STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135053	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IVY COURT	2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0553 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow resident to participate in the development and implementation of his or her person-centered plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and resident and staff interview, it was determined the facility failed include a resident or their representative to participate in their care planning. This was true for 1 of 19 residents (Resident #10) reviewed for care plans. This failure created the potential for harm if a resident experienced a decline in physical, mental, or psychosocial functioning due to lack of their input toward their goals. Findings include: The facility's Care Plan policy, undated, documented the following: * Care plans addressed issues to provide for a resident's highest practicable level of wellbeing and were re-evaluated and updated quarterly, annually, and when a significant change in status occurred. * Care plans reflected the resident/resident's representative input and goals for health care. * Care plans involved the resident/resident's representative and other representatives as appropriate. This policy was not followed. Resident #10 was admitted into the facility on [DATE], with [DIAGNOSES REDACTED]. An MDS assessment dated [DATE], stated Resident #10 was cognitively intact. A Care Conference Note, dated 6/18/19, documented a self care conference was conducted about Resident #10. There was no documentation Resident #10 was asked to participate. A Care Conference Note dated 9/18/19, documented a self care conference was conducted about Resident #10 and no concerns were voiced from Resident #10. It was unclear when Resident #10 was asked for his concerns as it was documented he was not in attendance at the meeting. On 3/3/20 at 10:57 AM, Resident #10 stated he did not know what a care plan was. The care plan and care plan conference were defined for Resident #10 and he was asked if he ever attended one, or if anyone asked him for input for one. He replied no. When asked if he would like to go to his care plan meetings, he replied yes. On 3/5/2020 at 3:43 PM, the DON said he expected all care plans to be followed. He said he expected all care conferences were offered to residents.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure a resident's privacy in their room. This was true for 1 of 18 residents (Resident #27) reviewed for privacy when a resident's room had private health information hanging on the wall in view of any person who entered the room. This deficient practice had the potential for psychosocial harm if the resident felt embarrassed with the placement of the sign. Findings include: The facility's privacy and confidentiality policy, dated 12/1/17, documented residents had the right to personal privacy in their accommodations. This policy was not followed. Resident #27 was readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #27's care plan, dated 4/12/18 and 8/2/18; respectively, directed staff to provide him with a homelike environment and to elevate the head of his bed at least 30 degrees related to tube feeding and his preference. Resident #27's physician orders, dated 1/23/20, directed staff to keep the head of his bed elevated at least 30 degrees related to his gastrostomy tube (a tube inserted through the abdomen that brings nutrition directly to the stomach). On 3/2/20 at 9:55 AM, 3/3/20 at 8:41 AM, and 3/4/20 at 9:56 AM and 4:28 PM, a wall to the left of Resident #27's bed had a sign posted that documented, HOB (head of bed)(greater than) 30 (degrees) AT ALL TIMES. On 3/5/20 at 1:08 PM, the DON observed the sign on the wall in Resident #27's room and said he was not sure who put the sign up. He said the sign was not needed because his orders and his care plan documented the same thing. The DON said he expected staff to follow privacy guidelines.
F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, review of facility Incident and Accident reports, resident interview and staff interview, it was determined the facility failed to ensure residents were free from intimidation when reporting abuse for 1 of 18 residents (#176).This failure resulted in psychosocial harm due to fear of intimidation and retaliation by the facility in reporting abuse and neglect by staff. Findings include: The facility's policy, Prevention and Reporting: Abuse, Neglect and Mistreatment, dated February 2018, defined abuse as the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It further defined mental abuse as verbal or non-verbal and included humiliation, harassment, and threats of punishment or deprivation. The policy stated residents had the right to be free from abuse, neglect, and exploitation. This policy was not followed. Resident #176 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A quarterly MDS assessment, dated 12/10/19, stated Resident #176 was cognitively intact. An Incident and Accident Report, dated 8/25/19, documented on 8/24/19, Resident #176 reported to an unnamed CNA that Staff Member A was rough during cares. Resident #176 stated Staff Member A smacked his forehead against the side rails of the bed and smacked and pinched his scrotum with the urinal. It was documented in the report Resident #176 stated he did not want to say anything, because he was worried it would make things worse for him in the facility. Resident #176's care plan, dated 8/26/20, stated Resident#176 had a potential concern for psychosocial well-being related to accusations of abuse. The interventions documented were as follows: * allow Resident #176 to verbalize perceptions and fears * protect Resident #176 * offer reassurance * use positive conversation * rule out abuse/pain * report allegation An undated follow up interview in the Incident and Accident Report documented Resident #176 stated he had a verbal disagreement with Staff Member A. It documented Staff Member A turned Resident #176 and bumped his head on the siderail unintentionally. The report also documented when Staff Memer A was providing cares, the urinal also unintentially pinched Resident #176's thigh. The report documented Resident #176 stated during the undated follow up interview he felt safe in the facility and denied any abuse. On 3/2/20 at 10:50 AM, Resident #176 stated There is a lot going on here that is just not good. Resident #176 stated he had a copy of the investigation report and They minimized what I said. Resident #176 stated there was a staff member, Staff Member A, that was just really, really, bad. He stated Staff Member A went to turn him and banged his head against the rails over and over. Resident #176 stated Staff Member A then took the urinal and smashed it against his genitals over and over. Resident #176 stated he got thumped up pretty good by Staff Member A and the facility sent Staff Member A to another hall to work. Resident #176 stated what Staff Member A was doing was not right and he only felt safe once Staff Member A left the facility. Resident #176 stated the facility fired Staff Member A after another resident complained of abuse. Resident #176 stated he contacted the local Ombudsman at the time, but then changed his mind about discussing the incident when the local Ombudsman asked for information because he was afraid of repercussions from staff. On 3/5/20 at 9:44AM, Resident #176 reported he thought the abuse started because he was telling Staff Member A he shot the biggest bear

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

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 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) in Idaho and he called BS on me. Resident #176 stated a couple of days later Staff Member A was turning him in bed and Staff Member A hit his head on the siderail really hard. Resident #176 stated Staff Member A then grabbed his shoulders and hit his head against the siderails over and over, really hard, an unknown amount of times. Resident #176 stated he later asked for the urinal and Staff Member A took the urinal and forcefully slammed it into his groin area over and over an unknown amount of times. Resident #176 stated he felt unsafe around Staff Member A so he reported the incident to the nurse. Resident #176 was asked about his statement in the follow up interview. Resident #176 denied he made the statement that he felt safe in the facility and denied he stated the abuse did not happen. He stated the facility was sweeping things under the rug. Resident #176 stated he currently was not comfortable about his safety at all in the facility. Resident #176 stated regarding his denial the abuse happened, I'm not stupid and I never said that. I am afraid of retaliation in here. Resident #176 stated he was currently concerned about retaliation for talking to the state and worried he will be starved out, for talking to state surveyors. When asked to clarify, he stated he was not afraid of physical abuse but worried about things staff control, such as his medications being late, his call light not being answered, and not getting food served to him. Resident#176 was tearful during the interview and when describing the allegation he hung his head down and was tearful. On 3/5/20 at 10:08 AM, Resident #176 called a family friend in the surveyor's presence and asked the surveyor to listen to the call. Resident #176 asked the family friend if she remembered the interview about the allegation and she stated yes. She then stated she was with Resident #176 during the staff interview for the Incident and Accident follow up report and Resident #176 never stated during the interview he felt safe in the facility and denied any abuse. She stated she did not remember the facility staff asking those questions in her presence. On 3/5/20 at 10:35 AM, the Administrator was interviewed about the Incident and Accident report regarding Resident #176. She stated the person who conducted the Incident and Accident investigation on Resident #176 no longer worked at the facility.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, review of incident reports, and resident and staff interview, it was determined the facility failed to conduct complete and thorough investigations for 1 of 4 residents (#65) reviewed for abuse allegations. This failure had the potential for harm if staff failed to conduct a thorough and credible investigation of abuse if staff failed to recognize when abuse occurred, and for the inability to protect the residents from further abuse. Findings include: The facility's Abuse policy, dated February 2018, documented, When allegations that meet the definition of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property are received, the center shall .thoroughly investigate all alleged violations and retain documents showing that all alleged violations are thoroughly investigated. This policy was not followed. Resident #65 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. An incident report of alleged abuse, dated 8/8/19, documented two CNAs reported to the RCM Resident #65 slapped them both in the arm while they were trying to assist another resident in his wheelchair. The report documented Resident #65 said, I slapped them, because they slapped me first. The incident report, dated 8/8/19, stated the incident occurred in the dining room and two CNAs, one LPN, and one RCM were interviewed as witnesses to the incident. Resident #65 was interviewed and stated she slapped the CNAs when they were trying to assist another resident and she was holding on to the resident's wheelchair. Resident #65 stated she slapped them because the CNAs would not allow her to assist the resident to his room, she then stated later it was because they grabbed her hands to attempt to remove them from the wheelchair. There were no other residents interviewed concerning the incident or potential alleged abuse. On 3/5/20 at 10:55 AM, the DON said as part of investigations, the facility suspended people involved, and interviewed staff and other residents. He said he thought since there were enough staff that witnessed the event for Resident #65 they did not think they needed to interview other residents. The DON said residents should have been interviewed regarding abuse concerns as part of the investigation.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review and staff interview, it was determined the facility failed to ensure an MDS assessment was completed. This was true for 1 of 19 residents (Resident #1) 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: The facility's MDS policy, dated 10/2019, documented a discharge MDS assessment must be completed no later than 14 days after a resident discharged from the facility. This policy was not followed. Resident #1 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #1's record documented the most recent MDS assessment was a 14-day MDS assessment completed on 9/19/19. His record did not include a discharge MDS assessment. Resident #1's nurse progress notes, dated 10/7/19, documented he discharged to a different facility that day. On 3/5/20 at 3:54 PM, MDS Coordinator #1 said a discharge MDS assessment was not completed for Resident #1. She said she was not sure why the MDS assessment was missed.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, record review, and resident and staff interview, it was determined the facility failed to ensure a resident was provided daily oral care. This was true for 1 of 3 residents (Resident #10) reviewed for activities of daily living relating to oral care and hygiene. This failure created the potential for harm if residents experienced weight loss, increased mouth pain from poor fitting dentures, or mouth sores related to poor fitting dentures. Findings include: The facility's Activities of Daily Living policy, undated, stated brushing teeth was a grooming procedure. Resident #10 was admitted into the facility on [DATE], with [DIAGNOSES REDACTED]. An admission MDS assessment dated [DATE], documented Resident #10 had no natural teeth and he was cognitively intact. Resident #10's care plan, dated 6/12/18, stated Resident #10 had upper and lower dentures and mouth inspections should occur daily and concerns were reported to the nurse. Resident #10's record did not include documentation of daily mouth inspections. On 3/3/20 at 10:53 AM, Resident #10 shook his head side to side indicating no, when asked if anyone helped him with dental care. When asked if he would like someone to help him with dental care Resident #10 stated yes. When asked if anyone took his dentures out or provided dental care supplies so he could clean his dentures and mouth he shook his head side to side, indicating no. On 3/3/20 at 10:57 AM, no dental care supplies were on Resident #10's side table or in his bathroom. On 3/5/20 at 4:03 PM, the DON stated there was no documentation for oral care for Resident #10. The DON stated oral care was not a scheduled task for the CNAs on the computer, so it was not getting charted in Resident #10's record. He stated if a task was not in the CNA charting, they were instructed to tell the nurse and the nurse made a progress note and started a task in the chart.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure staff followed professional standards of practice for disposition of controlled medications. This was true for 2 of 6 residents (#178 and #179) whose records were reviewed for controlled substances (narcotics) and had the potential to affect each of the 72 residents residing in the facility if controlled medications were diverted and residents did not receive medications as ordered for pain. Findings include: The facility's Destruction of Controlled Drugs policy, undated, stated all controlled substances were destroyed in the presence of two licensed nurses designated by the Director of Nursing or according to the local, State, and Federal regulations. It stated when controlled drugs needed to be stored, the proof of use inventory page (for disposition of unused medication) required the signature of two licensed nurses at the bottom, and they were transferred to the DON. The policy stated record keeping for destruction of controlled drugs was logged into the DON's Controlled Substance Record book, which was completed by the DON. The policy stated at the time of destruction, the DON and another licensed nurse must document destruction at the bottom of the DON's controlled substance record book. This policy was not followed. An email, dated 2/26/20, from the facility pharmacist to the DON, stated she had a concern about the

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) release of narcotics to residents without the correct documentation. In the e-mail the pharmacist documented it appeared there was only a signature of who the controlled medication was released to and did not include the signatures of licensed nurses for verification and reconciliation. On 3/6/20 at 12:30 PM, three resident narcotic books were reviewed and the following residents' narcotic medication sheets were not signed off as the facility's policy directed for the reconciliation of narcotics, as follows: *Resident #178's record included three reconciliation logs for her unused [MEDICATION NAME], 5mg each, dated 1/1/20, 1/3/20, and 1/15/20, which totaled 43 pills. At the bottom of each log was a section which stated Disposition of Unused Medication which included an area for the date of the disposition, the quantity of unused medication, an area for the method of disposition, an area for the staff to write the resident's name, address and telephone if the medications were released to the resident or their responsible party. The three logs documented the remaining [MEDICATION NAME] was released to the resident and had Resident #178's signature. The logs did not include Resident #178's complete name, address, and phone number. The logs were not signed by two licensed nurses for verification the narcotics were verified and reconciled. *Resident #179's record include one reconciliation log for his unused [MEDICATION NAME], 5/325 mg each, dated 2/12/20. At the bottom of the log was a section which stated Disposition of Unused Medication which included an area for the date of the disposition, the quantity of unused medication, an area for the method of disposition, an area for the staff to write the resident's name, address and telephone if the medications were released to the resident or their responsible party. The log had a line through it and was signed by one person, it was unclear if the signature was by a nurse or Resident #179. The log documented the remaining medication was released to Resident #179. There was no date of disposition documented on the bottom of the log. On 3/6/20 at 10:11 AM, LPN #1 stated he reviewed the narcotic book with the DON and they counted the narcotics, signed them off in the narcotic book, and then they both put them in the drug buster. He stated when there was a concern about a narcotic count being incorrect, they looked into it and assessed if the resident was in pain or if the resident stated they did not receive their medication. On 3/6/20 at 11:32 AM, The DON stated when a resident was discharged , the medications were taken out of the narcotic medication cart locker and if there were any narcotics left, two nurses destroyed the medications themselves. When asked if the floor nurses destroyed narcotics, the DON said they could, but it was usually him and two RCMs. The DON was asked if the facility had a drug destruction book (as referenced in the policy), he stated there was no requirement for one and he did not have one. When asked where the staff nurses documented their narcotic destruction, he stated they log them in the narcotic log book and both sign to note the destruction on the resident's individual narcotic page. The DON was asked if the narcotics were taken out of the medication cart and held somewhere before destruction. He stated no, the narcotics stayed in the carts until they were destroyed. On 3/6/20 at 2:30 PM, the Pharmacist said she did a 10% storage audit monthly to check documentation for controlled substances. She said she talked to the DON last month about incomplete documentation for narcotics. She said if there was only 1 nurse's signature on the log, she informed the DON, Administrator, or a charge nurse.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure a resident received restorative services through the restorative nursing program as needed. This was true for 1 of 2 residents (Resident #55) reviewed for the restorative nursing program. This failure created the potential for residents to experience a decline in Range of Motion (ROM). Findings include: The facility's Restorative Nursing Program policy, undated, documented the restorative program was to enable residents to attain or maintain their highest practicable level of physical functioning, and to provide restorative interventions as indicated. This policy was not followed. Resident #55 was readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #55's physician orders, dated 1/30/20, included an order for [REDACTED].#55's therapy referral to the RNA program, dated 1/31/20, documented he was to receive upper extremity strengthening exercises with weights and therabands five days a week. The referral did not include the use of a sit-to-stand with parallel bars. A 5-day MDS assessment, dated 2/5/20, documented Resident #55 had limited ROM impairments in both his upper and lower extremities. A care conference note, dated 2/3/20, documented Resident #55 would participate in the restorative exercise program. An RNA progress note, dated 2/14/20, documented Resident #55 was appropriate for the RNA program. Resident #55's care plan, dated 2/14/20, documented he received upper extremity strengthening exercises with weights and therabands five days a week. Resident #55's ROM activity records, dated 1/31/20 to [DATE], documented he was to receive upper extremity strengthening exercises with weights and therabands five days a week, Tuesday through Saturday. The referral did not include the use of a sit-to-stand with parallel bars. The record documented he received upper extremity exercises on 2/16/20 and 2/19/20. Resident #55 did not receive RNA services on 15 out of 17 opportunities. Resident #55's physician orders, dated [DATE], included an order for [REDACTED].#55 said a month prior he was on the light therapy program. He said he was frustrated because he had not received the therapy for two-to-three weeks. He said he complained about the lack of exercises and was working with therapy since he complained. On 3/6/20 at 9:57 AM, the Director of Therapy said Resident #55 was referred to the RNA program on 1/31/20. She said the referral form did not include the use of a sit-to-stand with parallel bars and said she expected it to be on the referral form. She said she expected nursing staff to follow-up on the therapy referrals and start the RNA program in a timely manner. The Director of Therapy said Resident #55 spoke with her and said he was not getting enough RNA services and she placed him back on the therapy program the following day ([DATE]). On 3/6/20 at 10:13 AM, the RNA program manager said Resident #55 was added to the RNA case load on 2/14/20 from a referral from therapy and it did not document to assist him with sit-to-stand with parallel bars. She said she did not know why the referral was delayed. She said she expected RNA staff to provide ROM services as directed by therapy.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview, it was determined the facility failed to ensure residents were provided with adequate supervision regarding the level of supervision necessary to prevent falls. This was true for 1 of 4 residents (Resident #10) reviewed for falls. This failure placed Resident #10 at risk of pain, bone fracture, brain damage and other life changing injuries as a result of falls. Findings include: Resident #10 was admitted into the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #10's care plan, dated 9/22/17, stated interventions for falls included bilateral assist rails and a lipped mattress, keep furniture in locked position, keep needed items within reach, and he would wear appropriate non-slip shoes and/or socks at all times. An admission MDS assessment dated [DATE], documented Resident #10 was cognitively intact. Incident and Accident reports documented Resident #10 fell in the facility three times. An Incident and Accident Report, dated 9/7/19, stated Resident #10 was found on the floor next to his bed. The report stated he was attempting to self-transfer from his bed to his wheelchair. The brakes were not locked on his wheelchair and he was wearing regular socks. A fall risk evaluation, dated 9/7/19, stated Resident #10's care plan interventions to prevent falls were bilateral assist rails and a lipped mattress on his bed, ensure he was wearing appropriate footwear, non-skid socks or well-fitting shoes when ambulating or mobilizing in his wheelchair, and keep his needed items in reach. There were no changes documented in the care plan related to the 9/7/19 fall. An Incident and Accident Report dated 9/9/19, stated Resident # 10 was found by staff on the floor on his knees and his wheelchair was moving. The report stated Resident #10 kept pointing to the table with his books. His wheelchair was unlocked. Resident #10's care plan interventions regarding falls were unchanged from 9/22/17. An Incident and Accident Report dated 12/15/19, stated Resident #10 was found lying on the floor between his bed and his wheelchair. He was wearing regular socks and no shoes. The care plan interventions were unchanged from 9/22/17. Three falls occurred after the Care Plan noted fall interventions were initiated on 9/22/17. These interventions were not implemented as follows: * On 9/7/19 Resident #10's wheelchair was not locked and he did not have grip socks or shoes on. * On 9/9/19, Resident #10's wheelchair was witnessed moving while he was on the floor pointing to books on his side table . * On 12/15/19 Resident #10 was found wearing regular socks without shoes. These interventions were not implemented correctly and consistently per the fall

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) incident documentation nor were they evaluated for effectiveness or modified for prevention of further falls. On 3/5/2020 at 3:43 PM, the DON was asked if he expected care plans to be followed, he stated I do, yes.
F 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure adequate care and treatment was provided to 1 of 1 resident (Resident #27) reviewed for feeding tube use. This created the potential for harm if complications developed from improper tube feeding practices. Findings include: The facility's Enteral Tubes policy, undated, documented staff were to follow physician orders. This policy was not followed. Resident #27 was readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. The manufacturer's operating manual for Resident #27's Enteral Feed and Flush Pump, revised 1/2016, documented the feed error screen appeared when the enteral formula was no longer delivered because the bag was empty or there was a clog in the line. Resident #27's care plan, dated 12/26/18, directed staff to administer tube feedings, and water flushes as ordered to supplement his oral intake and to monitor his tube for dysfunction or malfunction. Resident #27's significant change MDS assessment, dated 2/23/20, documented he was severely cognitively impaired and dependent on staff for all ADLs. Resident #27's physician orders, dated 2/26/20, included an order for [REDACTED].#27's February and (NAME)2020 MARs, documented he received 2 Cal nutrition formula 35 ml per hour continuously for a total of 840 ml to start at 5:00 PM. On 3/2/20 at 9:55 AM, Resident #27 was asleep in his bed in his room. The Enteral Feed and Flush Pump displayed feed error, clog in line, valve not loaded. There was formula in the tube feed line with an empty 1,000 ml bottle of 2 Cal nutritional formula hung next to the bed. The bottle had a hand written date and time of 2/29/20 at 7:30 PM on it, almost 39 hours after the date written on the bottle. On 3/2/20 at 10:11 AM, the surveyor alerted LPN #2 to come to Resident #27's room to assess his tube feeding pump. LPN #2 said the pump had stopped. She said the date and time on the bottle documented when it was started. She said due to the date, time, and the empty bottle, it appeared he had not received a new bottle of formula the evening of 3/1/20. LPN #2 filled up a 60 ml syringe half-way, disconnected the tube feeding, and connected the syringe to the gastrostomy tube port and attempted to complete a gravity flush without success. She then used the plunger on the syringe and attempted to push water through and it was unsuccessful. LPN #2 said only a scant amount of water went through the port and she would notify the RCM or the DON about the clogged tube. On 3/2/20 at 12:06 PM, LPN #2 said her shift started at 6:00 AM that morning and had not been in Resident #27's room prior to being alerted by the surveyor. On 3/6/20 at 9:17 AM, RCM #1 said she expected nurses to check on Resident #27's feeding pump every two hours and expected nurses to follow physician orders [REDACTED].
F 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Post nurse staffing information every day.** Based on observation, review of daily staffing records, and staff interview, it was determined the facility failed to ensure nurse staffing information was posted daily, at the beginning of each shift, and was complete. This failed practice had the potential to affect the 72 residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include: On 3/4/20 at 9:04 AM, the daily nurse staffing information was observed in the hallway near the nurses' station. The posted information was for the night, day, and evening shift, and documented the following: * Night Shift: CNAs - 4 for a total of 30 hours, LPNs - 2 for a total of 16 hours * Day Shift: CNAs - 9 and transportation driver - 1 for a total of 75 hours, LPNs - 3 for a total of 24 hours, and RNs - 1 for a total of 8 hours * Evening Shift: CNAs - 7 for a total of 52.5 hours, LPNs - 2 for a total of 16 hours, and RNs - 1 for a total of 8 hours * The facility's census was 69 On 3/6/20 at 2:17 PM, the daily nurse staffing information was observed in the hallway near the nurses' station. The posted information was for the night, day, and evening shift, and documented the following: * Night Shift: CNAs - 3 for a total of 22.5 hours and LPNs - 2 for a total of 16 hours * Day Shift: CNAs - 9 and transportation driver - 1 for a total of 75 hours, LPNs - 3 for a total of 24 hours, and RNs - 1 for a total of 8 hours * Evening Shift: CNAs - 8 for 60 hours, LPNs - 3 for 24 hours, and RNs - 1 for 8 hours * The facility's census was 68 The Nurse Staffing postings were not posted at the beginning of each shift and the van driver was included under the CNA section for total hours. The Nurse Staffing postings from 2/1/20 to 3/6/20 were reviewed. The postings included the transportation driver for 2/1/20 to [DATE], 2/11/20, 2/12/20, 2/17/20, 2/25/20 to 2/28/20, and 3/3/20. On 3/6/20 at 2:22 PM, the Staffing Coordinator said she was told she could post the van driver on the nurse posting because that person was a CNA. She said the van driver did not work as a CNA on the floor on the days she was listed as transportation. She said on the night shift the nurse posted all of the shifts for the day. On 3/6/20 at 2:42 PM, the Administrator and the Regional Vice-President said they thought the van driver could be counted on the posting because that person was a CNA and provided cares to residents she transported. They said they thought all of the shifts could be posted at the same time.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure residents were free from unnecessary drugs. This was true for 1 of 5 residents (Resident #50) reviewed for unnecessary medications. This deficient practice created the potential for adverse consequences if residents received duplicate medications and were not monitored for harmful side effects. Findings include: Resident #50 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. A quarterly MDS assessment, dated 1/30/20, documented Resident #50 had moderate cognitive impairment. A consultation report from the pharmacy, dated 1/22/20, stated Resident #50 had orders for duplicate therapy for the medications [MEDICATION NAME] ER (a medication used to relax bladder smooth muscle) and Myrbetriq (a medication used to relax bladder smooth muscle). The consult stated a follow up with the nephrologist was needed to determine which of these medications Resident #50 should take. A fax, dated 1/23/20 at 11:37 AM, was sent from the facility to Resident #50's nephrologist requesting clarification on the [MEDICATION NAME] ER and Myrbetriq orders. On 2/5/20 the nephrologist replied to stop both medications. The facility received the order on [DATE] and the medication was stopped on [DATE], 11 days after the consultation report from the pharmacy requesting clarification. On 3/6/20 at 3:36 PM, the DON stated when the clarification from the pharmacist was requested he expected the nurse to call the physician to follow-up before the end of the week.

F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure [MED] was administered as ordered and at the appropriate time for 3 of 6 residents (#39, #63, and #65) who were reviewed for diabetic management. This failure placed the residents at risk of their [MED] being less effective and the therapeutic dose at low or high levels which may increase the risk of high or low blood sugar. Findings include: The facility's Medication Administration policy, undated, stated the licensed nurse checked the following to administer medication: Right medication, Right dose, Right route, Right resident, and Right time. The Food and Drug Administration website, accessed on 3/17/20, documented the following: * Rapid-acting [MED] starts working within 15 minutes after use. It is mostly out of the body after a few hours and should be taken just before or just after eating. * Long-acting [MED] starts working within 2 to 4 hours after use and it could last in the body for up to 24 hours. It is often used in the morning or at bedtime to help control blood sugar throughout the day. The facility's Flexible Medication Pass Policy, undated, documented the following guidelines for medication administration, unless otherwise indicated by the nature of the medication: * AM (morning) - Medications were to be administered between 6:00 AM and 10:00 AM * HS (bedtime) - Medications were to be administered between 8:00 PM and 10:00 PM 1. Resident #39 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #39's annual MDS assessment, dated 1/2/20, documented he was moderately cognitively impaired and received [MED]. Resident #39's Medication Orders, as of 3/6/20, documented: * [MEDICATION NAME] Solution (long-acting [MED]) 30 units to be given via injection at bedtime. * [MEDICATION NAME] Solution 40 units to be given via injection in the morning. The MARs for January and February 2020 documented Resident #39's [MEDICATION NAME] was not given between 6:00 AM and 10:00 AM and between 8:00 PM and 10:00 PM. Examples include: * The MAR for January 2020 documented the [MEDICATION NAME] scheduled to be given in the morning was administered at the following times: - On 1/3/20, administered at 11:45 AM - On 1/6/20,

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F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) administered at 11:36 AM - On 1/7/20, administered at 11:21 AM - On 1/9/20, administered at 12:14 PM - On 1/16/20, administered at 12:31 PM - On 1/17/20, administered at 12:13 PM - On 1/23/20, administered at 1:11 PM - On 1/31/20, administered at 12:16 PM * The MAR for January 2020 documented the [MEDICATION NAME] scheduled to be given at bedtime was administered at the following times: - On 1/11/20, administered at 10:28 PM - On 1/12/20, administered at10:21 PM - On 1/18/20, administered at 10:37 PM - On 1/22/20, administered at 10:34 PM - On 1/26/20, administered at 10:17 PM - On 1/27/20, administered at 10:59 PM - On 1/28/20, administered at 10:22 PM - On 1/29/20, administered at 10:42 PM * The MAR for February 2020 documented the [MEDICATION NAME] scheduled to be given at bedtime was administered at the following times: - On 2/5/20, administered at 10:52 PM - On [DATE], administered at 11:05 PM On 3/4/20 at 2:42 PM, LPN #2 reviewed Resident #39's MARs. LPN #2 said she documented the [MED] for Resident #39 at the end of the day. LPN #2 said she had to document at the end of the day on several occasions because she runs out of time. 2. Resident #63 was readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #63's quarterly MDS assessment, dated 2/9/20, documented he was cognitively intact and received [MED]. Resident #63's record included an order for [REDACTED].#63's January 2020 MAR indicated [REDACTED]. On 1/18/20, the [MEDICATION NAME] was scheduled for 7:00 PM and was administered at 11:00 PM Resident #63's February 2020 MAR indicated [REDACTED]#63's (NAME)2020 MAR indicated [REDACTED]. On 3/3/20, the [MEDICATION NAME] was scheduled for 7:00 PM and was administered at 10:06 PM 3. Resident #65 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #65's annual MDS assessment, dated 2/19/20, documented she was cognitively intact and received [MED]. Resident #65's Medication Orders documented: * Bydureon (a non-[MED] medicine that helps to stabilize blood sugar) 2 mg to be given via injection in the morning every Friday. * [MEDICATION NAME] (rapid-acting [MED]) to be given via injection per sliding scale before meals and at bedtime for diabetes. * [MED] (long-acting [MED]) 75 units to be given via injection at bedtime. Resident #65's January 2020 MAR indicated [REDACTED]. The MAR indicated [REDACTED]. The January 2020 and February 2020 MARs documented Bydureon was not administered each Friday between 6:00 AM and 10:00 AM as ordered. On 1/24/20 it was administered at 11:46 AM, on 2/7/20 it was administered at 2:39 PM, and on 2/28/20 it was administered at 12:04 PM. On 3/3/20 at 1:53 PM, LPN #1 reviewed Resident #65's MARs. LPN #1 said he documented the [MED] when he had time during or at the end of his shift. He said he should document when he administered the medication. On 3/4/20 at 2:50 PM, the DON said he expected staff to document at the time of [MED] administration. He reviewed Resident #39's, Resident #63's, and Resident #65's MARs for January, February, and (NAME)and said the [MED] administration times were documented later than what the physician orders [REDACTED]. On 3/6/20 at 9:56 AM, the facility's Physician's Assistant said he expected the [MED] to be given as ordered in a specific time frame otherwise it could cause false blood sugar readings and inaccurate dosing of [MED] which can lead to low or high blood sugar. On 3/6/20 at 2:27 PM, the Pharmacist said she expected [MEDICATION NAME] and [MEDICATION NAME] (long-acting [MED]) to be consistently given at the same time. The Pharmacist said that if the [MED] was not documented accurately it could lead to medication being omitted or given twice.
F 0790 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide routine and 24-hour emergency dental care for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and resident and staff interview, it was determined the facility failed to ensure a resident was provided dental services. This was true for 1 of 2 residents (Resident #10) reviewed for dental services. This failure created the potential for harm if residents experienced weight loss due to inability to chew food or increased mouth pain from poor fitting dentures. Findings include: The facility's dental services referral policy, undated, documented the Social Service department worked to assist residents with routine dental services, appointments, and arranging transportation. The policy stated all dental interventions were documented in the medical record. Resident #10 was admitted into the facility on [DATE], with [DIAGNOSES REDACTED]. An admission MDS assessment, dated 9/9/16, documented Resident #10 had no natural teeth and he was cognitively intact. Resident #10's care plan, revised on 12/3/19, documented he was able to clean his dentures after set up with one person assist and he was to receive complete mouth inspections daily. The care plan also documented the facility would coordinate arrangements for dental care, and transportation to dental appointments as needed. Resident #10's record documented he had no dental appointments from 2016 to present. No dental visits were documented in his progress notes since admission. There was also no documentation in Resident #10's record from a dentist. Resident #10's transportation documentation had no record of transportation to a dental appointment. On 3/3/20 at 10:53 AM, Resident #10 was asked if he wanted to see a dentist for care and he stated yes. On 3/5/20 at 4:03 PM, the DON stated the staff documented dental concerns and if there was a recommendation from the physician or provider the facility sent residents to the dentist.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on policy review, test tray evaluation, and resident and staff interview, it was determined the facility failed to ensure palatable food was served. This was true for 13 of 16 residents (#4, #8, #10, #15, #23, #42, #45, #48, #51, #63, #65, #70, and #176) reviewed for food and nutrition, and had the potential to affect all residents in the facility. This created the potential to negatively affect residents' nutritional status and psychosocial well-being. Findings include: The facility's Food Quality and Palatability policy, dated 9/2017, documented food was to be palatable and served at an appetizing temperature. This policy was not followed. Residents were interviewed individually regarding the food served at the facility, and they responded as follows: * On 3/2/20 at 11:20 AM, Resident #45 said she thought a new contractor took over managing the kitchen and since then the food quality and taste had gotten bad. * On 3/2/20 at 11:55 AM, Resident #176 said the quality of food was bad. * On 3/2/20 at 2:45 PM, Resident #51 said the food was cold and tasted bad. He said sometimes there was too much garlic and other times the food was bland. * On 3/3/20 at 10:55 AM, Resident #10 said the food was not good. * On 3/3/20 at 11:39 AM, Resident #65 said the food was awful most of the time and sometimes had to ask for an alternate because the meat was tough. * On 3/3/20 at 2:54 PM, Resident #70 said the food was gross. On 3/3/20 at 2:58 PM, during the Resident Group interview, Residents #4, #8, #15, #23, #42, #48, #63, #65, and #176 said they did not like the food and it was often served cold. On 3/4/20 at 12:07 PM, the test tray was evaluated by two surveyors along with the CDM and the RD. The turkey was 134.6 degrees Fahrenheit (F), the green beans were 111.9 degrees F, and the sweet potato souffle was 120 degrees F. The CDM said the turkey was palatable with the cranberry sauce. The surveyors determined the turkey was flavorless without the cranberry sauce. The CDM and RD said the green beans were warm. The surveyors determined the green beans were crunchy and not hot enough. The surveyors determined the sweet potato souffle was not hot enough.
F 0808 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to ensure a physician ordered diet was served to a resident. This was true for 1 of 6 residents (Resident #68) reviewed for altered diets. This failure created the potential for harm if residents did not receive adequate nutritional intake due to incorrect diets. Findings include: The facility's meal policy, dated 9/2017, documented meals were to be served according to the individualized diet order and nursing staff were responsible for verifying meal accuracy. This policy was not followed. Resident #68 was admitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. Resident #68's care plan, dated 2/18/20, directed staff to serve his diet as ordered for adequate nutritional intake. Resident #68's nutrition evaluation, dated 2/22/20, documented he required a high protein diet for [MEDICAL TREATMENT]. Resident #68's physician orders, dated 3/2/20, documented he was to receive a renal diet with double protein. Resident #68's tray tickets, dated 3/2/20 and 3/4/20, documented he was to receive a renal diet with double protein. On 3/2/20 at 11:10 AM, Resident #68 said he was on [MEDICAL TREATMENT] and needed extra protein. He said it's been a battle to receive the correct diet because the kitchen was not reading his tray tickets and he had to send food back for the correct renal diet. On 3/4/20 at 8:17 AM, Resident #68's tray was observed with two empty plates with remnants of eaten food. His tray ticket documented the protein was scrambled eggs. He said he had not received a double portion of eggs that morning and had to request additional eggs which was why he had the additional plate. On 3/4/20 at 11:55 AM, Resident #68 was in his room when his lunch tray was delivered. His tray ticket documented a renal diet with double protein. The documented protein was turkey. On his plate

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F 0849 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure there were orders for hospice care, that care was coordinated with a hospice provider, and duties of the hospice provider and the facility were delineated. This was true for 1 of 2 residents (Resident #27) reviewed for hospice care and services. This failure placed residents at risk of receiving inadequate and inappropriate care and services. Findings include: The facility's Hospice policy, undated, documented the facility was to coordinate the plan of care with the hospice agency, to coordinate the provision of medications as needed to manage terminal illness and related conditions, and to delineate what services hospice provided and what services the facility provided. This policy was not followed. Resident #27 was readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED].#27's hospice provider, dated 6/7/18, documented the facility and hospice provider would develop a coordinated plan of care. Resident #27's hospice election form for a local hospice provider was signed by his guardian on 2/11/20. Resident #27's record did not include a physician order [REDACTED].#27's hospice plan of care, dated 2/11/20, documented medications were obtained through the hospice pharmacy. Resident #27's care plan, dated 2/12/20, directed staff to obtain orders through hospice, alert the hospice provider for resident changes, and provide end of life care. The care plan did not include documentation of the detailed responsibilities or care provided between the facility and the hospice agency. Resident #27's significant change MDS assessment, dated 2/23/20, documented he received hospice services. On 3/4/20 at 4:44 PM, LPN #2 said the hospice pharmacy provided some of Resident #27's medications. On 3/4/20 at 4:56 PM, LPN #3 said hospice staff came to the facility on e-to-two times a week to provide cares for Resident #27 and the coordinated information could be found in his record. She said his hospice physician was responsible for his medications related to hospice and were filled by the hospice pharmacy. On 3/5/20 at 1:19 PM, the DON said he could not find physician orders [REDACTED].
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on observation, record review, review of the QAPI (Quality Assessment Performance Improvement) plan, review of allegations of abuse, review of the QAPI meeting minutes, and resident and staff interviews, it was determined the facility failed to take actions to identify, track performance, and to resolve systemic problems. These failed practices directly impacted 9 out of 23 residents (#27, #39, #63, #65, #176, #177, #178, and #179), and had the potential to affect all residents residing in the facility. As a result, the facility failed to implement improvement actions to resolve identified insufficient quality control measures regarding diabetic management, narcotic medication controls, abuse investigations, and infection control outcomes. Findings include: The facility's QAPI plan, dated 2/2019, directed the QAPI committee to do the following: * Take a proactive approach to improve resident care. * Incorporate QAPI principles to achieve performance improvement goals. * Establish goals that are specific, measurable, attainable, relevant, and time bound. * Monitor care and services, drawing data from multiple sources. * Demonstrate proficiency using root cause analysis. * Conduct on-going evaluations or assessments of its performance improvement efforts to determine achievement of intended goals. * Revise goals if benchmarks were not achieved, attained or sustained. This plan was not followed. The facility's QAPI minutes from 5/30/19 to 2/27/20 were reviewed. a. The QAPI meeting minutes, dated 5/30/19, documented, F610 100% of accidents and incidents in (NAME)were completed within 5-day parameter. The QAPI minutes from 6/27/19, 7/25/19, 8/22/19, 9/29/19, 10/24/19, 11/21/19, 12/19/19, 1/22/20, and 2/27/20 did not include F610 or abuse reporting and investigations as a QAPI item. The facility was cited for F610 on 1/10/19. Please refer to F610 where the facility failed to ensure a resident's (#65) allegation of abuse was thoroughly investigated and F600 where the facility failed to ensure a resident was free from intimidation when reporting abuse (Resident #176). b. The QAPI meeting minutes, dated 11/21/19, documented under infection control, Process identified and being resolved. The minutes did not document what was identified, what was being resolved, and/or what goals were in place that were specific, measurable, attainable, relevant, and time bound. The QAPI meeting minutes, dated 12/19/19, documented an infection control summary which included different types of infections in the facility and where they were located. There was no action plan to address the infection control concerns or identify a root cause analysis for the infections. Please refer to F880 where the facility failed to ensure nursing staff followed hand hygiene practices which affected Resident #27 and had the potential to affect other residents in the facility. c. The QAPI meeting minutes, dated 1/22/20, documented a QAPI plan for blood glucose management. The concern was identified and dated 1/9/20. The issue documented staff were failing to complete physician notification with documentation of blood glucose outside of parameters. The root cause was attributed to staff knowledge deficits. The action plan was to educate nurses and review orders for necessity and completeness. The minutes documented the completion date was 1/14/20. The plan did not identify what monitors were put into place and what measurable efforts would be assessed to attain and maintain compliance. The 2/27/20 minutes did not include blood glucose as a QAPI item or documentation of follow through. Please refer to F760 where nursing staff failed to document the administration of [MED] within 60 minutes of the prescribed time and/or following a blood glucose reading requiring [MED] for residents (#39, #63, and #65). d. An email from the pharmacist to the DON, dated 2/26/20, documented the pharmacist identified a concern with narcotics that were sent home with residents. The pharmacist documented the narcotic ledger should include the contact information of who the medications were released to and not just a signature of the person receiving them which was the process at that time. The QAPI minutes from 5/30/19, 6/27/19, 7/25/19, 8/22/19, 9/29/19, 10/24/19, 11/21/19, 12/19/19, 1/22/20, and 2/27/20 did not include medications which were sent home with residents or narcotic destruction procedures were identified as concerns. Please refer to F684 where the facility failed to keep accurate narcotics records for 3 residents (#177 and #179) and failed to follow the facility's protocol related to destruction of narcotics. On 3/6/20 at 3:35 PM, the Administrator said the QAPI committee focused on F610 related to making sure the facility had abuse allegations completed within 5-days and had three people reviewing each investigation. She said she thought the facility was in compliance based on the process that was in place. The Administrator said the QAPI process had not identified a lack of thorough abuse investigations. She said infection control concerns were reviewed in QAPI and said hand hygiene had not been discussed as an agenda item. The Administrator said she was aware clinical staff discussed missed medications in their daily meeting and said medication administration and [MED] concerns were not being discussed or followed-up in QAPI. She said narcotic medication controls had not been brought up until the end of February. The facility failed to ensure an effective QAPI program was implemented and maintained to address identified concern areas.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure appropriate hand hygiene was performed. This was true for 1 of 18 residents (Resident #27) reviewed for infection control practices and 3 staff members (CNA #3, CNA #4, and LPN #2) and had the potential to affect all residents in the facility. This deficient practice created the potential for harm if residents experienced infections from cross contamination. Findings include: The facility's policy for Hand Hygiene, revised 1/2017, directed staff to wash hands with soap and water when visibly soiled and to use an alcohol-based hand rub for routine decontamination of hands when not visibly soiled, including: * Before having direct contact with residents. * After touching body fluids. * During resident care if moving from a contaminated-body site to a clean-body site. * After removal of gloves. This policy was not followed. 1. Resident #27 was readmitted to the facility on [DATE], with multiple [DIAGNOSES REDACTED]. On 3/2/20 at 10:11 AM, LPN #2 was

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IVY COURT	**2200 IRONWOOD PLACE COEUR D'ALENE, ID 83814**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) observed while attempting to flush Resident #27's gastrostomy tube (a tube inserted through the abdomen that brings nutrition directly to the stomach). LPN #2 sanitized her hands and donned gloves as she entered Resident #27's room. With her gloved right hand, she pulled on the light cord for the light at the head of the bed. LPN #2 then touched Resident #27's tube feed bottle with both hands without changing her gloves or performing hand hygiene. She then picked up the call light off of the floor using both hands and laid it on the bed. LPN #2 next picked up the water flush container off of the bedside table went to the sink and turned it on with her left gloved hand to fill the container. LPN #2 did not change her gloves or perform hand hygiene. She brought the container back to the table and opened a package containing a clean 60 ml syringe. With the same gloved hands, LPN #2 disconnected Resident #27's tube feeding catheter from the gastrostomy tube and connected the syringe to the tube using her left gloved hand to handle the port and her right gloved hand to handle the syringe and then attempted to flush the gastrostomy tube using gravity. LPN #2 then retrieved more water from the sink without changing her gloves or performing hand hygiene. She then reconnected the syringe to the gastrostomy tube and attempted to flush the tube using the syringe plunger. LPN #2 said the tube was clogged and reconnected the tube feed to Resident #27's gastrostomy tube. On 3/2/20 at 10:33 AM, LPN #2 said she should have changed her gloves and sanitized her hands after handling Resident #27's call light cord and before she performed the care of the gastrostomy tube. On 3/5/20 at 2:00 PM, the DON said he expected staff to change gloves and sanitize their hands after touching potentially contaminated surfaces and prior to handling Resident #27's gastrostomy tube. 2. On 3/3/20 at 11:18 AM, CNA #3 was observed without wearing gloves as she walked down the hall carrying trash to the dirty utility room. After delivery she sanitized her hands. When asked about not having gloves while carrying trash she stated the staff were instructed not to wear gloves in the hallway. 3. On 3/3/20 at 2:33 PM, CNA #4 was observed as she came out of a resident's room wrapping up a trash bag with her bare hands. She threw the trash away in the dirty utility room and went into room [ROOM NUMBER] to answer a call light, without performing hand hygiene prior to entering the room. From room [ROOM NUMBER] she went into room [ROOM NUMBER] to answer the call light without performing hand hygiene when she exited room [ROOM NUMBER] or prior to entering room [ROOM NUMBER]. On 3/5/20 at 2:41 PM, the Infection Control Preventionist said she expected staff to sanitize their hands after touching things from the floor, before and after personal cares, and when leaving residents' rooms.