

HB

4/8

(7)

Date Referred: January 16, 1990

FURTHER REFERRALS: FINANCE

Date of Committee Action: 2/15/90

The HEALTH, EDUCATION, & SOCIAL SERVICES Committee considered: HB 418

HOUSE BILL NO. 418

QUALITY OF NURSING HOME CARE

"An Act related to quality of care in nursing facilities; establishing a nursing facility resident security fund; and providing for an effective date."

RECOMMENDATIONS:

- be replaced with _____ the same title
- have attached amendment(s) a new title
- do pass
- do not pass
- no recommendation
- individual recommendations
- additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(S):
(Dept)

APPROVES PREVIOUS: (Date/Dept)

- fiscal impact _____
- zero fiscal note DHSS
- zero with analysis _____

- fiscal note(s) _____
- zero fiscal note(s) _____
- zero fn/analysis _____

SIGNING DO PASS:

H. Ellis

Peter Jones

Mark Bunker

Mark Boyer

SIGNING:

(Check approp. column)

Do Not
Pass
No Rec
Amend

| | Do Not Pass | No Rec | Amend |
|--------------------|----------------|--------|-------|
| <i>Cheri Davis</i> | | ✓ | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

H. Ellis
Chairman's Signature

health
association
of alaska

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
FAX (907) 463-3573

REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

Chairman of the Board
C. Keith Campbell
Seward General Hospital

Chairman-Elect
Ed Malewski
Sitka Community Hospital

Immediate Past Chairman
Jim Gingerich
Fairbanks Memorial
Hospital

Secretary/Treasurer
Sister Dona Taylor
Providence Hospital
Anchorage

Delegate to the American
Hospital Association
Charles Stokes
Humana Hospital-Alaska
Anchorage

Alternate Delegate to the
American Hospital Assoc.
Ed Zeine
Cordova Community
Hospital

Delegate to the American
Health Care Association
Tom Boling
Our Lady of Compassion
Care Center
Anchorage

Alternate Delegate to the
American Health Care
Mark Bertilrud
Denali Center
Fairbanks

Delegate to the Healthcare
Forum
John Vowell
Wrangell General Hospital

Delegate to Congress of
Hospital Trustees
Jan Tretlner
Seward General Hospital

Government Institutions
Representative
Frank Sulton
Mt. Edgecumbe Hospital
Sitka

Outpatient Facilities
Representative
John J. Conway
Veterans Administration
Anchorage

President/CEO
Harlan R. Knudson

February 20, 1990

Representative Johnny Ellis, Chairman
House Health & Social Services Committee
Alaska State Legislature
P. O. Box V
Juneau, AK 99811

RE: HB 418, Sanctions
Nursing Homes

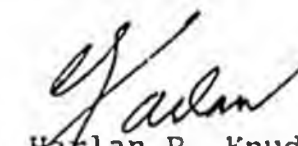
Dear John:

This is in response to Representative Furnace's question regarding sanctions against limited partners or venture capitalists who may be part owners of an Alaskan nursing home. (HB 418, Page 3, line 27)

All of Alaska's nursing homes are owned by communities, the state, or non-profit organizations, therefore the 5% or more ownership clause would not impact investors at this time. That doesn't mean things couldn't change over the years.

Increasing that level to 20% or 25% may help attract investors in Alaska nursing homes.

Sincerely,


Harlan R. Knudson
President/CEO

HRK/ma
cc: Representative Furnace

FISCAL NOTE

REQUEST:

Revision Date: _____
 Title: An Act relating to Quality Nursing care
 Sponsor: Rules Committee
 Requestor: Governor

Agency Affected: Health & Social Services
 BRU: _____
 Components: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

| OPERATING | FY 91 | FY 92 | FY 93 | FY 94 | FY 95 | FY 96 |
|------------------------|-------|-------|-------|-------|-------|-------|
| PERSONAL SERVICES | | | | | | |
| TRAVEL | | | | | | |
| CONTRACTUAL | | | | | | |
| SUPPLIES | | | | | | |
| EQUIPMENT | | | | | | |
| LAND & STRUCTURES | | | | | | |
| GRANTS, CLAIMS | | | | | | |
| MISCELLANEOUS | | | | | | |
| TOTAL OPERATING | -0- | -0- | -0- | -0- | -0- | -0- |
| CAPITAL | -0- | -0- | -0- | -0- | -0- | -0- |
| REVENUE | -0- | -0- | -0- | -0- | -0- | -0- |

FUNDING: (Thousands of Dollars)

| | | | | | | |
|---------------|-----|-----|-----|-----|-----|-----|
| GENERAL FUND | | | | | | |
| FEDERAL FUNDS | | | | | | |
| OTHER | | | | | | |
| TOTAL | -0- | -0- | -0- | -0- | -0- | -0- |

POSITIONS:

| | | | | | | |
|-----------|-----|-----|-----|-----|-----|-----|
| FULL-TIME | -0- | -0- | -0- | -0- | -0- | -0- |
| PART-TIME | -0- | -0- | -0- | -0- | -0- | -0- |
| TEMPORARY | -0- | -0- | -0- | -0- | -0- | -0- |

ANALYSIS : (Attach a separate page if necessary)

Will be ZERO For 1990

Prepared by: Kim Busch, Director *Kim Busch* Phone: 465-3355
 Division: Division of Medical Assistance Date: 1/15/90
 Approved by Commissioner: Myra M. Munson *Myra M. Munson* Date: 1/15/90
 Agency: Department of Health & Social Services

Distribution (by preparer):
 Legislative Finance
 Legislative Sponsor
 Requestor
 Office of Management and Budget
 Impacted Agency(ies)

STEVE COWPER
GOVERNOR



STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

CC
7MB 418

January 16, 1990

The Honorable Sam Cotten
Speaker of the House
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Mr. Speaker:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to the quality of care in nursing facilities. The bill primarily contains provisions that implement federal requirements that are mandatory in order for Alaska's medicaid program to comply with the federal program, and for nursing facilities in the state to continue to receive medicaid funding. The Alaska medicaid program receives approximately 50 percent federal reimbursement. The total medicaid costs for nursing facilities in the state in FY 90 amount to over \$42,000,000.

Additionally, the bill will help to maintain the high quality of services generally provided in the nursing facilities in this state.

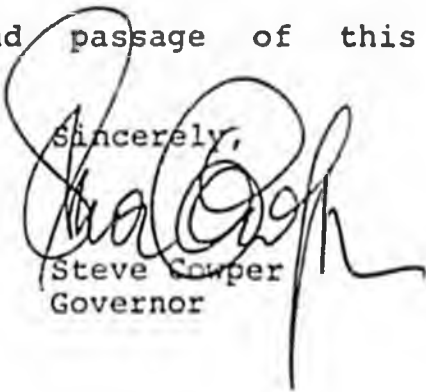
The bill allows the Department of Health and Social Services to impose sanctions against nursing facilities for substantially failing or refusing to comply with basic requirements of state licensing and certification laws for all nursing facilities, or with certification and other requirements for those facilities participating in the medicaid and general relief-medical programs. The sanctions include effects on state licensure and continued participation in the medicaid program. Also, the department could impose a ban on admissions of new patients in a nursing facility, or could assess a civil fine for each day of noncompliance with state or federal statutes or regulations. The bill would also authorize denial of payment for services rendered to medicaid and general relief-medical recipients, whose care is paid for in full or part by state money. The bill also authorizes the department to seek a court-appointed temporary administrator or a receiver to manage a nursing facility until residents

at risk can be removed from the facility or conditions improve at the facility. Finally, the bill authorizes the department to seek a court order to close a facility or transfer residents from the facility, or both, if a significant deficiency occurs affecting residents' health and safety.

The bill establishes a separate fund (the nursing facility resident security fund) into which certain civil fines, assessed by the department under this quality assurance program, will be deposited. Use of money in the fund is limited to the protection of the health or property of residents of nursing facilities found to be out of compliance with federal requirements. Article IX, sec. 7, of the Alaska Constitution prohibits the "dedication" of state revenue for a special purpose, but it provides an exception to this prohibition "when required by the federal government for state participation in federal programs." As a condition of participation in the federal medicaid program, 42 U.S.C. 1396r(h) requires that certain civil fines collected by the department be used only for certain protections of nursing facility residents. The nursing facility resident security fund established by the bill implements this federal requirement and, therefore, meets the criterion for an exception to the dedicated fund prohibition. Passage of this bill would allow the Department of Health and Social Services to comply with federal medicaid requirements, so that the state can continue to receive significant amounts of federal money. It also gives the Department of Health and Social Services an expanded list of sanctions to ensure that a high quality of nursing facility care continues to be offered in Alaska.

I urge your support and passage of this important legislation.

Sincerely,



Steve Cowper
Governor

1. Statement of Deficiencies report from a LTC facility. This report is required to be posted "in a place readily accessible to resident". This report was lengthy because termination action was initiated against this facility.

HB 418

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|--|----------------------|
| | 405.1121 Governing Bndy (Condition Met) | | | |
| | (k) Resident Rights (Standard Met) | | | |
| F61 | In 11 of 13 records reviewed, documentation was not found to indicate that residents or resident representatives had been given the opportunity to participate in their individual care planning and medical treatment. | F61 | Notification of and invitation to participate in residents HCC will be given each resident and each resident's guardian and documented on residents chart. Participation or lack of participation will be documented. Social Services Coordinator | 10-12-89 |
| F69 F70 | Each resident had not been encouraged and assisted to exercise his/her rights as a resident of the facility to submit complaints and recommendations concerning the policies and services of the facility. For example, surveyors requested documentation of resident's complaints or grievances for the past 6 months. Facility staff reported that there was no mechanism or need for a resident complaint procedure because all complaints were channelled through the Resident Council. Review of Resident Council minutes for 6 months revealed 1 resident complaint. However, surveyor interviews with residents revealed the following: | F69 F70 | Each resident will be encouraged and assisted to voice their feelings/complaints/requests. These comments will be documented as will the follow-up action by facility to respond to their comments. Additionally, a complaint box will be provided for residents use in cases where resident may prefer confidentiality. The resident council meetings will also be utilized for this purpose with documentation provided. Activities Coordinator | 9-22-89 |

PROVIDER REPRESENTATIVE'S SIGNATURE

[Redacted Signature]

TITLE

Administrator

(X6) DATE

10-17-89

* Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are discloseable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continue program participation.

FEB 13 '90 15:42 TOC PLM211

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X4) COMPLETION DATE |
|---------------------|--|---------------------|--|----------------------------|
| F76 | <p>1. Interview with 1 resident on 9/13/89 revealed resident's complaint of too few community outings.</p> <p>2. Interview with another resident on 9/14/89 revealed resident's complaints of dry food and having to sit with residents who smoke as she is allergic to smoke.</p> <p>The facility had not insured an adequate system of accounting for personal possessions. For example:</p> <p>1. Updated records were not signed by the responsible employee, the resident or resident representative.</p> <p>2. Personal property inventories were found in two locations. Initial inventories were located in the individual medical record and updates were found in a separate folder.</p> <p>3. The facility did not provide a system to protect residents' property and valuables.</p> | F76 | <p>A new system of resident personal property inventory has been implemented. This system will insure accuracy, date, signatures, etc. and will be located on the residents chart.</p> <p style="text-align: center;">Nursing & Activities</p> | 10-03-89 |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X4) DATE

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FEB 13 '90 15:43 TCC FILMS/H

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|--|---------------|---|----------------------|
| F80 | <p>Restraints had been used without physician orders which stated conditions or provision for use, type of restraint to be used, specified period of time for use, and instruction for release. For example:</p> <ol style="list-style-type: none"> Six of 6 records reviewed where restraints were being used indicated physician orders as "may restrain for self protection." Please refer to F237 for examples of inappropriate use of restraints. | F00 | <p>The use of restraints will be initiated on physician orders which will include stated conditions or provision for use, type of restraint to be used, specific period of time for use, and instruction for release. Physician and Nursing</p> | 10-30-89 |
| F93 | Please refer to F242 and F244 regarding residents' participation in activities. | F93 | Refer to responses to F242 and F244 | |
| F94 | Please refer to F76 regarding residents' retention and use of personal possessions and clothing. | F94 | Refer to response to F76 | |
| <u>(h) Staff Development (Standard Met)</u> | | | | |
| F100 | Please refer to F749 and F761 regarding facility staff's level of knowledge about the problems and needs of the aged, ill, and disabled. | F100 | Refer to response to F747 and F761. Additionally, the facility is currently developing a facility wide continuing education/in-service program (with documentation of inservices attended & presented). Administrator | 1030-89 |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|-------------------------------------|--|---------------|--|---|
| F101 | Please refer to F126, F181, and F237 regarding facility staff not practicing proper techniques in providing care to the aged, ill, and disabled. | F101 | Refer to response to F126, F181 and F237 | |
| 102 | <p>The facility staff did not display proper training and awareness in the following areas:</p> <ol style="list-style-type: none"> 1. Prevention and control of infections. For example: <ol style="list-style-type: none"> a. Proper handwashing between residents during the medication pass did not occur including the administration to a resident on isolation precautions. b. Ten of 10 employee records reviewed failed to indicate knowledge/training in infection control. 2. Fire safety. For example: <ol style="list-style-type: none"> a. Four of 10 employee records reviewed lacked documentation that employee had received fire safety training. b. Fire drills had not been performed as required on each of 3 shifts quarterly. Only 4 fire drills of the minimum of 12 had been done. | F102 | <p>In-service/instruction will be provided to insure knowledge and conformance to Infection Control and sanitation requirements.</p> <p style="text-align: center;">INS</p> <p>The annual staff-wide Fire inservice was scheduled for October. Documentation of attendance will be available for review. Documentation will also be noted in personnel records. Administration (Fire Inservice was held Oct 12, 1989)</p> <p>Documentation on fire drills will be available for review. A copy of the fire drills will be sent to Administrator, D'S, & Fire</p> | <p>10-30-89</p> <p>10-30-89</p> <p>9-19-889</p> |
| PROVIDER REPRESENTATIVE'S SIGNATURE | | | TITLE | (X6) DATE |

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FEB 13 '90 15:45 TCC ALABAMA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

ADDRESS, CITY, STATE, ZIP CODE

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY SHOULD BE PRECEDED
BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-
REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5)

COMPLETION
DATE

c. Fire drill records were fragmented. The maintenance department responsible for conducting the fire drill exercises had records of only two drills. Records of the other two drills were found in the policy and procedure manual by the surveyor. See also F358 and F359.

3. Proper use of restraints for safety and protection. Please refer to F237.

405.1124 Nursing Services (Condition Met)

Each resident had not received his/her diet as prescribed. In addition, deviations had not been reported with appropriate action taken. For example, resident #14 was observed at evening meals on 9/13 and 9/14/89 with the following noted:

1. Physician's orders were "2 gm. Na and lactose free diet chopped, double portions with Ensure BID."

Resident was served single portion, pureed for both meals. Interview with meal preparer on both evenings revealed no difference in meals served between

Continued:

Marshall (in-house), and maintenance. The staff has been instructed as to the importance of fire drills and documentation of the drills. Administration

Inservice and specific instruction has been provided to Dietary Service personnel regarding adherence to prescribed diet orders. All meals served are without added salt. Nursing & Food Service Sup.

A mechanism has been initiated to identify, monitor and insure that weight information and tracking is exchanged/shared between nursing and dietary to provide immediate weight gain intervention for persons experiencing weight loss. Nursing & Food Service Supervisor

10-2-89

10-2-89

F126

F126

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are actionable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FEB 13 '90 15:16 TEL 444-1111

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

U2-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | | | | | | | | | | | | | | | | | | |
|--------------------|--|---------------|---|----------------------|-----|------|-----|------|-----|------|------|------|-----|------|-----|------|-----|------|------|------|-----|--|---|---------|
| | <p>residents receiving regular diets versus 2 gm. Na diets.</p> <p>2. Review of dietary assessment dated 5/8/89 revealed IBW of 150-160 lbs. Review of resident's record revealed the following weights:</p> <table border="1" data-bbox="353 659 796 1006"> <thead> <tr> <th>Date</th> <th>Weight (lbs)</th> </tr> </thead> <tbody> <tr><td>1/89</td><td>137</td></tr> <tr><td>2/89</td><td>132</td></tr> <tr><td>3/89</td><td>124</td></tr> <tr><td>4/89</td><td>129½</td></tr> <tr><td>5/89</td><td>121</td></tr> <tr><td>6/89</td><td>114</td></tr> <tr><td>7/89</td><td>118</td></tr> <tr><td>8/89</td><td>123½</td></tr> <tr><td>9/89</td><td>110</td></tr> </tbody> </table> <p>Hence, the resident has experienced a significant weight loss of 20% over the past nine months. Resident is currently at 71% of his average IBW. The facility had not responded to this resident's weight loss.</p> <p>3. Observation of resident during evening meal on 9/13/89 revealed resident in geri-chair at 4:45 pm. Meals were delivered to dining area at</p> | Date | Weight (lbs) | 1/89 | 137 | 2/89 | 132 | 3/89 | 124 | 4/89 | 129½ | 5/89 | 121 | 6/89 | 114 | 7/89 | 118 | 8/89 | 123½ | 9/89 | 110 | | <p>Continued:</p> <p>Residents experiencing weight loss will be served first. Dietary</p> | 10-2-89 |
| Date | Weight (lbs) | | | | | | | | | | | | | | | | | | | | | | | |
| 1/89 | 137 | | | | | | | | | | | | | | | | | | | | | | | |
| 2/89 | 132 | | | | | | | | | | | | | | | | | | | | | | | |
| 3/89 | 124 | | | | | | | | | | | | | | | | | | | | | | | |
| 4/89 | 129½ | | | | | | | | | | | | | | | | | | | | | | | |
| 5/89 | 121 | | | | | | | | | | | | | | | | | | | | | | | |
| 6/89 | 114 | | | | | | | | | | | | | | | | | | | | | | | |
| 7/89 | 118 | | | | | | | | | | | | | | | | | | | | | | | |
| 8/89 | 123½ | | | | | | | | | | | | | | | | | | | | | | | |
| 9/89 | 110 | | | | | | | | | | | | | | | | | | | | | | | |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosure 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|---|----------------------------|
| | 5:10 pm. Resident was not assisted with meal until 1 hour, 10 minutes later. | | | |
| | 4. Review of medication sheet revealed resident to receive Ensure at 9:00 am and 7:00 pm. Observation of resident on 9/13 and 9/14/89 revealed resident did not receive 7:00 pm Ensure. | | | |
| <u>F128</u> | Please refer to <u>F126</u> regarding care necessary to prevent skin breakdown. (c) 24-Hour Nursing Services (Standard Met) | <u>F128</u> | Refer to response to <u>F126</u> | |
| <u>F130</u> | Please cross reference to <u>F00</u> regarding justification of and provisions for use of restraints. | <u>F130</u> | Please refer to <u>F00</u> response | |
| <u>F134</u> | Infection control techniques were not always carried out in the provision of care for each resident. Please refer to <u>F102</u> regarding proper handwashing technique. | <u>F134</u> | Please refer to response to <u>F102</u> | |
| <u>F135</u> | Proper nursing procedures and techniques were not always used when medications were given to residents. For example: 1. Liquid Maldol mixed with wine was left with the resident to finish. The nurse | <u>F135</u> | The nurses will remain with the resident until the resident takes / finishes taking entire dose of medication. Nursing | 9-30-89 |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY SHOULD BE PRECEDED
BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-
REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5)

COMPLETION
DATE

asked the nursing assistant to observe the resident while finishing the medication.

2. Medication for one resident was mixed into liquid prepared for bottle feeding and left with the nursing assistant to administer to the resident.

3. See also F134 and F102 regarding proper hand washing techniques.

F167

(d) Patient Care Management
(STANDARD NOT MET)

F167

Refer to responses to F134 & F102

F169
F170

Each resident's needs were not addressed in a written plan of care which demonstrates that the plans of all services are integrated, consonant with the physician's plan of care, and implemented shortly after admission. Needs were not identified for all services, goals developed, plans recorded, and progress notes did not indicate evaluations of interventions in relation to established goals. For example:

F169
F170

Care Plans have been reviewed, re-evaluated and re-written to identify current nursing needs of each resident. The plans will be consistent with the physician's plan of care.

10-30-89

Progress notes will relate to goals. All disciplines will chart on interdisciplinary notes to provide an easily identifiable flow of progress/care.

Nursing

1. Thirteen of 13 records reviewed did not contain assessments of nursing needs to validate appropriateness of goals found

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the residents. (See reverse for further instructions.) The findings above are actionable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is required to continue program participation.

FEB 13 '90 15:48 TOL HLHSH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONTRACT

A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUBSIDIARY

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|--|----------------------|
| F173 | <p>In the care plan. In addition, progress notes did not relate to goals.</p> <p>2. Please cross reference to <u>F233</u>, <u>F236</u>, and <u>F237</u>, regarding lack of social services assessments, goals, plans interventions and progress notes.</p> <p>3. Please cross reference to <u>F239</u>, <u>F240</u>, <u>F242</u>, and, <u>F244</u> regarding lack of activities assessments, individualized goals, appropriate plans and goals related progress notes.</p> <p><u>(e) Rehabilitative Nursing Care (Standard Met)</u></p> <p>Each resident had not received rehabilitative nursing care to maximize physical functioning and to prevent deformity, immobility, and contractures. Please cross reference to <u>F237</u>. For example:</p> <p>1. Resident #8 had an RPT plan to be exercised five times a week but the restorative aide record for July, 1989 indicated that exercise occurred only 8 of 22 possible times.</p> | F173 | <p>Continued:</p> <p>Please refer to responses to: F233, F236, F237, F239, F240, F242 and F244</p> <p>Each resident will receive rehabilitative Nursing Care as identified in their individualized plan of care. Also, please refer to response to P237.</p> <p>An additional Restorative Aide has been added to the staff. Nursing Assistants will be instructed through in-service as to their participation in aiding this function. In-service will be provided by our Physical Therapist and Occupational Therapist. Nursing, OT & PT</p> | 10-15-89 |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X7) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. (See reverse for further instructions.) The findings above are actionable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is required to continue program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY SHOULD BE PRECEDED
BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-
REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5)
COMPLETION
DATE

2. Observation of resident #4 who manifested contractures of all major joints had a record of having had exercise 8 times in May, 11 times in June, and 11 times in July. Standards of practice indicate that range of motion should be done 5-7 times a week to prevent contractures and deformity.

F178

Please cross reference to F169, and F170 regarding comprehensive plans and services of all disciplines involved in care of each resident.

F178

Please refer to responses to F169 and F170

(f) Supervision of Resident Nutrition
(Standard Met)

F180

Please cross reference to F126 regarding conformance to physician dietary orders.

F180

Please refer to response to F126

F181

Each resident needing assistance in eating or drinking had not been provided prompt assistance. Specific self-help devices were not provided where necessary to promote resident dignity and independence. For example:

F181

Staffing has been rescheduled to accommodate meal feeding times to assist with feeding residents who are unable to feed themselves.
Nursing
Additional self-help devices will be provided.
Dietary

10-2-89

10-20-89

1. Observation of the evening meal on 9/13/89, indicated that 11 residents were present. Three were self-feeders

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. (See reverse for further instructions.) The findings above are due within 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is required to insure program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>and 8 required assistance. Two facility staff were available to assist residents. Approximately 40 minutes passed before the 2 staff moved from the first resident they were assisting to the next. Hence, 6 other residents needing assistance sat without food for forty minutes.</p> <p>2. During the same meal, it was noted that 2 of the residents who were self-feeders would have benefited from special devices due to severe tremors and motor function deficits. The two residents ate two bites of their dinners each.</p> <p><u>(h) Conformance With Physician Drug Orders (Standard Met)</u></p> | | | |
| F191 | <p>Drugs were not always administered in accordance with written orders of the attending physician. For example, liquid Maudol mixed with wine was observed given to one resident. Neither the physician orders or the pharmacy review had addressed the appropriateness of mixing psychotropic medication with alcohol.</p> | F191 | <p>Drugs will be given with juice or water, not with alcohol. Drugs will be given consistent with physicians order. Nursing & Physician</p> | 10-26-89 |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are dischargeable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <u>405.1125 Dietetic Services (Condition Met)</u> | | | |
| | <u>(b) Menus and Nutritional Adequacy (Standard Met)</u> | | | |
| 196 | Please refer to F126 regarding menus planned to meet nutritional needs, in accordance with physician's orders. | F196 | Please refer to response to F126 | |
| | <u>(c) Therapeutic Diets (Standard Met)</u> | | | |
| F199 | Please refer to F126 regarding therapeutic menus served as ordered with supervision from the dietician. | F199 | Please refer to response to F126. Also, this area will be specifically reviewed by Dietician with inservice to staff. Dietician & Administration | 10-20-89 |
| | <u>(e) Preparation (Standard Met)</u> | | | |
| F207 | Where residents refused food served, appropriate substitutes of similar nutritive value were not offered. For example: 1. During the dinner meal served on 9/13/89, it was observed that the meal served differed from the planned menu for that evening. Two residents complained to staff that they didn't like or want what was served. Neither resident was offered a substitute. Each ate two bites of their meal only. | F207 | Substitutes will be offered and residents informed of their availability. Administration, Nursing & Dietary | 10-05-89 |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER: **02-A005**

(X2) MULTIPLE CONSTRUCTION:
A. BUILDING: _____
B. WING: _____

(X3) DATE SURVEY COMPLETED: **September 12-15, 1989**

NAME OF PROVIDER OR SUPPLIER: _____
ADDRESS: _____

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| <u>F218</u> | <p>2. During the dinner meal served on 9/14/89, it was observed that the meal served differed from the planned menu. Two residents complained to staff that they "didn't want" what was served. Neither resident was offered a substitute. Surveyor asked residents if they knew a substitute could be requested. Both reported they had not been informed. Residents requested substitutes. Soup was provided.</p> <p>3. Interview with dietary staff on 9/13/89 revealed substitutes for main entree were consistently limited to soup or sandwiches. These substitutes do not provide the resident with food items of similar nutritive value.</p> <p><u>405.1126 Specialized Rehabilitative Services (Condition Met)</u></p> <p><u>(b) Plan of Care (Standard Met)</u></p> <p>Please refer to <u>F237</u> regarding therapy provided in accordance with accepted professional practices.</p> | <u>F218</u> | Please refer to response to <u>F237</u> | |

PROVIDER REPRESENTATIVE'S SIGNATURE: _____ TITLE: _____ (X6) DATE: _____

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are actionable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FEB 13 20 15:51 OR. ST 934

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(1) PROVIDER NUMBER

02-A005

(2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (5) COMPLETION DATE |
|-------------------|---|---------------|---|---------------------|
| | <u>405.1127 Pharmaceutical Services</u> <u>(Condition Met)</u> | | | |
| | <u>(a) Supervision of Services (Standard Met)</u> | | | |
| F224 | The pharmacist had not always reported irregularities to the physician and administrator. Please refer to F191. | F224 | Pharmacist will routinely perform drug reviews and report irregularities to the physician, Head Nurse, DNS & Administrator. DNS & Administrator | 10-30-89 |
| F233 | <u>405.1130 Social Services</u> <u>(CONDITION NOT MET)</u> | F233 | Please note responses as follows: | |
| F234 | <u>(a) Social Service Functions</u> <u>(STANDARD NOT MET)</u> | F234 | Conformance will be assured by Social Services Coordinator | 10-30-89 |
| F236 F237 | The medically related social and emotional needs and problems of residents were not identified. Services to meet the social and emotional needs of residents were not provided by the facility nor were referrals to an appropriate agency consistently made. The scope and severity of subsequent outcomes was found to limit the facility's capacity to provide adequate care and services to the residents. For example: 1. Nine of 13 records reviewed revealed an absence of Social Service assessments identifying residents' needs. | F236 F237 | Social service assessments will be kept on the charts. Social and emotional needs and behavioral problems will be addressed and documented. Documentation of referrals will be maintained in chart. Referrals for medication review have been made or requested on all residents on psycho-tropic medications. Referrals to local mental health agencies for assistance in developing and delineating behavior mgmt. programs have been made. Behavior management programs will be reviewed by Social Services in conjunction with Nursing Service and Physicians to minimize the need for and use of physical and / or chemical restraints. | 10-30-89 |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(6) DATE

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is required to continue program participation.

FEB 13 1990 15:52 TOC ALH/CH/H

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER _____ STREET ADDRESS, CITY, STATE, ZIP CODE _____

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| | <p>2. Ten of 13 records reviewed revealed an absence of Social Services identification of residents' goals or approaches in interdisciplinary plans of care.</p> <p>3. Eleven of 13 records reviewed revealed the absence of current progress notes to reflect ongoing assessments of residents' needs, problems, evaluations of goals or interventions.</p> <p>4. Three of 13 residents were selected for an in-depth review of Social Services identification and response to residents' medically related social and emotional needs and problems. The following was noted:</p> <p>a. Resident #13:</p> <p>1. Review of resident's record revealed physician's order dated 9/87 for "behavior modification to correct disruptive behavior." Examples of unwanted behavior located in record included: "uncooperative and biting at staff"; "abusive verbally using foul language and obscene</p> | | <p>Continued</p> <p>Nursing service and physicians have addressed the use of physical and chemical restraints.</p> <p>Social service goals and approaches as specified in the assessments and notes will be included in the plan of care.</p> <p>Social service notes have been moved from social service office to social service section in residents chart.</p> <p>Social service notes will reflect ongoing assessment of needs, problems, evaluations, and interventions including referrals for services and reviews of current programs.</p> | |

PROVIDER REPRESENTATIVE'S SIGNATURE _____

TITLE _____

(X6) DATE _____

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are checkable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER
02-A005

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED
September 12-15, 1989

NAME OF PROVIDER
[REDACTED]

STREET ADDRESS, CITY, STATE, ZIP CODE
[REDACTED]

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | <p>gestures;" "inappropriate sexual behavior towards another resident." These unwanted behaviors were not identified nor responded to by the facility. For example:</p> <ul style="list-style-type: none"> a. Review of record revealed no Social Service assessment identifying these problems. Social history was dated 7/1/86 with no updates located. Social services progress notes were not current or informative. Note of 8/5/88 indicates a psychiatric evaluation was scheduled. No follow-up was located. b. Plan of care did not reflect any intervention being utilized in response to ongoing behavioral problems originally noted by physician in 1987. c. Plan of care did not address inappropriate sexual behavior by resident. | | | |

PROVIDER REPRESENTATIVE'S SIGNATURE _____

TITLE _____

(X6) DATE _____

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FEB 13 '90 15:54 100 ALBERT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY SHOULD BE PRECEDED
BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-
REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5)
COMPLETION
DATE

2. Further review of resident's record revealed inappropriate use of restraints, resulting in decline of physical functioning and reinforcement of unwanted behaviors. For example:
- a. Note of 4/17/89: "Pt. was put to bed as a disciplinary measure following an episode of verbal abuse (and) threat of physical aggression.
 - b. Note of 6/9/89: "Due to (staff's) inability to observe his location (and) actions at all times, (resident) to be allowed in (wheelchair) only with direct supervision; re: to dining room (and) back". Resident was otherwise kept in a geri-chair even though "loss of ambulation" was identified as a problem in his record.
 - c. Nursing note of 7/26/89: "OT consultant stated that (Pt.) agreeable to ROM exercise while smoking at same time. RA's have (her) ok to use this

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are discloseable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is required to continue program participation.

FEB 13 '90 15:55:11.00 HLHSH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---------------------|--|---------------------|--|----------------------------|
| | <p>technique to increase (Pt's) cooperation."</p> <p>d. Physician's order: "Haldol PRN."</p> <p>B. Resident #11:</p> <p>1. Review of resident's record reveals numerous behavioral problems reflected in the Nursing progress notes. For example: "awake and noisy during evening," "restless;" "loud and uncooperative;" "verbal abuse and aggressive towards patients and staff;" "sleeps during day and awake at night;" "sexual advances towards aides both physically and verbally." Problem behaviors noted in Nursing progress notes were not addressed in the resident's plan of care, assessment or intervention by Social Services.</p> <p>2. Observation and record review indicated interventions to reduce unwanted behaviors were primarily use of physical and chemical</p> | | | |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

>Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | <p>restraints. The use of restraints resulted in increased loss of physical functioning resulting in numerous falls and injuries. For example:</p> <ul style="list-style-type: none"> a. Review of incident reports for March, April, and May, 1989, revealed resident, while in restraints, fell five times during three months. b. Note of 2/14/89: "(resident) suffered a Fx (R) shoulder about 2 weeks ago" during walk to bathroom assisted by aide. c. Note of 6/8/89: "Patient fell about 2 weeks ago when getting up by himself and Fx (L) clavicle". d. Physician order: Haldol 2.5 mg PO Bid. <p>In addition, the use of restraints was not an appropriate intervention to restrict unwanted behavior. For example, nursing note of 3/17/89 indicated "if can't observe at all</p> | | | |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

19 of 31

* Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is required to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

02-A005

A. BUILDING _____

B. WING _____

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---------------------|---|---------------------|--|----------------------------|
| | <p>times, might help to tie w/c to hall railing."</p> <p>C. Resident #12:</p> <p>1. Review of resident's record revealed resident admitted to facility April, 1989, with a primary diagnosis of a progressive, degenerative neurological disorder of unknown etiology. Review of record further revealed history of suicidal ideation with an active suicide attempt 2/89. Review of Nursing progress notes revealed progressive decline of resident's general health and level of physical functioning. Progress notes also revealed resident with suicidal ideation in May, June, and August, 1989. Interview with facility staff on 9/13 and 9/14/89, revealed the resident "wanting to die so won't be a financial burden on family." Staff further reported their belief that resident is "dying" and "getting ready to die." Observations of this</p> | | | |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------------|--|---------------------|--|----------------------------|
| | <p>resident during survey revealed significant decline in resident's physical energy and functioning. Interview with resident's wife on 9/14/89 revealed she may be having difficulty accepting resident's condition. In addition, she reported having transportation and financial difficulties. Social Services had not addressed these problems.</p> <p>Relative to the problems of death and dying, suicidality, degenerative illness, and family problems, Social Service assessment and intervention were limited to the following:</p> <ol style="list-style-type: none"> 1. Behavior: When he is depressed, he has talked of suicide and staff need to be alert to subtle shifts in his emotion. 2. Assist in filing Alaska Permanent Fund Dividend. Assist transfer to Pioneer Home. Encourage durable power of attorney. | | | |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|---|
| F747 | <p><u>(b) Staffing (STANDARD NOT MET)</u></p> <p>The facility had not arranged for sufficient consultation and assistance by the social work consultant to meet resident needs. For example:</p> <ol style="list-style-type: none"> 1. Please refer to <u>F236</u> and <u>F237</u> regarding assessments not identifying resident's needs, interdisciplinary plans of care lacking resident's goals, progress notes not reflecting resident's needs, problems, goals, or interventions. 2. Please refer to <u>F236</u> and <u>F237</u> regarding examples from resident's #11, and #13. These resident examples indicate significant problems regarding lack of appropriate interventions to reduce unwanted behaviors. | F747 | <p>Additional training and consultant services have been scheduled, and received. Review of the services and documentation thereof including assessments, histories, roles and interventions of other Long Term Care Facilities Social Service Departments (via visits to other facilities) took place 9-19-89, 9-25-89 and 9-26-89. The MSW Consultant began chart review and will continue to provide training and chart review on a monthly basis to bring current charting into conformance, thereafter, consulting at such frequency to insure continued compliance.</p> | 10-30-89 was put into place on 10/15-16/89 |
| F239 | 405.1131 Activities (CONDITION NOT MET) | F239 | | |
| F240 | <u>(b) Patient Activities Program (STANDARD NOT MET)</u> | F240 | | |
| F242 F243 | An ongoing program of meaningful activities had not been provided based on identified needs and interests of each resident. | F242 F243 | <p>New programs have been initiated which will meet the individual needs and interests of each individual resident.</p> <p style="text-align: right;">Activities Coordinator</p> | 10-5-89 |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|--|--|
| | <p>Further, the facility's program of activities did not promote opportunities for engaging in normal pursuits of daily living, or the physical, social, and mental well being of each resident. For example:</p> <ol style="list-style-type: none"> 1. Ten of 13 records reviewed revealed the absence of Activities assessments which identified residents' problems or needs. 2. Thirteen of 13 records reviewed revealed the absence of current progress notes, to include ongoing evaluations and assessments of residents' needs or effectiveness of interventions. 3. The activities observed by surveyors were not appropriate to the resident participants in relation to the special needs resulting from cognitive, communicative, interactive and physical deficits with the addition of cultural diversities. For example: <ol style="list-style-type: none"> a. On 9/12/89 the "Native Culture" activity consisted of the showing of a film depicting a Greek tragedy. | | <p>Continued:</p> <p>A new, reorganized activities program has been initiated (after review of activities programs in other facilities via site visits to four other facilities by the Activities Coordinator and by review and input / consultation by the Activities Consultant and the Occupational Therapist as well as Speech Therapist and Speech Pathologist). This new activities program promotes opportunities for the residents to engage in normal daily living and is structured to reflect the individual physical, social and mental capability as well as plan and goal(s) for each individual resident.</p> <p>Activities assessments will be provided and documented identifying residents problems and needs and located on each resident chart. Activities Coordinator</p> <p>Current progress notes including ongoing evaluations, assessments, needs and interventions as well as the effectiveness of interventions will be documented on the interdisciplinary notes section of each residents chart. Activities Coordinator</p> <p>Multiple small group activities are now offered concurrently. Activities Coordinator</p> | <p>10-5-89</p> <p>10-30-89</p> <p>10-30-89</p> <p>10-05-89</p> |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See reverse for further instructions.) The findings above are actionable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

23 of 31

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|--|----------------------|
| | <p>b. Observation of an activity at 11:00 am on 9/13/89, which involved a "talking book" on the subject of classical musicians, indicated the following.</p> <ol style="list-style-type: none"> 1) No interaction occurred between staff and residents. 2) Five of 6 residents were in restraints and asleep. The 5 residents were Alaska Native. 3) The awake resident was not attending to the activity. <p>c. Observation of a movie activity at 3:00 pm on 9/13/89 indicated inappropriate placement of residents with a visual or hearing impairment. For example, residents with identified hearing and visual problems were placed 20-30 feet from the 19" television.</p> <p>4. The facility activities program did not provide all residents with an opportunity for community interaction. For example, an interview with activities staff on 9/13/89 revealed the following:</p> | | <p>Continued:</p> <p>Increased community activities is integrated into the new activities program: ie: Senior Citizen potluck dinners, field trips, etc.</p> | ongoing |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|--|----------------------|
| | <p>a. Approximately 1 time per month, 4-5 residents attend a potluck outside the facility.</p> <p>b. Approximately the same number of residents go shopping in the community once per month.</p> <p>c. "Car rides" once per week allows only a small fraction of the resident population to get out of the facility.</p> <p>5. The facility did not provide meaningful activities for residents throughout each day. For example, review of the activities calendars for July, August, and September, 1989, revealed the following:</p> <p>a. Twenty-seven of 90 days did not have scheduled activities beyond 2:00 pm.</p> <p>b. Forty-four of 90 days did not have scheduled activities beyond 3:00 pm.</p> | | <p>The newly reorganized activities program now provides activities for each day and each evening of the week. This has been accomplished by the addition of more staff as well as gaining additional community volunteers.</p> <p style="text-align: right;">Activities Coordinator</p> | 10-05-89 |
| F761 | <p>(a) Staffing (STANDARD NOT MET)</p> <p>The facility did not arranged for sufficient consultation and assistance by</p> | F761 | <p>The frequency of visits / consultation and input by Activities Consultant has been increased to provide adequate direction to insure conformance with guidelines.</p> | 10-30-89 |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

25 of 31

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be accused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are dischargeable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FEB 13 1990 10:00 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4)
ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY SHOULD BE PRECEDED
BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-
REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5)
COMPLETION
DATE

a qualified Activities consultant to meet resident needs. For example, please refer to F240, F242, and F244 regarding examples of assessments, plans, and activities which do not meet the needs of each resident.

405.1132 Medical Records (Condition Met)

(c) Content (Standard Met)

F254

The medical records did not contain adequate physician documentation. For example:

1. Four of 4 discharge records did not have discharge summaries.
2. Two of 4 discharge records did not have a signed transfer record.
3. One of 4 discharge records did not have a signed statement of rehabilitation potential.
4. One of 4 discharge records did not have a statement of prognosis.

F254

Discharge summaries which historically, were promptly provided and made part of the residents chart will be made current. The physicians were temporarily hampered by time constraints due to large population increases experienced as a result of the oil spill. The physicians are fully aware of the importance of prompt documentation and are now expending the additional time necessary to bring charting, etc. current.
Physicians & Nursing

11-20-89

F255

The medical record did not have a physical examination report in 1 of 4 discharge records.

F255

Refer to response to F254

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are dischargeable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|----------------------|--|----------------------|--|----------------------|
| F260 F261 F263 | <p>The medical records in 10 of 10 active cases reviewed did not contain complete information regarding:</p> <ol style="list-style-type: none"> 1. An overall plan of care setting for goals to be accomplished through each service's designed activities, therapies and treatments. Please cross reference to <u>F233</u>, <u>F234</u>, <u>F236</u>, <u>F239</u>, and <u>F240</u>. 2. Progress notes of resident response to interventions in relation to goals. Please cross reference to <u>F233</u>, <u>F234</u>, <u>F237</u>, <u>F239</u>, <u>F240</u>, and <u>F244</u>. | F260 F261 F263 | <p>Charts will reflect/contain complete information including reactions/response from residents. Please refer to responses to: F233, F234, F236, F239, F240, F237, & F244.</p> <p>Nursing, Social Services, Activities, Physicians, Consultants, Dietary and Administrator</p> | 10-30-89 |
| F287 | <p><u>405.1134 Physical Environment</u> (Condition Met)</p> <p><u>(e) Patient Rooms and Toilet Facilities</u> (Standard Met)</p> <p>Mattresses were not always made available to residents which provide a safe and comfortable bed. Some residents' mattresses were found to be 12"-14" too short for the bed thereby exposing bed springs.</p> | F287 | <p>Replacement mattresses have been ordered to insure that all beds have mattresses, 66 sufficient length.</p> <p>Administration</p> | 10-10-89 |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is required to continued program participation.

| | | | |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER NUMBER 02-A005 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED September 12-15, 1989 |
|---|--|--|--|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER [REDACTED] | STREET ADDRESS, CITY, STATE, ZIP CODE [REDACTED] |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|--|----------------------|
| | <u>405.1135 Infection Control (Condition Met)</u> | | | |
| | <u>(b) Aseptic and Isolation Techniques (Standard Met)</u> | | | |
| <u>F340</u> | Please cross reference to F102 regarding proper handwashing techniques. | <u>F340</u> | Please refer to response to F102 | |
| | <u>(c) Housekeeping (Standard Met)</u> | | | |
| <u>F342</u> | The facility had not always maintained a safe and clean interior. For example: | <u>F342</u> | Ceiling tile will be replaced in areas where missing and / or damaged. Maintenance | 10-19-89 |
| | 1. Ceiling tile in the freight receiving area was missing and/or water damaged. | | Painting and repairs to gauged walls is now on an on-going revolving preventative maintenance schedule which is supplemented by work requisitions to bring to the attention of maintenance any areas of repair. Maintenance | 10-30-89 |
| | 2. Ceiling tile had been removed above the microwave in the medication storage room. | | Request has been made to Seward Cablevision TV cable service to address the tv cables throughout the facility. Seward Cablevision & Maintenance | 10-30-89 |
| | 3. Bathroom ceiling tile in rooms 33, 39, 42, and 43, were damaged by water, cracked and broken. | | | |
| | 4. Paint on bathroom walls in rooms 39, 42, and 44 was peeling off wall and stained in some cases. | | | |
| | 5. Dirty utility room paint was chipped. | | | |

| | | |
|-------------------------------------|-------|-----------|
| PROVIDER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|-------------------------------------|-------|-----------|

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X4) COMPLETION DATE |
|---------------------|---|---------------------|--|---------------------------------|
| | <p>6. Paint was chipped around the 2nd floor nurses station.</p> <p>7. Floor coving on 1st and 2nd floors was cracked allowing for potential bacteria build-up.</p> <p>8. Paint on door jams was chipped.</p> <p>9. Gouged walls were found in room 31 and on the 1st floor hallway.</p> <p>10. The antenna cord in room 31 was observed hanging down and out onto the floor between the hall and the resident's bed.</p> <p>11. Room #5 had a seam in the flooring which was separating.</p> <p>12. The dirty linen cart on the 3rd floor old section was left open.</p> <p>13. Room #12 had broken flooring and the toilet paper holder was off the wall.</p> | | <p>Continued:</p> <p>Flooring will be addressed on an ongoing maintenance requisition/preventative maintenance program to insure proper repairs.</p> <p style="text-align: right;">Maintenance</p> <p>This linen cart is located on the section where ambulatory male MI residents are located. These residents often place their dirty linen (socks, underwear, etc) in this linen cart for washing. (they do this on their own) We will remind the residents to please close the lid on the dirty linen cart; as well as to remind them that they do not need to put their linen in the cart, our staff will do it for them.</p> <p style="text-align: right;">Nursing</p> | <p>10-30-89</p> <p>10-30-89</p> |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is required to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

ADDRESS, CITY, STATE, ZIP CODE

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X4) COMPLETION DATE |
|---------------------|---|---------------------|--|----------------------------|
| | <p><u>405.1136 Disaster Preparedness</u> <u>(Condition Met)</u></p> <p><u>(a) Disaster Plan (Standard Met)</u></p> | | | |
| <u>F355</u> | <p>Facility staff were not aware of their specific responsibilities with regard to evaluation and protection of residents. Please refer to <u>F358</u> and <u>F359</u> regarding lack of staff training.</p> | <u>F355</u> | <p>Staff training will be provided, and documentation of this training maintained for review. (Please note response to F102(2))</p> <p>Fire Marshall _____ Department, Administration & DNS</p> | 11-30-89 |
| <u>F357</u> | <p><u>(b) Staff Training and Drills</u> <u>(STANDARD NOT MET)</u></p> | <u>F357</u> | <p>Please refer to response to F358</p> | |
| <u>F358</u> | <p>All employees were not trained, as part of their employment orientation in all aspects of preparedness for any disaster. For example:</p> <ol style="list-style-type: none"> Documentation in 4 of 10 staff records reviewed had no disaster plan or fire safety policy and procedure training. Seven of 10 staff records reviewed had no record of fire inservice training. | <u>F358</u> | <p>All new employees, as part of their documented orientation program will be trained in areas including but not limited to: Infection Control, Safety, Sanitation, Fire Drills, Disaster preparedness. Thereafter, refresher inservices will be provided on an annual basis. Administration</p> | 11-30-89 |
| <u>F359</u> | <p>Facility staff did not participate in ongoing training and drills in all procedures so that each employee promptly and correctly carries out a specific role in</p> | <u>F359</u> | <p>Please refer to response to F358 and F102</p> | |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are discloseable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

1.18

FEB 13 '90 16:04 TCC HLR/SH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER NUMBER

02-A005

(X7) MULTIPLE CONSTRUCTION

A. BUILDING _____
B. WING _____

(X2) DATE SURVEY COMPLETED

September 12-15, 1989

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS- REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X3) COMPLETION DATE |
|---------------------|---|---------------------|--|----------------------------|
| | <p>case of fire or disaster. Fire drills were not held as required. For example:</p> <ol style="list-style-type: none"> 1. 4th quarter, 1988: No fire drill held for night shift. 2. 1st quarter, 1989: No fire drill held for any shift. 3. 2nd quarter, 1989: No fire drill on day shift or night shift. 4. 3rd quarter, 1989: No fire drill on day shift or night shift. See also, F102. | | | |

PROVIDER REPRESENTATIVE'S SIGNATURE

TITLE

(X4) DATE

31 of 31

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FEB 13 '90 16:04 Fed. Health

2. Excerpts from OBRA '87 regarding resident's rights to information.
 - a. Sec. 4211(c)(1)(B) - Notice of Rights.
 - b. Sec. 4202 (c) and Sec 4212 (b) - Posting of Survey Results.

OBRA 187 excerpt - Notice of Rights

retary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

"(xi) OTHER RIGHTS.—Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room.

→ "(B) NOTICE OF RIGHTS.—A nursing facility must—

"(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility;

"(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights);

"(iii) inform each resident who is entitled to medical assistance under this title—

"(I) at the time of admission to the facility or, if later, at the time the resident becomes eligible for such assistance, of the items and services (including those specified under section 1902(a)(28)(B)) that are included in nursing facility services under the State plan and for which the resident may not be charged (except as permitted in section 1916), and of those other items and services that the facility offers and for which the resident may be charged and the amount of the charges for such items and services, and

"(II) of changes in the items and services described in subclause (I) and of changes in the charges imposed for items and services described in that subclause; and

"(iv) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under title XVIII or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

"(C) RIGHTS OF INCOMPETENT RESIDENTS.—In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this title shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

"(D) USE OF PSYCHOPHARMACOLOGIC DRUGS.—Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan included in the written plan of care described in paragraph (2) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent,

OBRA '87 excerpt - Posting Survey Results

"(ii) copies of cost reports of such facilities filed under this title or title XIX,

"(iii) copies of statements of ownership under section 1124, and

"(iv) information disclosed under section 1126.

"(B) NOTICE TO OMBUDSMAN.— Each State shall notify the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), with respect to a skilled nursing facility in the State.

"(C) NOTICE TO PHYSICIANS AND SKILLED NURSING FACILITY ADMINISTRATOR LICENSING BOARD.— If a State finds that a skilled nursing facility has provided substandard quality of care, the State shall notify—

"(i) the attending physician of each resident with respect to which such finding is made, and

"(ii) the State board responsible for the licensing of the skilled nursing facility administrator at the facility.

"(C) ACCESS TO FRAUD CONTROL UNITS.— Each State shall provide its State medicare fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys and certifications under this subsection."

(c) POSTING SURVEY RESULTS.— Section 1864(a) of such Act (42 U.S.C. 1395ac(c)) is amended by inserting, after "readily available form and place" in the fifth sentence, the following: ", and require (ii) the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives),"

SEC. 4203. ENFORCEMENT PROCESS.

(a) STATE REQUIREMENT.— Title XVIII of the Social Security Act is amended—

(1) in section 1864(d) (42 U.S.C. 1395c(d)), as added by section 4201(a)(2) and as amended by section 4202(a)(1) of this Act, by inserting before the period at the end the following: "and the establishment of remedies under sections 1819(h)(2)(B) and 1819(h)(2)(C) (relating to establishment and application of remedies)"; and

(2) by adding at the end of section 1819 of such Act, as added by section 4201(a)(3) and as amended by section 4202(a)(2), the end the following new subsection:

"(h) ENFORCEMENT PROCESS.—

"(i) IN GENERAL.— If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

"(A) immediately jeopardize the health or safety of its residents, the State shall recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(i); or

3. Excerpts from the Interpretive Guidelines for the new regulations for Skilled and Intermediate Care Facilities. These guidelines provide clearer interpretation of the OBRA '87 requirements for resident's rights to information.

a. Tag #F154 to F163 - Notice of Rights and Services.

b. Tag #F177 to F180 - Examination of Survey Findings.

1/ Except from Interpretive Guidelines for new regulations
tag # F154 to F163 - Notice of rights

INTERPRETIVE GUIDELINES - SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

P-30

| TAG NUMBER | REGULATION | GUIDANCE TO SURVEYORS |
|------------|--|---|
| | | <p><u>Survey Procedure and Probes: 483.10(a)(2)</u> Attend to resident or staff remarks and staff behavior that may represent deliberate actions to promote or to limit a resident's autonomy or choice, particularly in ways that affect independent functioning.</p> <ul style="list-style-type: none"> • (Group) How does the facility help you exercise your rights? |
| F153 | <p>(3) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.</p> | <p><u>Interpretive Guideline: 483.10(n)(5)</u> Defer entirely to State law regarding adjudicated cases. State law takes into account the fact that gradations of incapability exist to which graduated remedies can be adapted.</p> <p><u>Survey Procedure and Probes: 483.10(o)(3)</u> For residents in the sample adjudicated incompetent, is there clear documentation as to whom rights and responsibilities have been assigned? Are pertinent consents and documents signed by appointed guardians? How does the facility and guardians interact in behalf of the rights of a resident adjudged incompetent?</p> |
| F154 | <p><u>(b) Level B requirement: Notice of rights and services.</u></p> <p>(1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.</p> <p>Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing;</p> | <p><u>Interpretive Guideline: 483.10(b)(1)</u> "In a language that the resident understands" means that communication of information concerning rights and responsibilities must be both clear and understandable to the resident and, if the resident's knowledge of English is inadequate for comprehension, in the foreign language familiar to the resident.</p> <p>For foreign languages commonly encountered in the facility locale, the facility must have written translations of its statements of rights and responsibilities, and should make the services of an interpreter available. In the case of less commonly encountered foreign languages, however, a representative of the resident may sign that he or she has interpreted the statement of rights to the resident prior to the resident's acknowledgment of receipt. For hearing impaired residents who communicate by signing, the facility is expected to provide an interpreter. Large print texts of the facility's statement of resident rights and responsibilities should also be available.</p> <p>"Both orally and in writing," means if a resident can read and understand written materials without assistance, an oral summary along with the written document is acceptable.</p> <p>"During the resident's stay" means that if the rules and regulations governing residents' conduct or rights change, the facility updates residents about these changes.</p> |

Rev. 232

FEB 16 10:05 AM '81

REV. 2/77

| TAG NUMBER | REGULATION | GUIDANCE TO SURVEYORS |
|------------|--|--|
| | | <p><u>Survey Procedures and Probes: 485.10(b)(1)</u></p> <ul style="list-style-type: none"> • (Group and Individual) How did you find out about the facility's rules? About your rights here? What did staff say to you about rules? Did you have an opportunity to ask questions? • (Group and Individual) Do you know what the rules are here? Do you know what you can and cannot do? What rules are not clear to you? How do you learn of changes in facility rules and your rights here? <p>If residents are unclear about facility rules, or are unclear about what rights they have in the facility, interview staff to determine their knowledge about residents' rights and responsibilities and their ability to communicate it in a language or methods understood by residents.</p> |
| F155 | (2) The resident has the right to inspect and purchase photocopies of all records pertaining to the resident, upon written request and 48 hours notice to the facility; | <p><u>Interpretive Guidelines: 485.10(b)(2)</u></p> <p>"Purchase" means that residents may be charged for photocopy costs at prevailing community rates.</p> <p>"Records" includes all records pertaining to the resident.</p> <p>"The right to inspect" is conferred to individuals other than the resident based on State law. See 485.10(a)(3).</p> <p>"48 hours notice" means two business days, i.e., excluding weekends and holidays.</p> <p><u>Survey Procedure and Probes: 485.10(b)(2)</u></p> <ul style="list-style-type: none"> • (Group) Are residents able to look at their records if they want to? Are there any delays in the facility honoring these requests? • (Group) Are residents able to get photocopies of something in their records if they offer to pay for these copies? Are there any delays, of more than 48 hours, in the facility honoring these requests? |
| F156 | (3) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition; | <p><u>Interpretive Guideline: 485.10(b)(3)</u></p> <p>"Total health status" includes functional status, medical care, nursing care, nutritional status, rehabilitation and restorative potential, activities potential, cognitive status, oral health status, psychosocial status, and sensory and physical impairments. The resident should be involved in the assessment and care planning process, including the discussion of diagnoses, treatment options, risks, and prognosis. These discussions should be presented in language that the resident can be</p> |

P-31

INTERPRETIVE GUIDELINES • SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

2-32

| TAG NUMBER | REGULATION | GUIDANCE TO SURVEYORS |
|------------|---|--|
| | | <p>expected to understand, and the resident must be allowed to make choices based upon the information provided.</p> <p><u>Survey Procedure and Probes: 483.10(b)(3)</u></p> <ul style="list-style-type: none"> • [(Individual)] When staff or physician, as appropriate, provide care, what are you told about your treatments? Are you told about how this treatment affects your condition? • [(Individual)] If your treatment is stopped, are you told how this may affect your condition? • [(Individual)] How do you find out what medications you receive, what they're for, and what their side effects are? • [(Individual)] Are you asked for your consent before treatment or tests are started or stopped? |
| 1157 | (4) The resident has the right to refuse treatment, and | <p><u>Interpretive Guideline: 483.10(b)(4)</u></p> <p>A resident's refusal of treatment must be persistent and consistently documented in the resident's record. Refusals of treatment should also be countered by discussions with the resident of the health and safety consequences of the refusal and the availability of any therapeutic alternatives that might exist. If a resident consistently refuses all treatment, discharge on the grounds that the resident's welfare cannot be met in the facility may be the ultimate outcome. Transfer and discharge rights are dealt with under 483.12.</p> <p><u>Survey Procedure and Probes: 483.10(b)(4)</u></p> <ul style="list-style-type: none"> • [(Individual)] Have you ever refused a medication or a treatment? What happened? How did the staff react? • [(Individual)] Has the facility offered alternative treatments to the ones you've refused? <p>• [()]: "[(Individual)]" in a probe indicates its inclusion as a probe for individual interview.</p> |

Rev. 232

INTERPRETIVE GUIDELINES • SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

Rev.

| TAG NUMBER | REGULATION | GUIDANCE TO SURVEYORS |
|------------|------------|-----------------------|
|------------|------------|-----------------------|

Rev. 232

| TAG NUMBER | REGULATION | GUIDANCE TO SURVEYORS |
|------------|--|--|
| F158 | to refuse to participate in experimental research; | <p><u>Interpretive Guideline: 483.10(b)(6)</u> Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.</p> <p>A resident being considered for participation in experimental research must be fully informed of the nature of the experiment (e.g., medication, treatment) and understand the possible consequences of participating. The individual's or legal representative's written consent must be received prior to participation. Experimental research must respect the privacy of the resident. Any direct observation or use of resident-specific data requires the resident's consent, or for residents adjudicated incompetent under State law, that of the resident's legal representative or family member. Aggregated resident statistics, that do not identify individual residents, may be used for studies without obtaining residents' permission.</p> <p><u>Survey Procedure and Probes: 483.10(b)(6)</u> During the Entrance Conference, ask if the facility participates in any experimental research involving residents as subjects since the last standard survey. If so, <u>does the facility have an Institutional Review Board or other committee that reviews and approves research protocols?</u> In this regard, 483.75(d) <u>Relationship to Other HHS Regulations</u> applies (i.e., the facility must adhere to 45 CFR Part 46, protection of human subjects of research). Also, look for documentation of informed consent.</p> |
| F159 | <p>(5) the facility must--</p> <p>(1) Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid of--</p> <p>(A) the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;</p> | <p><u>Interpretive Guideline: 483.10(b)(5) and (6)</u> Periodically means as often as the facility changes its services or the charges for these services.</p> <p>If a Medicare SIF provider believes, on admission or during a resident's stay, that Medicare will not pay for skilled nursing or specialized rehabilitative services, then the facility must inform the resident or their legal representative in writing why these specific services may not be covered. The provider must keep a copy of this letter on file.</p> <p>If the resident requests that the bill be submitted to the intermediary or coverage carrier for a Medicare decision then evidence that this submission has occurred should also appear in the resident's record.</p> <p>Advance notice to the resident of changes in services or charges is not required. Whenever possible, however, advance notification should be given in order to be consistent with the intent of the law, which is to allow residents to be fully</p> |

P-33

INTERPRETIVE GUIDELINES - SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

P-34

| TAG NUMBER | REGULATION | GUIDANCE TO SURVEYORS |
|------------|---|---|
| | (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and | <p>Informed of what they owe the facility. Providers must make a good faith effort to inform the resident fully of services and charges and related charges.</p> <p><u>Survey Procedures and Probes: 485.10(b)(5) and (6)</u></p> <ul style="list-style-type: none"> • (Individual) Do you know what things or services you pay for out of your own pocket? Who handles the payment for these items? • (Individual) How do you find out how much these services or things cost? • (Group) Do you or your family receive an explanation of any charges or monthly bills? • (Group) Have there been any changes in the charges since you've been here? How do you find out about those changes? • (Group) How does the facility give you information about your Medicare or Medicaid benefits? |
| F160 | (ii) Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. | |
| F161 | (6) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. | <p>If residents are not clear about the scope of services they are entitled to or the additional services provided by the facility and the cost of these services, <u>interview</u> administrative staff to determine how the facility informs residents about their Medicare and Medicaid benefits, the non-covered services the facility provides, and the facility's charges for these services.</p> |
| | (7) The facility must furnish a written description of legal rights which includes-- | <p><u>Survey Procedure and Probes: 485.10(b)(7)</u></p> <ul style="list-style-type: none"> • (Group) Do you know how to contact the State Survey Agency or certifier? |
| F162 | (i) A description of the manner of protecting personal funds, under paragraph (c) of this section; and | <p>If residents do not know how to contact the State Survey Agency or certifier in the event of a complaint, <u>interview</u> administrative staff to determine how the facility informs residents of their legal rights.</p> <p>See 485.10(c) regarding protection of resident funds.</p> |
| F163 | (ii) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. | |

Rev. 2/81

Rev:

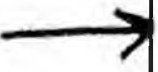
TAG

Excerpt from Int. Guidelines - Exam. of survey results.

INTERPRETIVE GUIDELINES - SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

Rev. 232

| TAG NUMBER | REGULATION | GUIDANCE TO SURVEYORS |
|------------|---|---|
| | | <p>+ (Individual) Has the facility ever asked you to allow them to release your clinical records to someone other than another health care institution like a hospital or to a health care insurer and you objected? What happened?</p> <p>If residents indicate there is a problem related to release of records, are there blanket consent forms in the record or individual consents?</p> |
| | <p>(f) <u>Level II requirement: Grievances.</u> A resident has the right to--</p> | <p><u>Survey Procedure and Probes: 483.10(f)(1)-(2)</u></p> <ul style="list-style-type: none"> + (Individual and Group) Have you ever complained formally about anything here? + (Individual and Group) Who did you complain to? What did you complain about? + (Individual and Group) If you submitted a written complaint, how did the facility respond? + (Individual and Group) Was your complaint resolved? Were you satisfied with the facility's resolution of the problem? If the facility could not resolve the problem, did they explain why? |
| F175 | <p>(1) Voice grievances with respect to treatment or care that is, or fails to be furnished, without discrimination or reprisal for voicing the grievances; and</p> | <p>If residents' responses indicate problems in voicing grievances and getting grievances resolved, determine how the facility deals with and resolves resident complaints and grievances. Examine facility policies.</p> |
| F176 | <p>(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> | |
| | <p>(g) <u>Level II requirement: Examination of survey results.</u> A resident has the right to--</p> | <p><u>Interpretive Guidelines: 483.10(g)(1)-(2)</u> "Survey results" means the Statement of Deficiencies (NCFR 2567) and plan of correction, if required. A "place readily accessible to residents" means at eye-level in a central, public space in the facility, such as a lobby, in areas frequently visited by most residents.</p> |
| F177 | <p>(1) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> | <p><u>Survey Procedures and Probes: 483.10(g)(1)-(2)</u> Are survey results posted in a place readily accessible to residents?</p> <ul style="list-style-type: none"> + (Group) Have you wanted to see the results of the most recent State or Federal survey? Did the facility provide you with this information? + (Group) Do you know where the survey results are posted? |



INTERPRETIVE GUIDELINES - SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

P-40

| TAG NUMBER | REGULATION | GUIDANCE TO SURVEYORS |
|------------|--|--|
| F178 | The results must be posted by the facility in a place readily accessible to residents; and | <ul style="list-style-type: none"> * [Group] How do residents communicate with advocacy agencies in the community? For example, can residents meet with the local nursing home ombudsman when they choose to do so? |
| F179 | (2) Receive information from agencies acting as client advocates, and | |
| F180 | be afforded the opportunity to contact agencies. | |
| | (h) <u>Level B requirement: Work.</u> The resident has the right to-- | <p><u>Interpretive Guideline: 483.10(h)(1)-(2)</u> "Prevailing rate" is the wage paid to non-disabled workers in the community surrounding the facility for essentially the same type, quality, and quantity of work requiring comparable skills.</p> |
| F181 | (1) Refuse to perform services for the facility; | <p>All resident work, whether of a voluntary or paid nature, must be part of the plan of care. A resident's desire for work is subject to discussion of medical appropriateness. As part of the plan of care, a therapeutic work assignment must be formally agreed to by the resident. The resident also has the right to refuse such treatment at any time that he or she wishes. At the time of development or review of the plan, the voluntary or paid nature of the work can be negotiated.</p> |
| F182 | <p>(2) Perform services for the facility, if he or she chooses, when--</p> <p>(i) the facility has documented the need or desire for work in the plan of care;</p> <p>(ii) the plan specifies the nature of the services performed and whether the services are voluntary or paid;</p> <p>(iii) Compensation for paid services is at or above prevailing rates; and</p> <p>(iv) the resident agrees to the work arrangement described in the</p> | <p><u>Survey Procedure and Probes: 483.10(h)(1)-(2)</u> Are residents engaged in what may be paid or volunteer work (e.g., doing housekeeping, doing laundry, preparing meals, cottage industry). Pay special attention to the possible work activities of residents with mental retardation or mental illness. If you observe such a situation, determine if the resident is in fact performing work and, if so, is this work, whether voluntary or paid, described in the plan of care?</p> <ul style="list-style-type: none"> * [Group] Do any residents have other types of chores or unpaid duties which they perform here? |

Rev. 2/32

Re

TAG

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY
LEGISLATIVE REFERENCE LIBRARY

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

H. HESS 2-13-90

H. HESS 2-15-90