STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135058	A. Building B. Wing	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silverton Health and Rehabilitation of Cascadia	405 West Seventh Street Silverton, ID 83867

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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 0157 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on staff interview, review of Incident and Accident Reports, and review of residents' records, it was determined the facility failed to ensure residents' physicians were notified of significant changes in their conditions and/or a need to alter treatment. This was true for 2 of 13 sampled residents (#2 and #11) and had the potential for harm if physicians were not provided with information necessary to make decisions to initiate and/or alter interventions to meet residents' changing needs. Findings include: 1. Resident #2 was admitted to the facility on [DATE], with diagnoses which included Type II diabetes mellitus [DM]. The initial Minimum Data Set (MDS) assessment, dated 4/25/17, documented Resident #2 was cognitively intact. The Hyperglycemia Care Plan, revised 5/4/17, directed staff to monitor, document, and report to the physician, as needed, when Resident #2 experienced signs and symptoms (s/s) of hyperglycemia. The care plan did not document how often staff was to monitor Resident #2's BG (blood glucose) levels, when staff was to notify the physician if BG levels were outside of physician-established parameters, when to administer insulin, or when to follow hyper/hypo glycemic protocols. Resident #2's May 2017 Physician's Orders documented: * HumaLOG (Insulin Lispro) solution before meals and at bedtime (HS) per the following sliding scale for BGs (all measurements in milligrams/deciliter) of: 70 - 130 = 0 units; 131 - 180 = 4 units; 181 - 240 = 8 units; 241 - 300 = 10 units; 301 - 350 = 12 units; (continued on next page)

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

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F 0157 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	351 - 400 = 16 units; 401 - 499 = 20 units, and call physician for BG levels greater than 400 mg/dl, ordered 4/20/17. * 28 units of Tresiba (Insulin Degludec) solution in the morning for DM, ordered 5/1/17. * BG assessments before meals and at bedtime related to Type II DM. For BG level greater than 400 mg/dl the physician was to be called. If Resident #2 had a BG level less than 70 and was able to swallow, staff were to give the resident a rapidly absorbing carbohydrate such as 4 ounces juice. Resident #2's BG level was to be checked in 15 minutes and repeat if carbohydrate was necessary. This was initiated on 4/19/17. A Nurse's Note, dated 4/18/17 at 6:01 pm, documented Resident #2 had a BG level of 514 mg/dl. Resident #2's MAR from 4/19/17 through 4/30/17 documented: * BG levels ranged from 209 - 509 mg/dl. * 13 BG levels were greater than 400 mg/dl, including 1 BG greater than 500 mg/dl. * The resident's record documented the physician was notified of 4 of the 13 hyperglycemic assessments, those on 4/18/17, 4/20/17, 4/21/17, and 4/27/17. Resident #2's MAR from 5/1/17 to 5/16/17 documented: * BG levels ranging from 119 - 586 mg/dl. * 13 BG levels greater than 400 mg/dl, 6 of which were greater than 500 mg/dl. * Resident #2's record documented the physician was notified of 1 of the 13 hyperglycemic assessments, that on 5/14/17. On 5/18/17 at 8:42 am, the Interim Director of Nursing Services (IDNS) stated facility staff were to notify the physician as soon as possible when BG levels exceeded parameters specified by the physician. On 5/18/17 at 11:15 am, Licensed Practical Nurse (LPN) #1 stated she would notify a physician when BG levels were outside established parameters and document that she called the physician in a Nurse's Note. On 5/18/17 at 3:15 pm, Resident #2's physician stated he was aware of Resident #2's elevated BG levels and was not all that upset that he was not notified on every occasion, but that he expected nurses to follow his orders all the time. He stated the facility would usually send a fax notifying him of elevated BG levels. 2. Resident #11 was readmitted to the facility on [DATE] with diagnoses which included malignant neoplasm of the lung [lung cancer], dementia and mood disorder. (continued on next page)

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F 0157 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS assessment, dated 2/22/17, documented Resident #11 was cognitively intact, required supervision with transfers and ambulation, experienced 1 non-injury fall prior to the assessment, and rejected cares 1-3 days during the look back period. Resident #11 experienced 5 falls between 4/1/17 and 4/25/17. * Fall on 4/1/17 at 3:15 am: A Fall Scene Huddle Worksheet [FSHW] documented Resident #11 was found on 4/1/17 on her hands and knees crawling out of the bathroom. The worksheet documented the resident seemed forgetful, confused, [and] had just been out to [the] nurses station looking for her husband stating she had seen him outside her window. A Social Services Note, dated 4/1/17 and attached to an Incident & Accident Report documented, [Resident #11] had a large bruise to her left thorax. [Resident #11] stated she fell and her ribs hurt . The note documented Resident #11's Interested Party was contacted in regards to what appears to be a non-injury incident from a fall. Resident #11's clinical record did not contain the Social Services Note from the Incident Report or documentation that the facility reported her complaint of rib pain to the physician following the 4/1/17 fall. On 5/22/17 at 10:05 am, the Social Service Director [SSD] stated the notes she wrote on the Incident Report was not in the clinical record and were a reminder to herself. * Fall 4/3/17 at 4:00 pm: An FSHW, dated 4/3/17 at 4:00 pm, documented Resident #11 was found on the floor in her room attempting to ambulate. The worksheet documented the resident seemed agitated, but had otherwise sustained no injuries. Resident #11's clinical record did not contain documentation that the facility reported Resident #11's 4:00 pm fall on 4/3/17 to the physician. On 5/22/17 at 11:10 am, Resident #11's physician stated he expected nursing staff to notify him when residents complained of increased pain or potential injury following a fall.

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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 0224 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from mistreatment, neglect and misappropriation of personal property. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on record review, staff interview, and review of facility policies, investigations, and grievances, it was determined the facility failed to ensure 1 of 13 (#11) residents reviewed for abuse prevention, was protected from verbal/mental abuse by staff. Resident #11 was exposed to the potential for psychosocial harm when Registered Nurse [RN] #2 demeaned her for refusing to shower. Findings include: Resident #11 was readmitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the lung [lung cancer], dementia and mood disorder. A quarterly Minimum Data Set [MDS] assessment, dated 2/22/17, documented Resident #11 was cognitively intact, required supervision with transfers and ambulation, experienced a non-injury fall prior to the assessment, and rejected cares 1-3 days during the look back period. Progress Notes from 4/3/17 through 4/6/17 included 21 entries that Resident #11's pain had increased prior to the alleged abuse from RN #2. A Nurse's Note, dated 4/6/17 at 7:24 pm, documented Resident #11 did not want to bathe, but eventually consented to a bath. The Note documented Resident #11 indicated she was hurting too bad for a bath. A undated Witness Statement documented Certified Nursing Assistant [CNA] #1 offered a bath to Resident #11, who declined. After an unsuccessful second offer to the resident, CNA #1 asked RN #2 to ask Resident #11 to shower. CNA #1 stated Resident #11 declined again and she heard shouting between Resident #11 and RN #2. CNA #1 stated she heard RN #2 tell Resident #11 that she smelled like a dirty crotch at least three times. CNA #1 removed RN #2 from the room and RN #2 told two staff members of the incident. A 4/6/17 Witness Statement documented CNA #2 was at the nurses station on 4/6/17 at 6:45 pm, when she heard RN #2 respond to Resident #11 about her refusal to bathe. CNA #2 stated RN #2 told Resident #11 she could not refuse her bath because she smelled like a dirty crotch. CNA #2 stated she offered to re-approach Resident #11 with an offer to bathe. A 4/7/17 Witness Statement documented Licensed Practical Nurse [LPN] #3 observed Resident #11 come out of her room on 4/6/17 at 6:30 pm and state she did not want to take a shower. LPN #3 stated she saw Resident #11's agitation level was escalating when RN #2 approached her. LPN #3 stated RN #2 and CNA #1 entered Resident #11's room and closed the door. After a few minutes, LPN #3 said, RN #2 and CNA #1 emerged from the resident's room and RN #2 informed LPN #3 that she told Resident #11 that she smelled like a dirty crotch and could not refuse a bath. The Abuse Investigation included documentation of weekly meetings between RN #2 and the Administrator, who spoke with RN #2 and reviewed different types of abuse on 4/7/17. (continued on next page)

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F 0224 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #11 filed a grievance on 4/7/17, which documented she did not want a bath and was upset because of two falls she had experienced earlier in the week. She stated RN #2 told her she smelled like dirty crotch. A facility investigation validated the allegation and RN #2 was given a written warning and required to take elderly care and sensitivity training within the next 10 days. The Abuse Investigation documented a 4/10/17 phone conversation took place between LPN #4 and the Administrator regarding LPN #4's monitoring of RN #2. The dates that RN #2 was monitored by LPN #4 were not included in the document, which noted LPN #4 monitored RN #2 while both staff members were working in the building for two days. The Abuse Investigation documented a 4/17/17 phone conversation occurred between LPN #4 and the Administrator. The dates that RN #2 was monitored by LPN #4 were not included in the document, which noted RN #2 was monitored by LPN #4 while RN #2 was working in the building. The document noted . there were [no] episodes of concerns. If she wasn't in hearing distance of [RN #2], she tried to ensure that there was a care giver within hearing distance of [RN #2]. The Abuse Investigation documented a weekly meeting between RN #2 and the Administrator, who spoke with RN #2 and reviewed types of abuse, took place on 4/17/17. Resident #11's clinical record documented RN #2 came into contact with Resident #11 when she provided pain medication to the resident on 4/8/17, 4/14/17, 4/15/17, 4/19/17, 4/20/17, 4/21/17, and 4/22/17. The Abuse Investigation did not include documentation of a phone conversation between a staff monitor for RN #2 and the Administrator for 4/19/17 and 4/20/17 or whether RN #2 was monitored on those two days. The Abuse Investigation included documentation of a 4/24/17 phone conversation between LPN #4 and the Administrator and that RN #2 was monitored by LPN #4 on 4/21/17 and 4/22/17. The document stated if LPN #4 wasn't within hearing distance of [RN #2] there were care givers in the area. On 5/19/17 at 4:14 pm, the Administrator stated she had a monitor or other staff working with RN #2 and that these staff members could hear everything RN #2 said to residents. The Administrator stated a CNA was with RN #2 if the monitor was busy elsewhere and that she met with RN #2 weekly to discuss abuse prevention and review different types of abuse. The Administrator stated she met weekly with RN #2, and some residents RN #2 came into contact with, to assess for signs of abuse. The Administrator stated there were no signs of abuse.

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F 0280 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents the right to participate in the planning or revision of care and treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents' care plans were revised to reflect their current behavioral status, level of assistance required for activities of daily living [ADLs], and diabetic management. This was true for 1 of 13 residents (#2) sampled for care plan revision and had the potential to cause harm if residents did not receive appropriate care and interventions due to outdated and/or incomplete care plan information. Findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses which included Type II diabetes mellitus. The initial Minimum Data Set [MDS] assessment, dated 4/25/17, documented Resident #2 was cognitively intact and required limited assistance of 1 staff member with transfers. a. The Hyperglycemia Care Plan, revised 5/4/17, directed staff to monitor, document, and report to the physician as needed when Resident #2 experienced signs and symptoms (s/s) of hyperglycemia. The care plan did not document how often staff was to monitor Resident #2's BG levels, when to notify the physician if BG levels were outside of physician-established parameters, when to administer insulin, or when to follow hyper/hypo glycemic protocols. On 5/18/17 at 4:43 pm, the Interim Director of Nursing Services [IDNS] stated the care plan should include when to notify the physician and what to do if residents experienced hyper/hypo glycemic events. b. The ADL Care Plan, revised 5/4/17, documented Resident #2 required supervised stand by assistance of 1 staff member, with a mobility bar for transfers. On 5/16/17 at 8:34 am, Resident #2 was observed wheeling herself into her room and transferring into her recliner chair without staff assistance or supervision. On 5/17/17 at 10:15 am, Resident #2 was observed transferring herself into her recliner chair from her wheelchair without staff assistance or supervision. On 5/18/17 at 4:43 pm, the IDNS stated Resident #2 was independent with transfers and that the care plan needed to be updated. c. The Anti-anxiety Care Plan, revised 5/4/17, documented Resident #2 received an anti-anxiety medication for anxiety disorder. The care plan did not identify resident-specific behaviors staff was to monitor. On 5/18/17 at 4:43 pm, the IDNS stated Resident #2's behaviors present as picking at her skin and making herself bleed. The IDNS stated the resident's care plan needed to be updated to reflect these behaviors.

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F 0281 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27930 Based on resident and staff interview, review of clinical records, Fall Scene Huddle Worksheets (FSHW), and facility policy, it was determined the facility failed to ensure the neurological status of residents was consistently assessed after falls with the potential for head injury. This was true for 5 of 7 residents (#3, #4, #6, #7 & #11) reviewed for falls and created the potential for more than minimal harm if changes in a resident's neurological status went undetected and untreated. The facility also failed to ensure 5 of 13 (#1, #2, #5, #7, and #11) residents reviewed for pain control received PRN [as needed] pain medications and medications for the treatment of Parkinson's Disease as physician ordered, and fluid restrictions specified in physician orders were followed. This deficient practice placed residents at risk of harm as follows: * Residents #2, #7, and #11 were administered PRN Schedule II medications in frequency and dosages inconsistent with physician orders. * Resident #5's medications prescribed for a diagnosis of Parkinson's Disease were not administered per physician orders * Resident #1's physician-ordered fluid restriction was not implemented by staff. Findings include: The facility's Fall Prevention and Management policy and procedure documented, If a fall was not witnessed, neurological checks are required and must be documented in the medical record. The Neuro Check UDA [User Defined Assessment] is recommended. The Neuro Check - V 3 (UDA) documented the purpose was to record observations after a fall resulting in a known or possible head injury or any other condition requiring neuro-check. It also documented that after the completion of the initial neuro-check evaluation with vital signs, neuro-check evaluations are to continue every 30 minutes times 4, then every 8 hours for 3 days or as directed by the provider. This policy was not followed. Examples include: 1. Resident #3 was admitted to the facility in May 2016 with multiple diagnoses, including dementia with behavioral disturbance, restlessness, and agitation. The resident was readmitted on [DATE] for orthopedic aftercare following surgical intervention of a right hip fracture related to a fall in the facility. Fall Scene Huddle Worksheets (FSHW) documented Resident #3 experienced unwitnessed falls on 1/22/17 at 5:25 pm, 2/13/17 at 9:30 am and 11:10 pm, and on 2/15/17 at 12:30 pm. Resident #3's clinical record and FSHW records did not contain documentation of neurological evaluations for the above three unwitnessed falls. On 5/18/17 at 8:35 am, the Interim Director of Nursing Services (IDNS) said neurological evaluations should be performed for 3 days after unwitnessed falls and she did not find neuro-checks related to Resident #3's unwitnessed falls on 1/22/17, 2/13/17, or 2/15/17. (continued on next page)

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F 0281 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #4 was admitted to the facility on [DATE] with multiple diagnoses, including anorexia, altered mental status, anxiety, major depressive disorders, and dementia. FSHW records documented Resident #4 experienced unwitnessed falls on 2/15/16 at 11:45 am, 3/15/17 at 5:25 am, 3/22/17 at 9:30 pm, 4/5/17 at 12:10 pm and 4/7/17 at 6:20 pm. The FSHW for the fall on 4/5/17 documented Resident #4 sustained a Laceration back of head. Resident #4's Progress Notes documented the following: * 4/5/17 at 1:09 pm - .fall with injury to head .refusing to go out .or see a doctor . * 4/5/17 at 4:57 pm - .agreed to see [physician] .needed to have 4 stitches .did begin to dry heave .stated she had a head ache . * 4/5/17 at 8:49 pm - .neuro checks prior to going to [doctor] .Upon return .[d]id one more neuro before she fell asleep . * 4/6/17 at 9:01 am - .has a headache this morning . * No documentation was found that Resident #3's neurological status was checked or monitored after 4/5/17. On 5/18/17 at 8:35 am, the IDNS said neurological evaluations should be performed for 3 days after unwitnessed falls and that she found some neuro-check documentation for Resident #3. She provided Neuro Check - V 3 forms which documented Resident #4's neurological status was monitored on 4/5/17 at 12:10 pm, 12:25 pm, 3:10 pm, 3:40 pm and 4:10 pm. On 5/19/17 at 2:00 pm, the Medical Records Director said no other neuro-check documentation was found for the fall on 4/5/17, and that no documentation of neurological checks was found for the other falls on 2/15/17, 3/15/17, 3/22/17 and 4/7/17. 37265 3. Resident #6 was admitted to the facility on [DATE], with diagnoses which included dementia and depression. FSHW records documented Resident #6 experienced unwitnessed falls on 2/6/17 at 8:25 pm, 2/11/17 at 8:10 pm, 3/5/17 at 1:00 pm, and on 3/25/17 at 7:05 pm. Resident #3's clinical record and FSHW records did not contain documentation of neurological evaluations for the above noted unwitnessed falls. On 5/18/17 at 8:35 am, the IDNS said neurological evaluations should be performed for 3 days after unwitnessed falls. The IDNS noted neuro-checks related to Resident #6's unwitnessed falls on 2/6/17, 2/11/17, 3/5/17, and 3/25/17 could not be found in the clinical record. (continued on next page)

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F 0281 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4a. Resident #7 was admitted to the facility on [DATE], with diagnoses which included depression, insomnia, and Pseudobulbar Affect (involuntary, uncontrollable, and sudden crying and/or laughing). FSHW records documented Resident #7 experienced unwitnessed falls on 3/10/17 at 8:15 pm and on 3/23/17 at 12:45 pm. Resident #7's clinical record contained one Neuro Check - V 3 form, which documented Resident #7's neurological status was monitored on 3/23/17 at 3:06 pm. On 5/18/17 at 8:35 am, the IDNS said neurological evaluations should be performed for 3 days after unwitnessed falls. The IDNS noted neuro-checks related to Resident #7's unwitnessed falls on 3/10/17 and 3/23/17, other than that conducted at 3:06 pm, could not be located in the resident's clinical record. 4b. Resident #7's quarterly MDS assessment documented moderate cognitive impairment, mild signs and symptoms of depression, and no behaviors. A 4/3/17 Physician's Order documented Resident #7 was to receive Ativan 0.5 mg every 8 hours as needed for anxiety. Resident #7's Ativan Controlled Drug Record documented 0.5 mg of Ativan was administered on 5/2/17 at 1:00 pm and 2:30 pm, two doses within 1.5 hours. The May 2017 MAR documented Resident #7 received 0. 5 mg Ativan on 5/2/17 at 3:15 pm. On 5/19/17 at 8:25 am, the IDNS stated nursing staff were to administer medications per physician order. 5a. Resident #11 was readmitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the lung [lung cancer], dementia and mood disorder. FSHW records documented Resident #11's experienced unwitnessed falls on 4/1/17 at 3:15 am, 4/3/17 at 9:00 am and 4:00 pm, and on 4/24/17 at 1:00 pm, and 5:40 pm. Resident #11's clinical records contained one Neuro Check - V 3 form, which documented her neurological status was monitored on 4/24/17 at 9:26 pm. On 5/18/17 at 8:35 am, the IDNS said neurological evaluations should be performed for 3 days after unwitnessed falls. The IDNS stated neuro-checks related to Resident #11's unwitnessed falls on 4/1/17 at 3:15 am, 4/3/17 at 9:00 am, 4/3/17 at 4:00 pm, 4/24/17 at 1:00 pm, and 4/24/17 at 5:40 pm, other than that already noted, could not be located in the clinical record. 5b. Resident #11's April 2017 Physician's Orders documented: * 0.5 mg Ativan every 12 hours as needed for anxiety, ordered 8/23/16. * 5 mg Norco 5-325 mg (Hydrocodone - Acetaminophen) every 6 hours as needed for pain, ordered 2/23/17. (continued on next page)

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F 0281 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	** On 4/8/17, Resident #11's physician changed the Norco order from a PRN as needed administration to a scheduled administration of 4-times daily. This change was not reflected in the resident's recapitulated monthly orders nor the April and May 2017 MARs. Resident #11's January 2017 MAR documented Ativan was administered on 1/13/17 at 6:46 am and 7:26 am. Resident #11's Ativan Controlled Drug Record documented 0.5 mg of Ativan was administered on 1/15/17 at 3:30 pm and 10:00 pm. Resident #11's March 2017 MAR documented 0.5 mg of Ativan was administered on 3/13/17 at 2:30 pm and 10:30 pm. The Ativan was administered twice in 8 hours, instead of every 12 hours as ordered. The April 2017 MAR documented 0.5 mg of Ativan was administered on 4/23/17 at 12:00 pm, 12:30 pm, and 10:00 pm. The Ativan was administered twice in 30 minutes and then 9.5 hours later. On 4/24/17, the April 2017 MAR documented Resident #11 received 0.5 mg Ativan at 8:00 am, 12:00 pm, and 6:00 pm. Resident #11 received Ativan 0.5 mg three times in 10 hours, instead of once every 12 hours as ordered. Resident #11's Ativan Controlled Drug Record, as well as the January 2017 and April 2017 MARs, documented Ativan was administered on 18 additional occasions in a manner inconsistent with physician orders between 1/13/17 and 4/24/17. Resident #11's Norco Controlled Drug Record and MARs, between 2/15/17 and 4/24/17, documented similar findings involving the administration of Norco on 12 occasions in a manner inconsistent with physician orders, including 6 administrations of the medication on 4/23/17, and 2 administrations in 4 hours on 4/24/17, as follows: * On 4/23/17 Resident #11 was administered Norco 5-325 mg at 12:00 pm, 1:00 pm, 4:00 pm, 7:00 pm, 8:00 pm, and 10:30 pm. * On 4/24/17 Resident #11 was administered Norco 5-325 mg at 8:00 am and 12:00 pm. On 5/19/17 at 2:25 pm, the IDNS stated nursing staff were to administer medications per physicians' orders. 6. Resident #5 was readmitted to the facility on [DATE], with multiple diagnoses including Parkinson's Disease. Resident #5's 5/8/17 admitting physician orders directed staff to administer Sinemet [for treatment of Parkinson's Disease] 25/100 1.5 tablets QID (4 times a day). Resident #5's May 2017 (MAR) documented Sinemet 25/100 1.5 tablets was administered daily, rather than 4 times a day as ordered, from 5/9/17 to 5/16/17. On 5/17/17 at 3:30 pm, the MDS Coordinator compared Resident #5's Admitting Orders for Sinemet to the MAR documentation and stated the facility's administration of Sinemet once daily was a medication error. (continued on next page)

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	135058	A. Building B. Wing	05/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silverton Health and Rehabilitation of Cascadia	405 West Seventh Street Silverton, ID 83867

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F 0281 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/17/17 at 6:00 pm, the IDNS said the order for Sinemet QID was missed. 7. Resident #1 was admitted to the facility on [DATE] with diagnoses which included hyponatremia [low sodium levels in the blood], hypertension, dementia, and anorexia. Resident #1's quarterly MDS assessment, dated 3/29/17, documented severe cognitive impairment. An 8/3/16 Physician's Order documented Resident #1 was to have a 1000 cubic centimeter [cc] fluid restriction, and no free water. Staff was to notify the charge nurse before providing any fluids to Resident #1 between meals and to document all fluids provided to her. Resident #1's Nutrition Care Plan, revised 1/19/17, documented she was on a fluid restriction of 400 cc between meals and with medications. (Day shift 150 cc; Evening shift 150 cc; Night shift 100 cc.) Fluids at meals 600 cc per day. On 5/16/17 at 8:49 am, Resident #1 was observed in her room pouring water from a large carafe into a cup and drinking the water with her meal tray. On 5/17/17 at 2:40 pm, Resident #1 was observed in her room with a large, almost empty carafe of water setting on the table next to her. On 5/18/17 at 11:20 am, Resident #1 was observed in her room with a large, half full, carafe of water. Resident #1 stated she had been drinking water all day. An Activities of Daily Living [ADL] Flow Sheet from 4/19/17 to 5/17/17 for the intake of fluids outside of meals contained no monitoring documentation of Resident #1's fluid intake. Resident #1's ADL Flow Sheet from 4/19/17 to 5/17/17 for cc's of fluids consumed with meal documented an intake that was greater than 600 cc on 27 of 30 days. On 5/18/17 at 5:45 pm, the IDNS stated she was not aware Resident #1 had fluid restriction orders. On 5/19/17 at 9:15 am, the IDNS stated staff should have monitored the intake of Resident #1's fluids and the fluid restriction was a current order. The IDNS stated the carafe of water had been removed from Resident #1's room.

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F 0309 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide necessary care and services to maintain or improve the highest well being of each resident . **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on observation, record review, policy review, and resident and staff interview, it was determined the facility failed to: a) Ensure residents diagnosed with diabetes mellitus received care consistent with their needs, care plans, current standards of practice, and facility policy. This was true for 2 of 5 (#2 and #5) residents reviewed for diabetic management. As a result: * Residents' blood glucose [BG] levels were not monitored as ordered * Hyperglycemic BG levels were not reported to physicians * A policy for hyperglycemia was not developed * The facility's hypoglycemia policy was not followed * Insulin was administered without physician orders These systemic practices placed the health and safety of sampled residents #2 and #5, and 10 other residents in the facility with a diagnosis of diabetes [DM], in immediate jeopardy of serious harm, impairment, or death due to diabetic ketoacidosis [an acute, life-threatening complication of diabetes which may result in diabetic coma or death] related to hyperglycemia, and/or severe hypoglycemia, which has the potential to cause accidents, injuries, coma, and death. b) Ensure 1 of 13 (#11) sampled residents received timely assessments of injury and effective pain control. Resident #11 was harmed when the facility failed to promptly assess her complaint of rib injury in a timely manner and control the resulting pain after she experienced a fall. Findings include: 1. Resident #2 was admitted to the facility on [DATE], with diagnoses which included Type II diabetes mellitus. The initial Minimum Data Set [MDS] assessment, dated 4/25/17, documented Resident #2 was cognitively intact. a. The Hyperglycemia Care Plan, revised 5/4/17, directed staff to monitor, document, and report to the physician, as needed, when Resident #2 experienced signs and symptoms [s/s] of hyperglycemia. The care plan did not document how often staff was to monitor Resident #2's BG levels, when staff was to notify the physician if BG levels were outside of physician-established parameters, when to administer insulin, or when to follow hyper/hypo glycemic protocols. Resident #2's May 2017 Physician's Orders included: (continued on next page)

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F 0309 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* HumaLOG [Insulin Lispro] solution before meals and at bedtime [HS] per sliding scale for BGs [all measurements in milligrams/deciliters] of: 70 - 130 = 0 units; 131 - 180 = 4 units; 181 - 240 = 8 units; 241 - 300 = 10 units; 301 - 350 = 12 units; 351 - 400 = 16 units; 401 - 499 = 20 units, and call physician for BG levels greater than 400 mg/dl, ordered 4/20/17. * 28 units of Tresiba (Insulin Degludec) solution in the morning for DM, ordered 5/1/17. * Resident #2 was to have BG levels checked before meals and at bedtime related to Type II DM for BG > [greater than] 400 call physician for BG < [less than] 70 and resident is able to swallow give a rapidly absorbing carbohydrate such as: 4 oz [ounces] juice. Repeat BG in 15 min [minutes] and repeat if carbohydrate [is] necessary, beginning 4/19/17. The physician's orders did not document at what BG level staff were to notify the MD when hypoglycemic BG levels were less than 70 mg/dl. A Nurse's Note, dated 4/18/17 at 5:00 am, documented Resident #2 experienced a BG level of 68 mg/dl. Resident #2 received apple juice, but the clinical record did not contain documentation the facility rechecked her BG level after 15 minutes, as stated in her care plan. The 68 mg/dl BG level was not documented on Resident #2's April Medication Administration Record [MAR]. A Nurse's Note, dated 4/18/17 at 6:01 pm, documented Resident #2 experienced a BG level of 514 mg/dl. Resident #2's MAR from 4/19/17 through 4/30/17 documented: * BG levels ranging 209 - 509 mg/dl. * 13 BG levels greater than 400 mg/dl, including 1 BG greater than 500 mg/dl. Resident #2's record did not contain documentation of staff interventions for this time period. Resident #2's physician was notified of 3 of the 13 hyperglycemic BG levels above 400 mg/dl, on 4/20/17, 4/21/17, and 4/27/17. Resident #2's MAR from 5/1/17 to 5/16/17 documented: * BG levels ranging from 119 - 586 mg/dl. (continued on next page)

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F 0309 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* 13 BG levels greater than 400 mg/dl, 6 of which were greater than 500 mg/dl. * BG of 586 mg/dl on 5/1/17 at 4:00 pm. Resident #2's record did not contain documentation of staff interventions for this time period. Resident #2's physician was notified of 1 of the 13 hyperglycemic BG levels above 400 mg/dl, on 5/14/17. A Nurse's Note, dated 5/1/17 at 4:21 pm, documented Resident #2 received 25 units of insulin for the 586 BG level, however, the clinical record did not contain orders for the 25 units of insulin that were administered. A Nurse's Note, dated 5/2/17 at 10:09 pm, documented Resident #2's BG levels ranged over 600 . used sliding scale. The 600 BG level was not documented on the 5/2/17 MAR and the Nurse's Note did not document the resident's physician was notified. The May 2017 MAR documented Resident #2's BG was 512 mg/dl on 5/7/17 MAR at 11:00 am and 4:00 pm. Resident #2's record did not document whether insulin was administered. A Nurse's Note, dated 5/7/17 at 8:38 pm, documented Resident #2's BG level was 591 mg/dl and 20 units of insulin were administered. The 591 mg/dl BG levels was not documented on the 5/7/17 MAR. Resident #2's MAR on 5/7/17 at 9:00 pm, conversely, documented a BG of 291 mg/dl for which 10 units of insulin were administered; it was not clear whether the resident received a total of 30 units of insulin - 20 units at 8:38 pm and 10 units at 9:00 pm. A Nurse's Note, dated 5/9/17 at 11:44 am, documented Resident #2's BG level was 500 mg/dl and 25 units of insulin was administered. Resident #2's clinical record did not contain physician orders for the 25 units of insulin that were administered. Resident #2's MAR documented she was administered insulin on 5/8/17 at 11:00 am and on 5/12/17 at 7:00 am. The dosages of insulin administered was not documented on the MAR and there were no corresponding Nurses' Notes documenting the insulin dosages. Resident #2's clinical record did not document: * Rechecks of her BG levels after she experienced hyperglycemic and hypoglycemic episodes. This was true for all episodes. * Physician notification, as ordered, for 25 of 30 hyperglycemic episodes * Evidence the facility followed its hypoglycemic protocol for low BG levels * The reason for the excess doses of insulin administered on 5/1/17 and 5/9/17. (continued on next page)

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F 0309 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/18/17 at 8:42 am, the Interim Director of Nursing Services (IDNS) stated facility staff were to notify the physician, as soon as possible, when BG levels exceeded parameters specified by the physician and re-check the resident's BG levels in 15-30 minutes to assess whether insulin administrations were effective. For a resident experiencing a hypoglycemic episode, the IDNS said staff was to recheck the BG 15 minutes after administering 15 grams [g] of carbohydrates and that this process would be repeated until the BG level reached 70 mg/dl or greater. On 5/18/17 at 11:15 am, Licensed Practical Nurse (LPN) #1 stated she would notify a physician when BG levels were outside established parameters and document that she called the physician in a Nurse's Note. She stated she would recheck BG levels depending on physician orders and document the rechecks in a Nurse's Note. On 5/18/17 at 3:15 pm, Resident #2's physician stated he was aware of Resident #2's elevated BG levels and he was not all that upset that he was not notified on every occasion, but that he expected nurses to follow his orders all the time. He stated the facility would usually send a fax notifying him of elevated BG levels and that sometimes he received a phone call from nursing staff informing him Resident #2's BG levels were over 500 mg/dl, for which the nurse had administered 20 units of insulin. b. Physician's Order, dated 4/14/17, documented Resident #2 was to receive Ativan 0.5 milligrams [mg] every 4 hours as needed for anxiety related to her disease process. Resident #2's Antianxiety Care Plan, revised 5/4/17, documented staff was to monitor and document side effects and effectiveness of the Ativan. The Care Plan did not state the specific behaviors staff were to monitor and for which Resident #2 was to receive Ativan. Resident #2's Ativan Controlled Drug Record documented: * 0.5 mg of Ativan administered on 5/3/17 at 1:20 am. * 0.5 mg of Ativan administered on 5/3/17 at 2:00 am. 2. Resident #5 was readmitted to the facility on [DATE], with multiple diagnoses including diabetes mellitus and Parkinson's Disease. Resident #5's 5/8/17 admitting physician orders directed staff to administer Actos 30 mg daily and Sinemet [for treatment of Parkinson's Disease] 25/100 1.5 tablets QID (4 times a day). a. Resident #5's recapitulated May 2017 orders directed staff to obtain a FSBS (Fingerstick Blood Sugar) once daily beginning 5/12/17. Resident #5's May 2017 MAR documented the FSBS was completed daily from 5/12/17 to 5/16/17, however BG levels were not documented. On 5/17/17 at 3:30 pm, the MDS Coordinator said Resident #5's daily FSBS results should be documented on the MAR or on vital signs (VS) documents. At 5:00 pm the same day, the MDS Coordinator provided a Blood Sugar Summary for 2015 and said she did not find any results for 2017. (continued on next page)

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F 0309 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/17/17 at 6:00 pm, the IDNS said Resident #5's FSBS result was documented only once, on 5/12/17, in progress notes. The results and any need of intervention to address hypo- or hyperglycemia for Resident #5 were unknown 4 of 5 times (80%) the FSBS was performed. On 5/17/17 at 6:00 pm, the facility provided a copy of its diabetic management policy and procedure. The Facility's Hypoglycemic Policy, revised December 2015, documented For residents with diabetes, the practitioner should be called 'immediately' when the blood glucose value is less than 70 mg/dl .give 15 grams of carbohydrates .Repeat blood glucose test after 15 minutes. The Diabetic Management procedure did not address how staff was to manage residents with hyperglycemic episodes. The lack of a protocol for hyperglycemia created the potential for residents not to receive interventions for hyperglycemic episodes or to receive interventions that were incorrect. The combined effect of the facility's deficient diabetic management practices placed all 12 residents in the facility with diabetes at risk of imminent serious harm, impairment, or death due to diabetic ketoacidosis or severe hypoglycemia. Notification and Removal of Immediate Jeopardy: On 5/18/17 at 1:35 pm, the facility was informed Resident #2 and Resident #5, as well as all 12 residents in the facility diagnosed with diabetes, were at risk of imminent serious harm or death due to the facility's deficient diabetes management practices. The facility was informed it needed to develop and implement an acceptable plan to remove the Immediate Jeopardy. On 5/19/17 at 2:24 pm, the facility provided evidence that an acceptable plan to remove the immediacy had been developed and implemented. The plan included: * BG levels and diabetic medication orders for Resident #2 and Resident #5 were reviewed with their physicians on 5/18/17. * Resident #2 and #5's vital signs were assessed by nursing staff. * Notifications to responsible parties were completed for Resident #2 and #5 on 5/18/17. * Physician orders, including those for insulin, and MARs were audited for those residents diagnosed with diabetes to assure blood glucose parameters and physician notification requirements were specified by 5/19/17. * Guidelines for managing hyper- and hypoglycemic incidents were approved by the MD on 5/18/17. * The IDNS will provide education to nursing staff prior to their next shift on BG level parameters for hypo and hyperglycemia; treatment guidelines for hypo and hyperglycemia; notification to the physician and responsible party; and appropriate documentation of notification and interventions for hyper/hypo glycemic episodes. (continued on next page)

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F 0309 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	* The MARs and physicians' orders of residents who are diabetic will be monitored daily for 2 weeks, weekly for 2 weeks and then every two weeks for two months. The facility's Quality Assessment and Assurance Committee will evaluate the potential need for monthly audits. 4. Resident #11 was readmitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the lung [lung cancer], dementia, and mood disorder. A quarterly MDS assessment, dated 2/22/17, documented Resident #11 was cognitively intact; required supervision with transfers and ambulation; had 1 non-injury fall prior the assessment; rejected cares 1-3 days during the look back period; and was administered PRN, rather than scheduled, pain medications. a. Resident #11's April 2017 Physician's Orders documented: * 650 mg Acetaminophen every 4 hours as needed for pain, ordered 2/23/17. * 5 mg Norco Tablet 5-325 mg (Hydrocodone - Acetaminophen) every 6 hours as needed for pain, ordered 2/23/17. * 50 mg Tramadol every 6 hours as needed for pain, ordered 2/23/17. The Pain Care Plan, revised 12/12/16, documented Resident #11 had acute and chronic pain related to lung cancer as evidenced by non-verbal indicators such as grimacing, resistive to cares, and complaints of (c/o) itching or burning. She was able to call for assistance and able to ask for pain medication. Care Plan interventions included: * Staff was to monitor Resident #11 for signs and symptom (s/s) of non-verbal pain, initiated 2/1/16. * Staff was to evaluate the resident using the Pain Assessment in Advanced Dementia [PAINAD] scale, revised 12/12/16. On 5/19/17 at 2:25 pm, the IDNS stated the facility evaluated residents' pain levels at least once per shift and immediately prior to the administration of PRN pain medications. Staff also assessed residents who received PRN pain medication to determine whether it was effective. Resident #11's MARs for January 2017 through 4/24/17, did not contain documentation that her pain was consistently assessed prior to- or following the administration of pain medication. The April 2017 MAR documented Resident #11 received 9 doses of the PRN Tramadol from 4/3/17 through 4/24/17. The Controlled Drug Record for PRN Tramadol documented Resident #11 received 21 doses between 4/3/17 through 4/24/17. Resident #11's pain was not assessed prior to- or following 12 of the 21 PRN Tramadol administrations during this time period. (continued on next page)

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F 0309 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The April 2017 MAR documented Resident #11 was administered 34 doses of PRN Norco between 4/3/17 and 4/24/17. Resident #11's Controlled Drug Record for Norco documented she was administered 61 doses of Norco from 4/3/17 through 4/24/17. Resident #11's pain and was not assessed prior to- or following 27 of the 61 PRN Norco administrations. The conflicting records also created the potential for harm related to excessive dosage and this was not addressed in the resident's clinical record. b. Incident & Accident reports documented Resident #11 experienced a fall on 4/1/17 and 2 falls on 4/3/17. Progress Notes, for 4/3/17 through 4/7/17, included 24 entries that Resident #11 complained of left sided pain, requested pain medications, or that she suspected her ribs were broken. A Nurse's Note, dated 4/3/17, documented Resident #11 had fallen twice that day, and told the LPN she thought she had broken a rib. The note did not document physician notification of Resident #11's complaint of a broken rib. A Nurse's Note, dated 4/4/17 at 5:00 am, documented Resident #11 had a marked dark purple bruise on the left thorax from the 4/3/17 fall and [complains of] pain in rib area .and reports that she feels the rib was broken. The note did not document physician notification of Resident #11's pain and complaint of a broken rib. A Nurse's Note, dated 4/5/17 at 6:53 am, documented Resident #11 complained of pain on left flank rib area from [the] falls [she] sustained on 4/3/17 .[and] stated 'it feels like my rib is cutting me on the inside.' A Nursing Communication, dated 4/7/17 at 4:03 pm, documented two progress notes regarding Resident #11's complaint of left sided rib pain were sent to the physician. The first Progress Note, dated three days after the fall on 4/7/17 at 10:19 am, documented, Resident fell last Monday, she has a 10 x 10 discoloration on her upper waist. She has 8/10 pain at times. May we send her for a left rib x-ray at [hospital] today? The second Progress Note, dated 4/7/17 at 11:49 am, documented, Asking for an order to send [Resident #11] down for a x-ray for her left side . The physician responded to the facility on [DATE], ordering an x-ray of Resident #11's left ribs and changing the resident's Norco schedule from three times daily (TID) to four times daily (QID). On 4/8/17, an RN noted the orders and documented Norco was already ordered for every 6 hours PRN, and the clinical record did not document Resident #11's Norco order was changed from PRN administrations every six hours to scheduled dosages four times daily. Progress Notes 4/8/17- 4/24/17 documented Resident #11 complained of pain to the left rib area, was holding her left side in pain, and/or received PRN pain medications 37 more times. A Nurse's Note, dated 4/24/17 at 10:13 pm, documented Resident #11 was being transferred to hospice services for pain management. The note documented Resident #11 said she wanted hospice services because her pain definitely was not being controlled at this time. She also mentioned that she was relieved to finally get some help with her pain, rolled her eyes, and said, 'Finally!' (continued on next page)

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F 0309 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/19/17 at 8:25 am, the IDNS stated nursing staff were to administer medications per physicians' orders. On 5/19/17 at 2:25 pm, the IDNS stated if a resident requested more frequent administration of PRN pain medications the facility was to notify the physician, who then evaluated whether scheduled pain medications would be more appropriate for that resident. The IDNS stated she did not see changes to Resident #11's ordered pain medications. When asked about the 7-day delay between Resident #11's 4/3/17 fall with complaints of rib pain and the request for an x-ray, the IDNS stated Resident #11 declined an offer to go to the hospital on the day of the fall, but the nurse still should have notified the physician of the incident and complaints of pain. The IDNS stated a second x-ray on 4/24/17 documented Resident #11 had sustained acute fractures of the ribs. On 5/22/17 at 11:10 am, Resident #11's Physician stated he would expect nursing staff to notify him of a resident's complaints of increased pain after a fall and/or suspected injury.

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F 0310 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that each residents' abilities in activities of daily living do not decline, unless unavoidable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on record review and staff interview, it was determined the facility failed to ensure 1 of 10 (#6) residents reviewed for Activities of Daily Living (ADLs) was provided oral care. This failure created the potential for a decline in activities of living and emotional distress from unmet needs and decreased socialization. Findings include: Resident #6 was admitted to the facility on [DATE], with diagnoses which included dementia and deposits on teeth. Resident #6's quarterly Minimum Data Set [MDS] assessment, dated 3/24/17, documented moderate cognitive impairment, mild signs and symptoms of depression, and extensive staff assistance required for personal hygiene. The ADL Care Plan, revised 3/28/17, documented Resident #6 required assistance with ADL's. The care plan documented Resident #6 was able to brush her teeth with staff set-up and cueing. ADL flowsheets from 5/1/17 through 5/17/17 did not contain documentation that daily oral care was provided to Resident #6. On 5/18/17 at 5:12 pm, the Interim Director of Nursing Services stated oral care should be performed in the morning, especially for a resident with diagnoses of dementia and deposits on teeth, and should be documented on the ADL flowsheet.

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Silverton Health and Rehabilitation of Cascadia	405 West Seventh Street Silverton, ID 83867

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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 0315 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident who enters the nursing home without a catheter is not given a catheter, unless medically necessary, and that incontinent patients receive proper services to prevent urinary tract infections and restore normal bladder functions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on record review and staff interview, it was determined the facility failed to ensure catheter care was consistently performed for 1 of 3 residents (#7) reviewed for Foley catheter use. This failure created the potential for more than minimal harm if Resident #7 developed a Urinary Tract Infections [UTI] or other complication due to lack of catheter care. Findings include: Resident #7 was admitted to the facility on [DATE] with diagnoses which included UTI's. Resident #7's 4/28/17 quarterly Minimum Data Set [MDS] assessment documented moderate cognitive impairment and always incontinent of bladder. A 5/8/17 Physician's Order documented Resident #7 was to have a Foley catheter placed for urinary retention. The Foley catheter was to remain in place pending a urinalysis. Resident #11's Physician's Orders did not document when staff was to change the Foley drainage bag or when to perform Foley catheter care. The Catheter Care Plan, initiated 5/9/17, directed staff to document Resident #7's fluid intake and output and provide catheter care twice a day. The care plan did not document when staff was to change the Foley drainage bag. Resident #7's Activities of Daily Living (ADL) Flowsheet and Medication Treatment Administration did not contain documentation that catheter care was provided twice daily. On 5/18/17 at 8:25 am, the Staff Development Coordinator stated catheter care should be completed twice a day and as needed. The Staff Development Coordinator stated the catheter tubing should be changed monthly. She said the catheter was new and the facility would address the orders for tubing changes if Resident #7's catheter was to remain in place.

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F 0323 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provide adequate supervision to prevent avoidable accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27930 Based on observations, staff interview, and review of clinical records and incident/accident reports, it was determined the facility failed to ensure residents received sufficient supervision, toileting assistance, every 15 minute checks as care planned, and care plan updates to prevent falls and injuries for 2 of 7 sample residents (#3 & #11) reviewed for falls. As a result: a) Resident #3, was harmed when she fell 4 times in 24 days and sustained fractures to the right femur that required surgical intervention. b) Resident #11 experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to her left chest and rib area and required increased use of 2 pain medications and an antianxiety medication. Resident #11 was harmed when she fell twice more and was diagnosed with 3 rib fractures. c) Resident #3, who wandered into other residents' rooms, rummaged through other residents' things, layed on other residents' beds, and hit, kicked, and spit when redirected, was placed at risk of harm, as were other residents who may encounter Resident #3, if an altercation developed between them and one or both residents were injured. Findings include: 1. Resident #3 was admitted to the facility in May 2016 with multiple diagnoses, including dementia with behavioral disturbance, restlessness, and agitation. She was readmitted on [DATE] for orthopedic aftercare following surgical intervention of a right hip fracture related to a fall in the facility. Resident #3's most recent quarterly and significant change MDS assessments, dated 1/19/17 and 2/27/17 respectively, documented short- and long-term memory impairment; severely impaired cognition; delusions, and frequent urinary and bowel incontinence. The 1/19/17 quarterly MDS assessment also documented physical behavioral symptoms such as hitting, kicking, pushing, scratching, and grabbing directed toward others; verbal behavioral symptoms, such as threatening and/or screaming at others; and behavioral symptoms not directed at others, such as pacing, rummaging, and disrobing in public, all of which occurred 4-6 days during the look back period; rejection of care 1-3 days and wandered daily; supervised assistance with bed mobility, transfers and eating; limited 1 person assistance with ambulation in room/corridors and locomotion on/off the unit; extensive 1 person assistance with dressing, personal hygiene and bathing; and use of antipsychotic medication for 7 days. The 2/27/17 significant change MDS assessment documented the physical behavioral symptoms, rejection of care and wandering occurred 1-3 days in the look back period; extensive 2 person assistance with bed mobility, transfers, dressing, toileting, and personal hygiene; extensive 1 person assistance with eating, total 1 person assistance with bathing; ambulation in room/corridors did not occur; and total 2 person assistance with locomotion on/off unit, and no antipsychotic medication use. (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	On 5/17/17 at 3:10 pm, the MDS Coordinator said 2 non-injury falls and 1 fall with major injury were documented in Resident #3's 2/15/17 discharge MDS assessment. Resident #3 was observed in a wheelchair in the common areas of the facility, including the main dining room and hallways, with a staff member next to her on 5/15/17 at 5:20 pm; on 5/16/17 from 7:55 am to 8:05 am, 8:30 am to 8:45 am, 9:55 am, 10:55 am, 11:15 am, 11:55 am, 12:10 pm, and 3:15 pm; and on 5/17/17 at 9:05 am to 9:15 am, and 11:00 am. She was also observed in her room, either in bed with staff present or while being toileted by staff, on 5/16/17 at 11:20 am to 11:25 am and on 5/17/17 at 3:00 pm. a. On 5/19/17 at 12:30 pm, the care plan in place in January and February prior to Resident #3's falls was provided by the facility's medical records department. The care plan in place prior to 3 falls in February 2017 included focus areas and associated interventions related to falls, Activities of Daily Living (ADL), and bladder incontinence as follows: * ADL self care performance deficit - independent ambulation with four wheeled walker (FWW), needs cues, supervision to locations such as the dining room and her own room, revised 8/18/16; 1 staff assistance with toilet use, revised 1/25/17. * Bladder incontinence - prefers to use the bathroom for toileting and take to the bathroom before and after meals, at bedtime and when she indicates the need to void, revised 1/25/17. * Risk for falls - monitor every 15 minutes, initiated 5/24/16 and revised 1/25/17. On 5/18/17 at 5:30 pm, the MDS Coordinator and Staff Development Nurse (SDC) said that in addition to every 15 minute checks, the facility also began 1:1 monitoring (1 staff to 1 resident) and audio/visual monitoring when Resident #3 was alone in her room, was recently added. They agreed to provide documentation of every 15 minutes checks and 1:1 monitoring. On 5/19/17 at 9:30 am, the MDS Coordinator provided Progress Notes, dated 2/17/17 through 4/3/17, which she said documented 1:1 monitoring. She said that 1:1 monitoring started after Resident #3 returned to the facility on [DATE] and ended when Medicare ended. Resident #3's Fall Scene Huddle Worksheets (FSHW) and Investigations documented the following: * 1/22/17 at 5:25 pm - unwitnessed fall, no injury, last toileted at 5:00 pm, roommate notified staff the resident fell in the bathroom while sitting on trashcan trying to go to the bathroom. Resident #3 said she was going potty. Factors that may have contributed to the incident: Had been restless during the day [up arrow and down arrow]. Highly demented; does not understand instructions or safety needs. Corrective actions: Continue 15 minute checks and assistive device near door. Every 15 minute checks on 1/22/17 contained documentation that Resident #3 was checked at 3:19 pm and 6:09 pm, 2 hours and 50 minutes between checks. (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	* 2/13/17 at 9:30 am - unwitnessed fall, no injury, incontinent when last toileted at 8:30 am, dry at time of incident, 15 minutes between last staff member contact and fall, Resident #3 said she was trying to go to the bathroom, Lost balance one foot in pants leg all the way through, the other not. Factors that may have contributed to the incident: Attempting to toilet self. Highly confused, poor safety awareness. Corrective actions: Motion light added and toilet before breakfast. A 2/13/17 unsigned typed note attached to the FSHW documented Resident #3 was at high risk for falls, and exhibited poor safety awareness and decline in cognition. Breakfast started at 7:00 am in the facility, which was 2 1/2 hours before Resident #3's fall at 9:30 am. The FSHW documented Resident #3 was toileted at 8:30 am, an hour before the fall. Every 15 minute checks on 2/13/17 contained documentation that Resident #3 was checked at 8:58 am and 9:58 am, an hour between checks. * 2/13/17 at 11:10 pm - unwitnessed fall, no injury, time last toileted was blank, time between last staff contact and fall unknown. Factors that may have contributed to the incident: unsteady gait, shuffling gait, poor balance, anxious [and] restless. Comments included, Unaware of dangerous situations. Disregard for safety [no] longer has antianxiety med[ication] & very anxious/restless . Corrective actions: Toilet before all meals. Resident #3's 2nd fall on 2/13/17 occurred more than 3 hours after the last meal service of the day at 5:00 pm, and her care plan prior to the fall included toileting assistance before and after meals. The corrective action, toilet before all meals, did not address the factors that contributed to the fall or add interventions to further protect Resident #3 from falls. A 2/14/17 unsigned typed note attached to the FSHW documented Resident #3 was at high risk for falls and, 2/13/17 .found sitting on the floor .at 11:10 PM .unknown when or who last checked in on [Resident #3] . [Resident #3] had a fall at 10:00 am and has been on 15 minute checks .poor safety awareness, does not always remember to use her walker .continues to be restless and agitated .will not wait for staff and does not have the cognitive ability to use her call light when she has the urgency to urinate .anxious this morning and had been redirected back to her room. Continue with all current interventions per care plan. Every 15 minute checks on 2/13/17 contained documentation that Resident #3 was checked at 10:41 pm and 11:23 pm, 42 minutes between checks. * 2/15/17 at 12:30 pm - No injury fall witnessed by roommate, time last toileted 12:25 pm. The time between last staff contact and the fall was blank. Factors that may have contributed to the incident: Confusion, did not use walker for ambulation. Corrective actions: Do not leave seated on toilet by self. A 2/15/17 unsigned, typed note attached to the FSHW documented Resident #3 was at high risk for falls and that the roommate said Resident #3 had exited the bathroom and fell while attempting to open the door to the main hallway. It documented Resident #3 complained of pain with right leg movement and Emergency Medical Services was called to transport her to a local hospital. (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	A facility Suggestion or Concern form, dated 2/15/16, and signed as reviewed by the LSW (Licensed Social Worker) on 2/16/17 and by the Administrator on 2/17/17, documented Resident #3 had an injury fall and was transported to a local hospital then to a regional hospital for surgery for 2 breaks in her leg. The Concern form investigation documented a CNA assisted Resident #3 to the bathroom and placed the walker at the bathroom door. It documented that when Resident #3 exited the bathroom, the bathroom door swung into the door to the hallway causing it to close and Resident #3 fell when she attempted to open the door to the hallway. It also documented that the care plan for toileting was in compliance but indicated the CNA left Resident #3's room while she was in the bathroom. Therefore, the care plan for 1 staff assistance with toileting was not implemented. Every 15 minute checks on 2/15/17 were out of sequence chronologically. For example, 7:30 am was followed by 12:16 pm, which was followed by 9:30 am, then 12:16 pm again, then 10:30 am. In addition, every 15 minute checks were documented as done on 2/15/17, 2/16/17, 2/17/16, 2/18/17, 2/19/17, and 2/20/17, when the resident was hospitalized and not in the facility. On 5/19/17 at 3:30 pm, the Interim Director of Nursing Services [IDNS] said that out of sequence documentation of every 15 minute checks may have been due to more than one staff documenting the checks. She said multiple entries with the same time may have occurred because the staff documented multiple checks at the same time. The IDNS said documentation of every 15 minute checks after Resident #3 left the faciity on [DATE] was not accurate and it called into question the accuracy of all the documentation. Falls Tools documented Resident #3 was at medium risk for falls on 1/22/17 at 5:21 pm (4 minutes before a fall), high risk for falls on 2/13/17 at 9:20 am (10 minutes before the 1st fall on this day), medium risk for falls on 2/13/17 at 11:10 pm (the time of the 2nd fall on this day), and at high risk for falls on 2/15/17 at 12:30 pm (the time of the fall that day). Resident #3 was harmed when she fell and sustained fractures to the right femur which required surgical intervention. The facility did not provide staff assistance with toileting on 2/15/17 as care planned and failed to ensure every 15 minutes checks were consistently implemented as care planned. b. Resident #3's care plan focus areas and associated interventions related to wandering, resistance to cares, and physically aggressive behavior included: * Psychosocial well-being problem, interventions included: - Assistance/supervision/support to reduce/eliminate causative and contributing factors: may be redirected when she needs assistance, cued she is in the wrong room or bed . revised 11/3/16. - Wandering: ask if you can assist her back to her home, revised 1/25/17. * Mood/behavior problem, revised 1/25/17, interventions included: - Walking without assistance, forgets walker, unsafe: calmly approach and engage in conversation, cue her for walker/wheelchair assistance. - Sitting/sleeping in roommates' bed: in calm manner inform her where her bed is. (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	- Rummaging through others' belongings: redirect in calm manner and in quiet tone of voice. Inform her the things belong to her roommate, assist her to find her own things. - Physical abuse towards staff: if resident becomes agitated put enough space in between yourself and resident and speak calmly in a soft tone of voice. * Behavior symptom, physical abuse directed at others, interventions included: - Intervene as necessary to protect the rights and safety of others. Divert attention. Remove from situation and take to alternate quiet location, revised 7/26/16. Minimize potential for disruptive behaviors, such as hitting, offer distractions which may divert her attention after meals, revised 1/25/17. - Hitting/spitting: attempt non-pharmacological interventions, assess for possible needs, fear or disorientation, revised 1/25/17. - Physically abusive to others, hits, kicks, spits: remove from over stimulating situations which could cause increased agitation and escalate behaviors. If resident refuses to leave and becomes more agitated, give her space to walk where she can be monitored. Change of care provider may help, revised 1/25/17. Resident #3's Medication Review Report of current orders on or after 12/30/16 documented: * Aricept [to treat dementia] 10 mg one time a day for dementia started 12/28/16; * Namenda [to treat dementia] 10 mg two times a day started 5/23/16; * Zyprexa [antipsychotic] 2.5 mg in the morning started 11/13/16; * Zyprexa 5 mg one time a day started 11/14/16; and * Zyprexa 5 mg every 8 hours as needed for aggressive behavior, spitting, hitting, scratching, biting, started 12/30/16. All of these medications were ordered for dementia with behavioral disturbance. The Medication Review Report of current orders on or after 1/31/17 documented the same order for Aricept and Zyprexa 5 mg two times a day started 1/24/17. The other noted medications were not ordered. The Medication Review Report of current orders on or after 2/20/17, 2/28/17, and 3/31/17 documented Zyprexa 5 mg two times a day. The other noted medications were not ordered. The Medication Review Report of current orders on or after 5/16/17, documented Zyprexa was decreased to 5 mg in the evening on 4/18/17. Resident #3's Progress Notes, dated 6/29/16 to 2/15/17, documented the following: (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	* 9/11/16 at 3:48 am - Awake and eager to enter other residents rooms, unable to redirect. When brought to her room, sat on her roommate's legs. Roommate was kind and understanding of situation. Brought out to day room where she tried to go outside. Hit staff 3 times when guided away. * 11/8/16 at 9:53 am - Hit her daughter. Leaving messes in the bathroom. * 11/13/16 at 3:33 pm - Out of room wandering around several times this morning. Difficult to redirect and at one point tried to smack, punch, hit and scratch this nurse. * 12/17/16 at 12:38 pm - Slapped caregiver redirecting her away from another resident's room. * 12/27/16 at 3:22 pm - Very agitated, gets verbally abusive and physically abusive with staff when redirected. Took resident for a long walk offered warm blanket and her recliner. This worked for about 5 minutes and she was back up wandering into other rooms. When redirected, she slapped at and grabbed staffs' arms and led us to the door of another residents [sic] room and pushed us out and she turned around and went back in. A staff offered to walk resident to her room and she was willing to go. [H]as been this way all weekend. * 12:30/16 at 12:33 pm - Resident smacked, tried to bite, scratched and spit in nurse's face. * 1/16/17 at 10:28 am - Continues to exhibit significant behavioral problems. She will hit, scratch, kick and spit at staff. Recent addition of PRN sublingual Zyprexa has been effective when used. * 1/17/17 at 8:56 am - Wandering this morning. Tried to go into another resident's room, removed he pull up. Redirected to her room. * Date illegible (hole punch over month and day) 2017 at 3:43 pm - At breakfast time, resident wandered into a resident's room and was redirected to her room. Resident did not stay in her room and wandered down hall into another resident's room. Unable to redirect and she laid on the resident's bed. Resident informed her she was in the wrong room and bed. She tried to kick the staff member repeatedly and said to leave her alone. The resident was eventually redirected to her room. * 2/7/17 at 10:21 am - Combative with cares, got angry with CNA trying to change her. Shoved CNA into closet doors and tried to slap CNA. A second CNA came to help and while assisting the resident with soiled clothing the resident punched and kicked at the staff. They stepped back and tried to calm the resident. The resident then kicked one CNA in the stomach. * 2/8/17 at 10:21 am - Continues to be combative with cares. Out of room walking and very upset when redirected to her room. Punched and tried to bite nurse. Eventually went to her room and laid down. * 2/10/17 at 4:35 pm - Got into bed with her roommate. Redirected back to her bed without incident. * 2/15/17 at 1:46 pm - 1:1 with resident while waiting for ambulance. (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	CNA records included Monitor [Resident #3] every 15 minute for safety. 1:1 with staff as directed by nurse, PRN and contained documentation that every 15 minute checks were not consistently implemented January through March 2017 and ended on 4/14/17 at 5:46 pm. In addition, there was no documentation of when 1:1 was provided. On 5/19/17 at 9:30 am, the MDS Coordinator said that 1:1 care started when Resident #3 returned to the facility on [DATE] and ended when Medicare ended. On 5/19/17 at 11:45 am, the LSW said Resident #3's physical aggression was not predictable and it had everything to do with approach. The LSW said Resident #3 was able to self toilet, was independent, and that she wandered when she first came to the facility. The LSW said, Yes, when asked if another resident could be harmed if Resident #3 directed physical or verbal behaviors toward them. She said, Yes, that Resident #3 could be harmed if another resident did not tolerate her intrusion into their room, onto their bed or rummaging through their things. The LSW said Resident #3's physical and verbal behaviors had only occurred with staff. 37265 2. Resident #11 was readmitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the lung (lung cancer), dementia, and mood disorder. Resident #11's quarterly Minimum Data Set (MDS) assessment, dated 2/22/17, documented no cognitive impairment, staff supervision required with transfers and ambulation, 1 non-injury fall prior to the assessment, and rejection of cares 1-3 days during the look back period. Resident #11's April 2017 Physician's Orders included: * 5 mg Norco Tablet 5-325 mg every 6 hours as needed (PRN) for pain, ordered 2/23/17. * 50 mg Tramadol Tablet every 6 hours PRN for pain, ordered 2/23/17. * 0.5 mg Ativan Tablet every 12 hours PRN for anxiety, ordered 8/23/16. Resident #11's Limited Physical Mobility Care Plan, revised 7/7/16, documented she was at risk for falls. Interventions included: * Resident #11 required non-weight bearing staff support with mobility and required staff distant supervision of stand by assist and contact guard assist PRN with use of her All Terrain [NAME] (ATW). Resident #11 usually ambulated independently, revised 12/12/16. * Resident #11 used a wheelchair for locomotion and her ATW for ambulation, revised 2/18/16. Resident #11's Fall Care Plan, revised 9/22/16, documented she had an actual fall with minor injury related to weakness as evidenced by her history of falls, poor balance, unsteady gait, and poor safety awareness. Interventions included: * Staff was to encourage Resident #11 to do activities and exercise whenever possible and support Restorative Nursing Aide (RNA) walking program, initiated 3/22/16. (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	* Staff was to ensure Resident #11 was wearing appropriate footwear, revised 9/22/16. * Resident #11's bed was to be unplugged to keep the bed in one position due to Resident #11's inability to understand she cannot adjust the bed height for safety reasons, revised 7/7/16. * Staff was to ensure Resident #11's bed height was correct to the marking on the wall, to the headboard, or the mattress, initiated 3/22/16. * Resident #11 was to be reviewed for significant changes in cognition, safety awareness, and decision-making capacity, initiated 3/28/16. * Staff was to monitor Resident #11 every 15 minutes for whereabouts and keep her door ajar when cares were not being provided for ease in observation, revised 3/22/16. Resident #11's Activities of Daily Living [ADL] Care Plan documented an intervention that she required assistance of 1 staff member, as needed, and self-toileted often, initiated 2/1/16. a. Resident #11 experienced 5 falls between 4/1/17 and 4/25/17. * Fall on 4/1/17 at 3:15 am: Resident #11's 4/1/17 at 3:15 am, Fall Scene Huddle Worksheet (FSHW) documented she was found on her hands and knees crawling out of the bathroom. The worksheet documented she seemed forgetful, confused and had just been out to [the] nurses station looking for her husband stating she had seen him outside her window. Resident #11's FSHW documented she had no injuries from this fall. The Incident Report had a Social Service Note attached, dated 4/1/17, which documented [Resident #11] had a large bruise to her left thorax. [Resident #11] stated she fell and her ribs hurt .SSD [Social Service Director] asked [Resident #11] if she hurt herself, had any bruising, [Resident #11] stated she did not think so but her ribs hurt. SSD asked [Resident #11] to lift her shirt and show SSD and SSD did not see any bruising at this time. The note documented Resident #11's Interested Party was contacted in regards to what appears to be a non-injury incident from a fall. Resident #11's clinical record did not contain the Social Services Note attached to the 4/1/17 Incident Report. Resident #11's clinical record did not contain documentation that her physician was informed of her 4/1/17 fall and her complaint of her ribs hurting. On 5/22/17 at 10:05 am, the SSD stated the Social Service Note attached to the 4/1/17 Incident Report was not in Resident #11's clinical record. The SSD stated she wrote the note to herself, to remind her of the incident and what she needed to do. A 4/1/17 Fall Tool documented Resident #11 had experienced a recent fall. The Fall Tool documented she was taking more than two psychoactive medications and had a moderate cognitive impairment. The Action Plan portion of the document was blank. Additional preventative measures to protect Resident #11 from falls were not initiated. Resident #11's Care Plan was not updated following the 4/1/17 fall. * Fall on 4/3/17 at 9:00 am: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silverton Health and Rehabilitation of Cascadia	405 West Seventh Street Silverton, ID 83867

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F 0323 Level of Harm - Actual harm Residents Affected - Few	Resident #11's FSHW, dated 4/3/17 at 10:15 am, documented she was found on the floor in the hallway. The worksheet documented she seemed agitated, and the documented root cause was, consider disease processes progressing. Resident #11's FSHW documented she had no injuries from this fall. A Fall Tool, dated 4/3/17 at 10:16 am, documented Resident #11 had experienced a recent fall. The Fall Tool documented she was taking more than two psychoactive medications and had a moderate cognitive impairment. The Action Plan documented she was referred to the RNA program and her physician, and her care plan was updated. The following interventions were added to Resident #11's Fall Care Plan on 4/3/17: - Staff was to encourage Resident #11 to ambulate with staff. - Staff was to modify her environment for maximum safety. Staff was to ambulate with Resident #11 all the way. - When Resident #11 was out of her room staff was to ambulate with her when she went back to her room. Resident #11's 4/3/17 Fall Care Plan, continued to include interventions found on her 9/22/16 Fall Care Plan. These included: - Staff was to encourage Resident #11 to do the RNA walking program. - Resident #11's bed was to be unplugged to keep the bed in one position due to Resident #11's inability to understand she cannot adjust the bed height for safety reasons. - Staff was to monitor Resident #11 every 15 minutes for whereabouts. - Staff was to keep her door ajar when cares were not being provided. As resident allows, was added at the end of this intervention on 4/3/17. * Fall on 4/3/17 at 4:00 pm: Resident #11's FSHW, dated 4/3/17 at 4:00 pm, documented she was found on the floor in her room attempting to ambulate. The worksheet documented she seemed agitated, and the documented root cause was, agitated; refusing to move away from the med-cart. Resident #11's FSHW documented she had no injuries from this fall. Resident #11's clinical record did not contain a Fall Tool for the second fall on 4/3/17 at 4:00 pm or care plan updates. Resident #11's clinical record did not contain documentation that the facility reported the fall Resident #11 experienced on 4/3/17 at 4:00 pm, to her physician. Progress Notes between 4/3/17 and 4/23/17 (21 days) documented 55 entries that Resident #11 complained of (c/o) left sided/left rib pain, requested pain medications, was holding her left side in pain, and/or that she suspected her ribs were broken. Progress Notes and x-ray reports included: (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	- A Nurse's Note, dated 4/3/17, documented Resident #11 had fallen twice that day, once in the morning and once in the afternoon. The note documented she was given all the medication available to her. The note documented Resident #11 told the Licensed Practical Nurse (LPN) she thought she had broken a rib. - A Nurse's Note, dated 4/4/17 at 5:00 am, documented Resident #11 had a marked dark purple bruise on the left thorax from the fall last shift. She c/o pain in [her] rib area under [her] left breast and reports that she feels the rib was broken. I medicated her for pain and advised her to drink plenty of fluids, rest, and intentionally take slow deep breaths for lung expansion to avoid complications. - A Nurse's Note, dated 4/5/17 at 5:14 am, documented Resident #11 stated, It feels like my rib is cutting me on the inside. - A Nurse's Note, dated 4/5/17 at 9:35 am, documented Resident #11 was given Ativan, her anti-anxiety medication, because she was anxious about falling. - A Nurse's Note, dated 4/6/17 at 7:24 pm, documented Resident #11 did not want to take a bath and was finally talked into taking one. The note documented Resident #11's reason for not wanting a bath was due to her hurting too bad. - A Mood and Behavior Note, dated 4/7/17 at 8:36 am, documented Resident #11 complained of pain in her rib area. - A Medication Review Note, dated 4/7/17 at 10:42 am, documented Resident #11 had increased behaviors and the writer was unsure if the behaviors were due to an increase in pain from an injury to her left rib from a fall or changes in her lung cancer. - A Nurse's Note, dated 4/17/17 at 10:11 am, documented Resident #11 had increased pain, was sleeping more, and experienced a decrease in mobility. - A Nurse's Note, dated 4/18/17 at 3:55 am, documented Resident #11 had a nose bleed and did not know how it happened. The note documented, She stayed up all night and remained confused. - A Nurse's Note, dated 4/23/17 at 1:11 pm, documented Ativan was given due to Resident #11's complaint of anxiety due to severe pain level 9. - A 4/23/17 at 1:03 pm, Nurse's Note documented Resident #11 had severe pain under her left breast and left side, giving her pain medication .she wakes up in severe pain. - A Nurse's Note, dated 4/24/17 at 11:41 am, documented Resident #11 slept in and did not want to wake up. The note documented Resident #11 was tired. * Fall on 4/24/17 at 1:00 pm: (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	Resident #11's FSHW, dated 4/24/17 at 1:00 pm documented staff found her on her hands and knees crawling out of the bathroom. The worksheet documented she seemed forgetful and was not sure what she was doing .then stated that she was coming out of the bathroom. Resident #11's FSHW documented she complained of left chest pain and left hip pain from this fall. A Fall Tool, dated 4/24/17 at 1:00 pm, documented Resident #11 had experienced a recent fall. The Fall Tool documented she was taking more than two psychoactive medications and had a moderate cognitive impairment. The Action Plan documented she was referred to her physician. A Nurse's Note, dated 4/24/17 at 1:43 pm, documented Resident #11 was transferred to a hospital, after a fall, for evaluation of her complaint of severe pain under [her] left breast near ribs. A Rib X-Ray Report, dated 4/24/17 at 3:04 pm, documented Resident #11 had a Posteroanterior [PA] x-ray and 2 additional rib detail view x-rays of her left side. The obliques rib detail view showed nondisplaced acute appearing fractures of the lateral portions of her left 6th, 7th, and 8th ribs. * Fall on 4/24/17 at 5:40 pm: Resident #11's FSHW, dated 4/24/17 at 5:40 pm, documented she was found on her right hip sitting on the floor trying to go to the bathroom. The worksheet documented she seemed forgetful, confused and agitated. Resident #11's FSHW documented she complained of left chest pain and right hip pain from this fall. Resident #11's clinical record did not contain a Fall Tool for the second fall on 4/24/17 at 5:40 pm. A Nurse's Note, dated 4/24/17 at 5:45 pm, documented Resident #11 fell on her way to the bathroom unassisted. The note documented she had increased intermittent confusion. Resident #11's Limited Physical Mobility Care Plan interventions were revised as follows: - Resident #11 required (specify: PT [Physical Therapy]/OT [Occupational Therapy] recommended adaptations, horn, adjusted speed, use of protective gear, rearview mirror, safety flag, reflective tape on device and/or clothing, etc,) initiated 4/24/17. - Resident #11 required the use of a gait belt during transfers and ambulation, initiated 4/24/17. Resident #11's Limited Physical Mobility Care Plan interventions were revised on 4/25/17, to require non-weight bearing staff support with mobility and staff distant supervision of stand-by assistance and contact guard assistance, as needed, with use of her ATW. Resident #11's ADL Care Plan was revised on 4/25/17, to include that she required assistance of 1 staff member, and staff was not to leave her unassisted in the bathroom. (continued on next page)

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F 0323 Level of Harm - Actual harm Residents Affected - Few	On 5/19/17 at 2:25 pm, the IDNS stated she was not working at the facility during the time of Resident #11's first falls in April 2017. The IDNS stated when Resident #11 complained of her rib cutting her on the inside the facility should have called the physician for orders and directions. The IDNS stated the x-ray on 4/24/17 documented acute fractures of the ribs. The IDNS stated Resident #11 was known to wander and walk without assistance. She stated she could not speak to what happened when she was not in the facility. The IDNS stated from experience staff should have reinforced/educated Resident #11 on the risks of not following care planned interventions and documented the refusals. On 5/22/17 at 11:10 am, Resident #11's Physician stated he would expect nursing staff to notify him when residents' complaints of pain increased after a fall and/or there was a suspected injury. The facility failed to ensure Resident #11 was provided sufficient supervision and care plan updates to prevent repeated falls. The facility fai [TRUNCATED]

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F 0329 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident's 1) entire drug/medication regimen is free from unnecessary drugs; and 2) is managed and monitored to achieve highest level of well-being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37265 Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure: * Residents' behaviors were identified prior to the administration of medications * Physicians' medication orders included specific indications for use * Medications were monitored for effectiveness This was true for 4 of 7 residents (#2, #6, #7, and #11) reviewed for psychoactive medication use. Findings include: 1. Resident #11 was readmitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the lung [lung cancer], dementia, and mood disorder. The quarterly Minimum Data Set [MDS] assessment, dated 2/22/17, documented Resident #11 was cognitively intact, required supervision with transfers and ambulation, experienced 1 non-injury fall prior the assessment, and rejected cares 1-3 days during the look back period. The MDS documented Resident #11 received PRN pain medication, rather than scheduled analgesics. An Antianxiety Care Plan, revised 4/14/17, documented staff were to monitor and document for side effects and effectiveness of Resident #11's antianxiety medication. The care plan did not document resident-specific behaviors staff was to monitor. Resident #11's Pain Care Plan, revised 12/12/16, documented she experienced acute and chronic pain related to lung cancer as evidenced by grimacing, resisting cares, and complaints of [c/o] itching or burning. Staff was to evaluate Resident #11 through the Pain Assessment in Advanced Dementia [PAINAD] scale, revised 12/12/16. The Plan documented Resident #11 was able to call for assistance when in pain and ask for medication, revised 12/12/16. Resident #11's April 2017 Physician's Orders included: * 5 mg Norco 5-325 mg (Hydrocodone - Acetaminophen) every 6 hours PRN for pain, 2/23/17. * 50 mg Tramadol every 6 hours PRN for pain, 2/23/17. * 0.5 mg Ativan every 12 hours PRN for anxiety, 8/23/16. * 650 mg Acetaminophen every 4 hours PRN for pain, 2/23/17. A Nurse's Note, dated 4/3/17, documented Resident #11 fell twice that day, once in the morning and once in the afternoon. The Note documented she received all the medication which was available to her and that she told a Licensed Practical Nurse [LPN] she thought she had broken a rib. (continued on next page)

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F 0329 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Progress Notes from 4/3/17 through 4/24/17 included 21 entries that Resident #11 experienced anxiety, decreased energy, behaviors, and/or increased confusion following the two falls on 4/3/17. Progress Notes included: A Nurse's Note, dated 4/17/17 at 10:11 am, documented Resident #11 was experiencing increased pain, sleeping more, and was exhibiting a decrease in mobility. A Medication Review Note, dated 4/7/17 at 10:42 am, documented Resident #11 exhibited increased behaviors that were attributed to either an increase in pain from an injury to her left ribs from a fall or changes in her lung cancer. A Nurse's Note, dated 4/18/17 at 3:55 am, documented Resident #11 had a nose bleed of unknown origin and that she stayed up all night and remained confused. A Mood / Behavior Note, dated 4/20/17 at 4:29 pm, documented Resident #11 did not want to go to counseling anymore, she states she does not have the energy. A Nurse's Note, dated 4/22/17 at 8:35 am, documented Resident #11 was very anxious. A Nurse's Note, dated 4/24/17 at 11:41 am, documented Resident #11 slept in and did not want to be awakened. The Note documented Resident #11 was tired. A Nurse's Note, dated 4/24/17 at 5:45 pm, documented Resident #11 fell on her way to the bathroom and exhibited increased intermittent confusion. The April 2017 MAR documented Resident #11 was administered 13 doses of PRN Ativan between 4/3/17 and 4/24/17. Resident #11's clinical record did not contain documentation of behaviors prompting administration of the Ativan or that nonpharmacological interventions were attempted prior to her receiving the medication for 4 of the 13 doses documented on the MAR. Resident #11's Controlled Drug Record for Ativan documented she received 29 doses of Ativan during the same time frame. Resident #11 was not assessed for pain prior to- or following administration of the PRN Ativan on 16 occasions. b. On 4/23/17, Resident #11's Controlled Drug Reviews and MARs documented the following medication administrations: * Ativan - 12:00 pm, 1:00 pm, and 8:00 pm * Norco - 12:00 pm, 1:00 pm, 4:00 pm, 7:00 pm, 8:00 pm, and 10:30 pm * Tramadol - 1:00 pm and 8:00 pm * Acetaminophen - 1:00 pm The April 2017 MAR did not document administration of Ativan, Norco, or Tramadol on 4/24/17. On 4/24/17, the Controlled Drug Reviews documented the following medication administration: * Ativan - 8:00 am, 12:00 pm, and 6:00 pm (continued on next page)

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F 0329 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* Norco - 8:00 am, 12:00 pm, 6:00 pm, 9:00 pm * Tramadol - 8:00: am, and again at an undocumented time The manufacturer's recommendation for Ativan document the medication is useful for short-term relief of excessive anxiety, but may result in cardiac complications, increased depression, sedation, fatigue, unsteadiness, insomnia, and other potential adverse side effects for the elderly. Long-term use of Ativan was not recommended. According to the Nursing Drug Handbook 2017, Ativan's overdose signs and symptoms included drowsiness, confusion, ataxia, hypotonia, hypotension, hypnotic state, coma, and death. The Drug Handbook documented Norco's potential adverse reactions included light-headedness, dizziness, sedation, drowsiness, mental clouding, lethargy, anxiety, fear, and mood changes. The Drug Handbook documented Tramadol's potential adverse reactions included dizziness, anxiety, confusion and nervousness. Resident #11 fell twice on 4/24/17; the facility's Fall Scene Huddle Worksheets (FSHW) for these two events documented Resident #11 was forgetful .not sure what she was doing .confused .agitated. On 5/19/17 at 2:25 pm, the IDNS stated nursing staff were to administer medications as ordered by the physician. On 5/22/17 at 11:40 am, the Consultant Pharmacist stated he did not compare Controlled Drug Records to residents' MARs and was not aware Resident #11's medications were not administered as ordered by the physician. 2. Resident #7 was admitted to the facility on [DATE], with diagnoses which included depression, insomnia, and pseudobulbar effect [a condition that causes uncontrollable crying and/or laughing that happens suddenly and frequently]. Resident #7's MDS assessment, dated 4/28/17, documented moderate cognitive impairment, mild signs and symptoms of depression, and no behaviors. a. A 4/3/17 Physician's Order documented Resident #7 was to receive Ativan 0.5 mg every 8 hours as needed for anxiety. Resident #7's Antianxiety Care Plan, revised 4/17/17, documented staff were to monitor and document side effects and efficacy of the antianxiety medication. Resident #7's care plan did not document resident-specific behaviors staff were to monitor. The 5/1/17 through 5/15/17 MAR documented Resident #7 was administered 13 doses of PRN Ativan. Resident #7's clinical record did not contain documentation of behaviors prompting administration of the Ativan or that nonpharmacological interventions were attempted prior to her receiving the medication for 5 of the 13 doses documented on the MAR. In addition, Resident #7's Controlled Drug Record for Ativan documented she was administered 18 doses of Ativan during the same time frame. Resident #7 was not assessed for pain prior to, or following, administration of the PRN Ativan on 5 occasions. (continued on next page)

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F 0329 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/19/17 at 8:25 am, the IDNS stated Resident #7's anxious behavior presented as repeated yelling that escalated until she became visibly upset. The IDNS stated Resident #7 presented with a fearful and anxious affect when she became forgetful. b. A 5/1/17 Physician's Order documented Resident #7 was to receive Melatonin 4 mg at bedtime related to insomnia. The physician's order allowed for a repeat dosage if the first administration was ineffective. Resident #7's Sleep Disturbance Care Plan, revised 4/17/17, documented staff was to monitor hours of sleep on the MAR to determine if the medication was effective. Resident #7's 5/1/17 through 5/16/17 MAR did not document that the facility was monitoring her hours of sleep. On 5/19/17 at 8:25 am, the IDNS and Staff Development Coordinator [SDC] stated hours of sleep documentation could not be located in Resident #7's clinical record. 3. Resident #6 was admitted to the facility on [DATE], with diagnoses which included dementia and depression. Resident #6's quarterly MDS assessment, dated 3/24/17, documented moderate cognitive impairment, mild signs and symptoms of depression, and extensive staff assistance required for all cares. A 12/30/16 Physician's Order documented Resident #6 received Lexapro 10 mg related to major depression. Resident #6's Depression Care Plan, revised 3/29/17, documented the presence of depression as evidenced by a sad, flat affect, and self-isolation. The April and May 2017 MARs and the April and May 2017 Progress Notes did not contain documentation that the facility monitored Resident #6 for signs and symptoms of depression or potential side effects of Lexapro. On 5/18/17 at 4:43 pm, the IDNS stated the facility should monitor residents for signs and symptoms of depression and/or side effects of related to the use of anti-depressants. Resident #6's clinical record did not contain documentation of persistent signs and symptoms of depression, there was no behavior monitoring for depression, and the facility did not monitor for potential side effects associated with Lexapro. 4. Resident #2 was admitted to the facility on [DATE], with diagnoses which included anxiety disorder. Resident #2's initial MDS assessment, dated 4/25/17, documented no cognitive impairment. A 4/14/17 Physician's Order documented Resident #2 was to receive Ativan 0.5 mg every 4 hours PRN for anxiety related to her disease process. (continued on next page)

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F 0329 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2's Antianxiety Care Plan, revised 5/4/17, documented staff was to monitor and document side effects and efficacy related to the use of Ativan. Resident #2's care plan did not document resident-specific behaviors staff was to monitor. The 5/1/17 through 5/15/17 MAR documented Resident #2 received 4 doses of PRN Ativan; the Controlled Drug Record documented Resident #2 received 18 doses of Ativan during the same time frame. Resident #2 was not assessed for specific behaviors or for the efficacy of the PRN Ativan provided to address behaviors on 14 occasions.

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F 0356 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information/data on a daily basis. 27930 Based on observation and staff interview, it was determined the facility failed to ensure nurse staffing information was posted and the data was retained for at least 18 months. These failures had the potential to affect all residents living in the facility, their family members, and/or visitors who wanted or needed the information to be uninformed of facility staffing levels. Findings include: Nurse staffing information was not observed posted anywhere in the facility on 5/15/17, 5/16/17 and 5/17/17. On 5/17/17 at 11:10 am, the Administrator said that nurse staffing information was not posted in the facility and she may have had maybe a month's worth of staffing information. The facility failed to post nurse staffing information and retain the information for 18 months.

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F 0371 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Store, cook, and serve food in a safe and clean way. 37265 Based on observation and staff interview, it was determined the facility failed to ensure food was stored under sanitary conditions. This was true for 10 of 10 (#1-#10) sampled residents and 31 of 31 other residents who resided in the facility and ate food prepared in the facility's kitchen. The deficient practice resulted in the storage of food without labeling of when opened, which created the potential for exposure to disease causing pathogens. Findings include: On 5/15/17 at 12:00 pm, the walk-in refrigerator was observed with outdated and un-dated food items. Food items included: * An opened, undated box of carrot cake which direction to staff to use within 4 days of opening * An opened, undated package of smoked ham * An opened, undated package of pre-sliced cheese On 5/15/17 at 12:34 pm, the Dietary Manager stated the facility should throw food items away within 5-7 days after opening and that all food should be labeled with a date the item was opened.

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Silverton Health and Rehabilitation of Cascadia	405 West Seventh Street Silverton, ID 83867

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F 0431 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards. 27930 Based on observation and staff interview, it was determined the facility failed to ensure medications were labeled. This was true for 1 of 8 residents (#13) observed during medication pass and created the potential for infection from cross contamination if Resident #13's unlabeled Symbicort inhaler was used for another resident. Findings include: On 5/16/17 at 8:10 am, Licensed Practical Nurse (LPN) #2, who was being oriented by Registered Nurse (RN) #1, was observed as she removed an unlabeled Symbicort inhaler from a clear plastic bag at the medication cart. Resident #13's name was written on the plastic bag. LPN #2, with RN #1 in attendance, then took the inhaler to Resident #13's room and administered 2 puffs of the medication to the resident. Immediately afterward, upon return to the medication cart, RN #1 said Resident #13 once self-administered the Symbicort and the bag with the label must have been thrown away.

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F 0490 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the facility is administered in an acceptable way that maintains the well-being of each resident . 37265 Based on observation, resident and staff interviews, and review of facility policies, investigations, grievances, and Incident and Accident Reports, it was determined the facility was not administered in a manner that effectively used its resources to assist residents attain or maintain their highest practicable well-being. Sufficient staff supervision was not provided to residents, policies were not followed, updated to reflect current standards of practice, and/or developed to provide staff guidance. Physician orders and care plans were not followed and care plans were not followed and revised as necessary. These failed practice: a) Placed 2 of 5 (#2 and #5) sampled residents reviewed for diabetic management, and the other 10 residents in the facility with a diagnosis of diabetes mellitus [DM], in Immediate Jeopardy of serious harm, impairment, or death, due to hypo/hyperglycemia. b) Resulted in harm to 1 of 13 (#11) sampled residents when the facility failed to assess her complaint of injury in a timely manner or control the resulting pain after she experienced a falls. c) Resulted in harm to 2 of 7 sample residents (#3 & #11) reviewed for falls when they experienced repeated falls resulting in bone fractures. d) Resulted in harm to Resident #11 when she experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to the left chest and rib cage area and required an increase in 2 as-needed (PRN) pain medications and an anti-anxiety medication. The pain and anti-anxiety medications were administered without consistent indication for use, resident specific behaviors, or monitoring for effectiveness. Resident #11 subsequently experienced two more falls and 3 fractured ribs. These deficient practices, and the failure of the facility's administration to ensure previously cited deficient practices did not recur, had the potential to harm all residents in the facility if care and services were not provided in a manner that was safe and effective. Findings include: 1. Refer to F309 of the current 5/22/17 recertification survey as it relates to the failure of facility administration to ensure sample residents Resident #2 and #5, and the other 10 residents in the facility with a diagnosis of DM, were not placed in Immediate Jeopardy of serious harm, impairment, or death, due to hypo/hyperglycemia. The deficient practices described at F309 describe the failure of facility administration to ensure: * Physician orders of residents who were diabetic were followed. * Staff followed the facility's diabetes policies and procedures. * Policies and procedures related to hyperglycemia were in place to provide guidance to staff. * Residents were not administered medications without physician orders. (continued on next page)

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F 0490 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Additionally, refer to F309 of the current 5/22/17 recertification survey as it relates to harm to Resident #11 when the facility failed to assess and provide treatment without delay when she complained of increased pain and injury following a fall. The facility was previously cited at F309 during the prior 3 recertification surveys and 1 revisit survey: * 6/24/16 recertification survey - related to resident harm due to delayed treatment, potential for harm due lack of effective pain management, and lack of indications for use and monitoring of psychotropic medications resulting in harm * 10/26/16 revisit survey - resulting in harm * 9/26/14 recertification survey * 7/19/13 recertification survey No surveys were completed at the facility during calendar year 2015. 2. Refer to F323 of the current 5/22/17 recertification survey as it relates to the failure of the facility to provide supervision, ensure staff followed care plans, and updated care plans to prevent repeated falls and related fractures. Resident #3, was harmed when she fell 4 times in 24 days and sustained fractures to the right femur that required surgical intervention. Resident #11 experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to her left chest and rib area and required increased use of 2 pain medications and an antianxiety medication. Resident #11 was harmed when she fell twice more and was diagnosed with 3 rib fractures. The facility was previously cited at F323 during the prior 3 recertification surveys and 1 revisit survey: * 6/24/16 recertification survey - related to lack of supervision and assistance to prevent falls * 10/26/16 revisit survey - related to lack of supervision to prevent falls * 9/26/14 recertification survey * 7/19/13 recertification survey 3. Refer to F329 of the current 5/22/17 recertification survey as it relates to the facility's failure to provide residents with medications as ordered by a physician and avoid excessive dosing, with specific target behaviors identified for monitoring, administered following identified behaviors, with specific indications for use, and monitored for effectiveness. Resident #11 was harmed when she experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to the left chest and rib cage area and required an increase in 2 as-needed (PRN) pain medications and an anti-anxiety medication. The pain and anti-anxiety medications were administered without consistent indication for use, resident specific behaviors, or monitoring for effectiveness. Resident #11 subsequently experienced two more falls and 3 fractured ribs. (continued on next page)

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F 0490 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility was previously cited at F329 during the prior 3 recertification surveys and 2 revisit surveys: * 6/24/16 recertification survey * 10/26/16 revisit survey * 12/13/16 revisit survey * 9/26/14 recertification survey * 7/19/13 recertification survey 4. The facility administration also failed to ensure previously cited deficient practices at F157 and F315 did not recur. * Refer to F157 of the current 5/22/17 recertification survey as it relates to the failure of the facility to notify physicians of hyperglycemic events and falls in a timely manner. Deficient practices at F157 were also identified during the previous recertification survey completed on 6/24/16 and subsequent revisit survey completed on 10/26/16. * Refer to F315 of the current 5/22/17 recertification survey as it relates to the facility's failure to provided adequate catheter care. Deficient practices at F315 was also cited during the previous recertification survey completed on 6/24/16. On 5/19/17 at 3:37 pm, the Administrator stated the facility had not identified the diabetic management concern as an issue, but had been working on falls, behavior monitoring, and abuse and neglect concerns. 5. Refer to F520 as it relates to the failure of facility administration to ensure the facility's QAA program effectively monitored facility care processes to protect residents from harm and previously identified deficient practices did not recur.

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F 0514 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep accurate, complete and organized clinical records on each resident that meet professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27930 Based on staff interview and clinical record review, it was determined the facility failed to ensure each resident's clinical record was accurate. This was true for 3 of 13 sample residents (#3, #6, & #11) and created the potential for more than minimal harm if medical decisions were based on documentation that was out of chronological order and when the residents were not in the facility, or if residents experienced embarassment or withdrew socially due to the lack of oral hygiene. Findings include: 1. Resident #3 was admitted to the facility in May 2016, with multiple diagnoses including dementia with behavioral disturbance, restlessness, and agitation. She was readmitted on [DATE], for orthopedic aftercare following surgical intervention of a right hip fracture related to a fall in the facility. Resident #3's care plan documented staff was to monitor her every 15 minutes, initiated 5/24/16 and revised 1/25/17. On 2/15/17, Resident #3 experienced a 4th fall in 24 days. She sustained 2 fractures to the right femur. Resident #3 was transported out of the facility by emergency medical services on 2/15/17 and hospitalized until 2/20/17. Documentation of Resident #3's every 15 minute checks on 2/15/17, was out of sequence chronologically. For example, 7:30 am was followed by 12:16 pm, which was followed by 9:30 am, then 12:16 pm again, then 10:30 am. Every 15 minute checks were also documented on 2/15/17 after Resident #3 was transported to the hospital, and on 2/16/17, 2/17/16, 2/18/17, 2/19/17 and 2/20/17 when she remained hospitalized . On 5/19/17 at 3:30 pm, the Interim Director of Nursing Services (IDNS) said the out of sequence documentation for every 15 minute checks may have been due to more than one staff documenting the checks and that multiple entries with the same time may have been because staff documented multiple checks at one time. The IDNS said that documentation of every 15 minute checks after Resident #3 left the faciity on [DATE], and when the resident was not in the facility, was not accurate and it called into question the accuracy of all the related documentation. 37265 2. Resident #11 was readmitted to the facility on [DATE], with diagnoses which included malignant neoplasm of the lung [lung cancer], dementia, and mood disorder. Resident #11's quarterly Minimum Data Set [MDS] assessment, dated 2/22/17, documented no cognitive impairment, staff supervision required with transfers and ambulation, 1 non-injury fall prior the assessment, and rejection of cares 1-3 days during the look back period. (continued on next page)

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F 0514 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #11's Fall Care Plan, updated on 4/3/17, documented staff was to monitor Resident #11 every 15 minutes. Resident #11's Activities of Daily Living [ADL] Flowsheet for 4/7/17, where the 15 minute checks were to be documented, did not include documentation she was monitored every 15 minutes from 10:00 pm to 12:00 am. A Chest X-Ray Report, dated 4/10/17 at 9:11 am, documented Resident #11 received a lateral and posteroanterior [PA] chest x-ray for lung cancer and left sided pain. On 5/22/17 at 9:00 am, the IDNS stated Resident #11 was out of the building for the chest x-ray on the 4/10/17. She stated she did not know how long Resident #11 was out of the building. Resident #11's ADL Flowsheet for 4/10/17, documented staff completed the 15-minute checks throughout the day, including the time she was out of the building for an x-ray. On 5/19/17 at 3:30 pm, the IDNS said that documentation of every 15 minute checks after a resident left the facility was not accurate and it called into question the accuracy of all the resident's related documentation. The facility failed to ensure clinical records were complete and accurate. 3. Resident #6 was admitted to the facility on [DATE], with diagnoses which included dementia and deposits on teeth. Resident #6's quarterly Minimum Data Set [MDS] assessment, dated 3/24/17, documented moderate cognitive impairment, mild signs and symptoms of depression, and extensive staff assistance required for personal hygiene. The ADL Care Plan, revised 3/28/17, documented Resident #6 required assistance with ADL's. The care plan documented Resident #6 was able to brush her teeth with staff set-up and cueing. ADL flowsheets from 5/1/17 through 5/17/17 did not contain documentation that daily oral care was provided to Resident #6. On 5/18/17 at 5:12 pm, the Interim Director of Nursing Services stated oral care should be performed in the morning, especially for a resident with diagnoses of dementia and deposits on teeth, and should be documented on the ADL flowsheet.

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F 0520 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 quarterly, and develop corrective plans of action. 37265 Based on observation, resident and staff interviews, and review of facility policies, grievances, investigations, and Incident and Accident Reports, it was determined the facility's QAA program failed to ensure sufficient monitoring of facility care processes to protect residents from harm and ensure previously identified deficient practices did not recur. These failed practice: a) Placed 2 of 5 (#2 and #5) sampled residents reviewed for diabetic management, and the other 10 residents in the facility with a diagnosis of diabetes mellitus [DM], in Immediate Jeopardy of serious harm, impairment, or death. b) Resulted in harm to 1 of 13 (#11) sampled residents when the facility failed to assess her complaint of injury in a timely manner or control the resulting pain after she experienced a fall. c) Resulted in harm to 2 of 7 sample residents (#3 & #11) reviewed for falls when they experienced repeated falls resulting in bone fractures. d) Resulted in harm to Resident #11 when she experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to the left chest and rib cage area and required an increase in 2 as-needed (PRN) pain medications and an anti-anxiety medication. The pain and anti-anxiety medications were administered without consistent indication for use, resident specific behaviors, or monitoring for effectiveness. Resident #11 subsequently experienced two more falls and 3 fractured ribs. Findings include: 1. Refer to F309 of the current 5/22/17 recertification survey as it relates to: *The failure of facility's QAA program to identify deficient practices which placed sample residents Resident #2 and #5, and the other 10 residents in the facility with a diagnosis of DM, in Immediate Jeopardy of serious harm, impairment, or death, due to lack of, or incorrect, treatment of hypo and hyper glycemia. * The failure of the facility's QAA program identify deficient practices which harmed Resident #11 when she complained of increased pain and injury following a fall and did not receive prompt treatment. The facility was previously cited at F309 during the prior 3 recertification surveys and 1 revisit survey, as follows: * 6/24/16 recertification survey - related to resident harm due to delayed treatment, potential for harm due lack of effective pain management, and lack of indications for use and monitoring of psychotropic medications * 10/26/16 revisit survey (continued on next page)

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F 0520 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	* 9/26/14 recertification survey * 7/19/13 recertification survey No surveys were completed at the facility in calendar year 2015. 2. Refer to F323 of the current 5/22/17 recertification survey as it relates to the failure of the facility's QAA program to ensure residents received sufficient supervision and interventions to protect residents from falls. Resident #3, was harmed when she fell 4 times in 24 days and sustained fractures to the right femur that required surgical intervention. Resident #11 experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to her left chest and rib area and required increased use of 2 pain medications and an antianxiety medication. Resident #11 was harmed when she fell twice more and was diagnosed with 3 rib fractures. The facility was previously cited at F323 during the prior 3 recertification surveys and 1 revisit survey: * 6/24/16 recertification survey - related to lack of supervision and assistance to prevent falls * 10/26/16 revisit survey - related to lack of supervision to prevent falls * 9/26/14 recertification survey * 7/19/13 recertification survey On 5/19/17 at 3:37 pm, the Administrator stated the facility was currently processing falls through the QAA process and determined the root cause of falls in the facility was lack of staff training and resident supervision. She stated the facility held Fall Committee meetings after a fall occurred, identified the cause of the fall, and then reviewed and implemented interventions to determine effectiveness. 3. Refer to F329 of the current 5/22/17 recertification survey as it relates to the failure to the failure of the facility's QAA program to ensure residents received medications as ordered by a physician, with specific target behaviors identified, specific indications for use, and monitoring of effectiveness. Resident #11 was harmed when she experienced 3 falls in 2 days that resulted in extensive bruising and severe pain to the left chest and rib cage area, and pain and anti-anxiety medications were administered without consistent indication for use, without resident-specific behaviors identified, and monitoring for effectiveness. Resident #11 subsequently experienced two more falls and 3 fractured ribs. The facility was previously cited at F329 during the prior 3 recertification surveys and 1 revisit survey: * 6/24/16 recertification survey - related to lack of supervision and assistance to prevent falls * 10/26/16 revisit survey - related to lack of supervision to prevent falls * 9/26/14 recertification survey (continued on next page)

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F 0520 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	* 7/19/13 recertification survey 4. The facility's QAA program also failed to ensure previously cited deficient practices at F157 and F315 did not recur. * Refer to F157 of the current 5/22/17 recertification survey as it relates to the failure of the facility to notify physicians of hyperglycemic events and falls in a timely manner. Deficient practices at F157 were also identified during the previous recertification survey completed on 6/24/16 and subsequent revisit survey completed on 10/26/16. * Refer to F315 of the current 5/22/17 recertification survey as it relates to the facility's failure to provided adequate catheter care. Deficient practices at F315 were also cited during the previous recertification survey completed on 6/24/16. On 5/19/17 at 3:37 pm, the Administrator said she attended the facility's QAA committee meeting, but did not keep the notes for those meetings. The Administrator stated the QAA committee also identified abuse related issues, behavior monitoring issues, and notification of change concerns, and were working on these, as well. The Administrator stated the QAA committee had not recently identified diabetic management, pain management, implementation of physician orders, completion of neuro-checks after resident falls, and lack of catheter care, identified during the current 5/22/17 survey as resident care concerns.