorough investigation, follow-up and resolution of the allegations.

In an interview about the grievance reports with the facility's Licensed Social Worker, she stated the incidents were viewed as grievances and not allegations of potential abuse or neglect.

In an interview about the grievance reports with the facility's Administrator, he stated the facility did not obtain resident interviews and staff statements, and there was no documentation corrective action was taken to prevent reoccurrence.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F600 as it related to ensuring residents were free from abuse, neglect, and exploitation, at F607 as it related to the facility's failure to implement their abuse and neglect policies, at F609 as it related to reporting to the State Agency allegations of abuse, neglect, exploitation, or mistreatment, and at F610 as it related to the facility's failure to investigate, prevent, and correct alleged abuse.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility did not ensure outside providers received current medical information for continuity of care.

FINDINGS #2:

During a phone interview on 12/17/19, a Certified Medical Assistant from one resident's wound clinic stated, the resident arrived for her appointment on 12/9/19 without paperwork about her current medical status, and the clinic did not receive a verbal report from the facility. She stated this made it difficult to provide needed care and treatment for residents when they did not receive information on their current medical status and medications.

Review of one resident's record included a progress note from the wound center she visited. The resident's record did not include documentation a verbal report prior to her transfer to the wound clinic was given or documentation paperwork was sent with her for her provider to review.

During an interview with the facility's Director of Nursing, she stated she expected the nurse or medical records personnel from the facility to print out the medication sheet, vital signs, daily weights, blood sugar reports, and progress notes and transport those records with the resident to outside clinic appointments.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F684 as it related to quality of care in accordance with professional standards of practice.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

The facility did not ensure a resident had oxygen as ordered by the physician.

FINDINGS #3:

One resident's record included a physician order she was to receive oxygen continuously. The resident's care plan documented she was to be provided with oxygen as ordered.

During an interview with the resident, she stated she went to see her doctor at the wound clinic recently. The resident said the CNA drove her to the appointment and she arrived without her oxygen. The resident said when she went into the building, it was discovered she did not have her oxygen. She stated the CNA went outside to the vehicle and brought back a small oxygen tank that was used for emergencies.

A progress note from a wound center documented the resident arrived to the wound clinic for an appointment. The note did not include documentation that she had her oxygen.

In an interview with a Certified Nursing Assistant (CNA), she stated she oversaw medical records and resident transport for the facility. The CNA said when residents were taken to appointments outside of the facility, she brought needed equipment with residents to keep them safe, such as wheelchairs, walkers, and oxygen.

In an interview with the Director of Nursing, she stated when residents were taken to outside appointments, she expected residents were assessed for their physical function and all needed equipment was transported to the appointment with them such as a wheelchair, walker, and oxygen.

During a phone interview with a Certified Medical Assistant (CMA) from the wound clinic, she stated the resident arrived for her appointment without oxygen or a nasal cannula to connect to the oxygen. The CMA stated the CNA who accompanied the resident to her appointment, went outside to the vehicle the resident was transported in and brought a small emergency oxygen canister and cannula for the resident.

Kurt Holm, Administrator
March 27, 2020
Page 4 of 4

Based on the investigative findings, the allegation was substantiated and the facility was cited at F695 as it related to the facility's failure to ensure residents are provided with needed respiratory care and treatment.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj