



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

FILE COPY

February 4, 2015

Steve Gannon, Administrator
Quinn Meadows Rehabilitation & Care Center
1033 West Quinn Road
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Gannon:

On **January 16, 2015**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Quinn Meadows Rehabilitation & Care Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

After each deficiency has been answered and dated, the administrator should sign both the Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Steve Gannon, Administrator
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Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 17, 2015**. Failure to submit an acceptable PoC by **February 17, 2015**, may result in the imposition of civil monetary penalties by **March 9, 2015**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

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

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

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

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 16, 2015**, if substantial compliance is not achieved by that time.

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

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provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Option #2, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **February 17, 2015**. If your request for informal dispute resolution is received after **February 17, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Lorene Kayser, L.S.W., Q.I.D.P. or David Scott, R.N., Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626.

Sincerely,



NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj
Enclosures

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM *OR SNFs AND NPs	PROVIDER # 135136	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/16/2015
NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 278	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure assessments were accurately documented. This was true for 1 of 6 residents (#4) sampled for MDS accuracy. Specifically, Resident #4 had two falls and the MDS Assessments done after each fall did not contain documentation the resident fell. Findings included:</p> <p>Resident #4 was admitted to the facility on 9/25/14 with diagnoses which included rehabilitation care, chronic ulcer of the skin, ulcer of lower limb, and edema.</p> <p>Record review of the incident and accident reports documented the resident fell 10/11/14 and on 10/25/14.</p> <p>On 1/15/15 at 2:15 PM, the MDS Coordinator was interviewed regarding the resident's falls and the MDS Assessment. She stated that she took the wording literally, at Section J1800, where it documented any falls since admission/entry or reentry or prior assessment, whichever is more recent. She stated, "The resident had not fallen since her prior PPS Assessment, or whatever the assessment was, that some resident's have quite a few assessments in three months."</p> <p>Record review of the Admission MDS Assessment, dated 10/8/14, and the Quarterly MDS Assessment, dated 1/8/15, did not contain documentation the resident had fallen. The PPS Assessments, dated 10/16/14 and 10/30/14, did not contain documentation of falls since admission or prior assessments of falls.</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 278	<p>Continued From Page 1</p> <p>Instruction at J1800 documents to review from day after ARD (Assessment Reference Date) of last MDS Assessment to ARD of current MDS. All documents in the medical record, i.e., incident reports, staff reports, etc., should be reviewed and to code if reported or documented.</p> <p>On 1/16/15 at 2:15 PM, the Administrator and DON were notified of the concern with inaccuracy of MDS Assessments. No further information was provided by the facility.</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

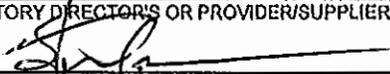
PRINTED: 02/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2015
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NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the annual federal recertification and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Sherri Case, Team Coordinator, LSW/BSW, QIDP Rebecca Thomas ,RN, BSN</p> <p>The survey team entered the facility on January 12, 2015 and exited on January 16, 2015.</p> <p>Survey Definitions: BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MR = Medication Record MDS = Minimum Data Set assessment MG = Milligram PPS - Prospective Payment System TAR = Treatment Administration Record</p>	F 000	<p>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</p>	
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff</p>	F 246	<p>F-246 SS=D §483.15(e) - Reasonable Accommodation of Needs/Preferences</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>Res. # 7 will be assessed by the Therapy Director or designee for appropriate sizing of her wheelchair by 02/12/2015. A new wheelchair will be ordered by 02/20/2015.</p>	2/28/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 2/16/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 246	<p>Continued From page 1</p> <p>Interview and record review it was determined the facility failed to provide reasonable accommodation of an individual's needs by ensuring a resident's wheelchair fit properly. This was true for 1 of 9 (#7) sampled residents. This had the potential for physical pain and discomfort to the resident. Findings included:</p> <p>Resident #7 was admitted to the facility on 11/5/10 with diagnoses which included lymphedema, abnormal posture, spasm of muscle, muscle weakness and osteoarthritis.</p> <p>During the surveyor meeting with the residents, on 1/13/15 at 3:00 p.m., Resident #7 was observed to have a pillow behind her back and white padding in the seat of the wheelchair. This caused her to sit without her legs and back supported by the wheelchair. The resident was observed to lift her self up with her arms and attempt to reposition herself in the wheelchair throughout the one hour meeting.</p> <p>On 1/14/15 at 3:45 p.m., the resident stated the "chair hurt her" and the right side of the chair was missing padding causing discomfort. The resident stated the wheelchair had not been evaluated by Physical Therapy</p> <p>On 1/15/15 at 9:40 a.m., the resident stated the seat cover on the wheelchair "cuts into her legs", the wheelchair was "lopsided", the back of the chair was too far back. The resident stated those problems were the reason for the pillow behind her back and "bath sheets" in the seat. The resident stated the bath sheets often get wrinkled and caused her legs to hurt.</p> <p>On 1/15/15 at 10:40 a.m., the DON was asked to</p>	F 246	<p>F-246 continued...</p> <p><i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i></p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all residents who use a wheelchair may have the potential to be affected by this deficiency; hence by 02/20/2015 their wheelchair will be inspected by the facility Administrator or designee and the Therapy Director or designee to ensure that their wheelchair properly fits and is functioning.</p> <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>To ensure that the deficient practice does not recur, starting on 02/20/2015 the Therapy Director or Therapist designee will;</p> <ul style="list-style-type: none"> · Include in their assessment for new residents the proper fitting and functioning of their wheelchair. · Assess the wheelchairs of long term residents who use a wheelchair at least quarterly to ensure that their wheelchair properly fits and is functioning. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through:</p> <p>The Administrator or designee will do visual observation on at least three (3) residents who use a wheelchair to ensure that the wheelchair properly fits and is functioning.</p> <p>Monitoring will start on 02/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p>		

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F 246	Continued From page 2 look at the resident's wheelchair and stated she preferred to have the Director of Therapy (DOT) assess the wheelchair. The DOT was contacted at that time and stated he had just received a physician order that morning to work with the resident and had not had a chance to assess the resident. The DOT stated he would accompany the surveyor and the DON to look at the wheelchair. The DOT observed the resident in the wheelchair and stated the sling (seat) was worn out and needed to be replaced and the resident's hips were not aligned properly with the knees. The resident informed the DOT the wheelchair brake handle was missing the cover and had caused a callus on her hand. The DOT agreed the cover on the brake needed to be replaced. A Physical Therapy Evaluation, with an onset date of 1/15/15, documented in the Positioning Assessment the resident was unable to sit back in the wheelchair and had difficulty repositioning. The Summary/Rationale section documented the wheelchair had been assessed and recommended the seat be lowered and the wheelchair cushion be changed. On 1/16/15 at 2:15 p.m., the DON and the Administrator were informed of the above concern. The facility provided no further information.	F 246	F-246 continued... The Administrator or designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	F- 280 SS=E §483.20(d) (3), 483.10 (k) (2) - Right to Participate Planning Care-Revise CP	2/28/2015	

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F 280	<p>Continued From page 3</p> <p>participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure care plans were updated for 5 of 6 (#s 1-5) residents reviewed for care plans. Failure to ensure care plans were revised to alleviate stress, address falls, and nutritional/ physical care needs created the potential for residents to not get needed care and a resident to receive diabetic care when not ordered by the physician. Findings include:</p> <p>1. Resident #1 was admitted to the facility on 4/30/14 with diagnoses which included hemiplegia and cerebrovascular disease.</p> <p>a) Resident #1's Care Plan related to delusions regarding her spouse documented the following interventions (start date of 9/15/14): reward</p>	F 280	<p>F-280 continued...</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>Res. #1, Care plan related to delusions regarding her spouse was revised to include the following interventions: · What would improve the resident's mood i.e. letting her know that she has pretty clothes on and offering to put make-up on her. · What triggers the behavior.</p> <p>Res. # 1, based on the assessment by the Director of Nursing on 02/12/2015, resident is able to remove the lap buddy. After discussion with the daughter (responsible party) regarding the risk versus benefit, the daughter requested the use of the self releasing seatbelt, therefore on 02/13/2015 the Physician gave an order for the use of the self releasing seatbelt. Fall prevention care plan updated.</p> <p>Res. # 3, Resident Diabetes Type 2 was clarified with the physician on 02/13/2015 and an order was obtained to start a.m. fasting blood sugars. If blood sugar is under 140 for three days, discontinue. On 02/13/2015 the recapitulation orders were revised to include Diagnosis of Diabetes Type 2.</p> <p>Res. # 3, by 02/20/2015 the Nutritional Care Plan will be updated to reflect the 12/19/2014 order for the supplement to be offered TID between meals.</p> <p>Res. #5, Care plan was revised by the MDS Coordinator on 01/29/2015 to include the right hand passive range of motion.</p> <p>Res. #2, Therapy Plan of Care will be updated by 02/20/2015 by the Therapy Director or designee to reflect resident assist (support) provided for transfers.</p>		

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F 280	<p>Continued From page 4</p> <p>positive behavior with positive feedback, compliment resident and/or spend time with the resident, identify if behavior is due to an unmet need, remain calm, adopt a non-critical approach and state boundaries on behavior in a firm but gentle manner and allow resident time and space to regain control.</p> <p>On 1/15/15 at 12:00 noon, the resident was observed sitting in the common area near the nurse's station. The resident told the surveyor her husband was in her room but she was not allowed to be in the room with her husband and began to cry. The resident's husband was not in the facility at that time. The surveyor attempted to redirect the resident by stating it was almost lunch time. The resident stated she was hungry but still appeared distressed. The surveyor went to the resident's room and observed a male visiting with the resident's roommate.</p> <p>On 1/15/15 at 2:55 p.m., the DON stated Resident #1 does get upset and feels she needs to see her husband. When asked if the roommate's male visitor may have triggered the behavior, the DON stated it could have. The DON stated the resident was easily directed by commenting to her about her appearance, such as stating she had pretty clothes on and offering to put make-up on her. The DON stated after the above incident the resident was redirected by putting on make-up. After the staff assisted her with her make-up the resident's mood improved.</p> <p>On 1/15/15 at 4:30 p.m. the MDS Coordinator and DON were asked about the interventions listed in the care plan for delusions. The Coordinator stated the interventions needed to be revised to include specific interventions to</p>	F 280	<p>F-280 continued...</p> <p>Res. #2, Bladder plan of care will be revised by 02/20/2015 by the MDS Coordinator or LN designee to reflect the correct date that the bladder retraining was initiated and completed.</p> <p>Res. #2, Depression care plan will be revised by 02/20/2015 by the MDS Coordinator or LN designee to include interventions for depression customized to what the resident actually exhibits as depression and the non-pharmacological interventions.</p> <p>Res. # 4, Fall Risk Care Plan will be updated by 02/20/2015 by the MDS Coordinator or LN designee to reflect resident assist (support) provided for transfers.</p> <p><i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i></p> <p>Residents who have diabetic diagnosis or on nutritional supplement or fall prevention or therapy care plan or on anti-depressant or those with physician order for passive range of motion, may have the potential to be affected by this deficiency, hence by 02/20/2015 the Director of Nursing or LN designee will review the identified residents that may have the potential to be affected by this deficiency to ensure any recommendations or changes are reflected in the care plan.</p> <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p>		

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F 280	<p>Continued From page 5</p> <p>address the resident's behavior. When asked what triggered the behaviors, the DON stated the facility was aware of the triggers and the care plan would be revised to include the triggers.</p> <p>b) The resident's 1/1/15 recapitulation Physician Orders included an order for a lap buddy for safety with a start date of 10/21/14.</p> <p>The resident's 5/20/14 care plan for fall prevention Included a revision, dated 10/22/14 to use a self releasing seat belt until the lap buddy was received.</p> <p>During observations on 1/12/15 at 4:45 p.m., 1/13/15 at 8:45 a.m., and throughout the survey the resident was observed in her wheelchair without the lap buddy.</p> <p>On 1/15/15 at 4:30 p.m., the MDS Coordinator and the DON were informed the resident was not observed using the lap buddy. The DON stated the facility had tried two different lap buddies but the resident did not like them and would remove them. The DON was asked if there was a care plan to address the refusal of the lap buddy or documentation the resident had removed the lap buddy. The facility provided no further information.</p> <p>2. Resident #3 was admitted to the facility on 12/9/14 with acute myocardial infarction (heart attack), encephalopathy (abnormal brain function) and a urinary tract infection.</p> <p>a. A 12/10/14 Therapy Care Plan documented the resident "has PMH (past medical history) significant for DM (diabetes mellitus) type 2..."</p>	F 280	<p>F-280 continued...</p> <p>A root cause analysis was done by the Administrator and DNS. Therefore, starting on 02/23/2015 a systemic measure will be put into place: The Inter Disciplinary Team (IDT) during their scheduled IDT Stand-up meetings will review any residents with recommendations or changes to their care plan to ensure that such recommendations or changes are reflected in the plan of care.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through: • The DNS or LN designee will review at least three (3) Residents care plans to ensure recommendations or changes are reflected in the plan of care.</p> <p>Monitoring will start on 02/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Director of Nursing or designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>		

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F 280	<p>Continued From page 6</p> <p>A 12/26/14 care plan included that the resident had the, "Potential for hyperglycemic or hypoglycemic episode secondary to diabetes," and directed staff to administer medications as ordered a to monitor blood sugar levels per physician order.</p> <p>The resident's 1/1/15 recapitulation Physician Orders did not include a diagnosis of diabetes, medications for diabetes, or instructions to monitor the resident's blood sugar levels.</p> <p>On 1/15/15 at 4:50 pm the DON confirmed that the resident's Physician Orders did not include any information regarding monitoring the blood sugar levels or diabetes medications.</p> <p>b) The resident's Calculation of Estimated Nutritional Needs, signed by the dietitian on 12/19/14, included in the plan section to "change supplement to be offered between meals..."</p> <p>The resident's 1/1/15 recapitulation Physician Orders included an order for a 6 ounce, no sugar added, house supplement to be offered between meals with a start date of 12/9/14.</p> <p>The resident's 12/23/14 Nutrition care plan included interventions to receive diet as ordered by the physician, weigh per facility policy, monitor during nutrition at risk, fortified meals, assist the resident with meals as needed and the meals could be left on the tray.</p> <p>On 1/15/15 at 4:50 p.m. the DON stated the nutrition care plan had not been revised to include the addition of supplements between meals.</p> <p>3. Resident #5 was admitted to the facility on</p>	F 280			

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F 280	<p>Continued From page 7 8/27/09 with diagnoses that included muscle weakness and dementia.</p> <p>a) The resident's 1/1/15 recapitulation Physician Orders included an order, with a start date of 11/24/14, to provide passive range of motion daily to the resident's right hand.</p> <p>The resident's 12/2014 and 1/1/15 - 1/13/15 Treatment Record documented the resident had received passive range of motion daily to the right hand. The Treatment Record did not have any other information.</p> <p>The resident's medical record did not include a care plan for passive range of motion.</p> <p>On 1/15/15 at 6:25 p.m. the DON stated the nurses did range of motion daily with the resident by opening her hand as far as possible, without hurting the resident and washing it with warm water. The DON stated the nurses would administer pain medication prior to the treatment as it did cause the resident pain. The MDS Coordinator stated a care plan had not been developed for range of motion for the resident.</p> <p>The DON and the Administrator were informed of the above concerns on 1/16/15 at 2:15 p.m. The facility provided no further information.</p> <p>4. Resident #2 was admitted to the facility on 11/4/14 with multiple diagnoses which included</p>	F 280			

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F 280	<p>Continued From page 8 rehabilitation care, fracture of left ankle, and diabetes mellitus.</p> <p>a. The Therapy Plan of Care, dated 11/4/14, documented the resident required a maximum assist of 2 persons for safe mobility.</p> <p>The ADL Plan of Care, dated 11/4/14, documented the resident needed extensive assistance for transfers, dressing, and toileting.</p> <p>On 1/14/15 at 12:15 PM, the TD (Therapy Director) was interviewed and stated the plan of care had not changed since admission. He stated they re-evaluated resident needs every 30 days and, if there were changes, then changes to the care plan would be made at that time. The TD was shown the Therapy Plan of Care and asked if the resident was still a two person assist for transfers. The TD stated the resident was now a one person and the change had been documented on the white board inside the resident's closet, which was how they communicated with nursing. The TD stated he would have been responsible for updating the plan of care and he must have missed it in this case.</p> <p>b. The Bladder Plan of Care, dated 11/21/14, documented an intervention to assess for bladder retraining program, initiated at admit.</p> <p>The resident's medical record documented that a Bowel and Bladder Training had been initiated on 11/4/14.</p> <p>c. The Depression Plan of Care, dated 11/5/14, documented medication interventions but did not document non-pharmacological interventions</p>	F 280			

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F 280	Continued From page 9 such as encourage activities, discuss family, etc. On 1/16/15 at 9:10 AM, the DON was interviewed regarding care plan concerns for therapy, bladder and depression. The DON acknowledged agreement that the plan of cares needed to be revised and updated. She added, "I don't see any interventions as far as depression. It should be customized to what she (the resident) actually exhibits as depression and there should be non-pharmacological interventions." 5. Resident #4 was admitted to the facility on 9/25/14 with multiple diagnoses which included rehabilitation care, chronic ulcer of the skin, ulcer of lower limb, and edema. The Fall Risk Plan of Care, dated 9/25/14, documented the resident was a two person extensive assist for transfers. The Quarterly MDS Assessment, dated 1/8/15, documented the resident was a limited assistance of 1 person for bed mobility, transfer, toilet use, personal hygiene, bathing, and locomotion on and off the unit On 1/16/15 at 10:45 AM, the DON was interviewed regarding the Fall Risk Plan of Care and stated the care plan should have been revised. On 1/16/15 at 2:15, the Administrator and DON were made aware of the concerns regarding care plans. No further information was provided by the facility.	F 280			
F 281 SS=D	483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	F- 281 SS=D §483.20(k)(3)(I) - Services Provided Meet Professional Standards	2/28/2015	

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F 281	Continued From page 10 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and the facility's policy and procedure for Obtaining a Fingerstick Glucose Level, it was determined the facility failed to ensure professional standards of quality of care were maintained. This was true for 1 of 9 sampled residents (#2), and 2 of 2 random residents (#s 11 & 12) observed during the medication pass observation when medications were initiated prior to administration and when blood glucose (BG) procedures were not followed correctly. Failure to adhere to professional standards of care created the potential for harm should residents not receive appropriate pain control or inaccurate doses of insulin sliding scale (SS). Findings included: 1. Informational Letter #97-3, dated April 16, 1997: The Medication Distribution Technique Clarification To Informational Letter, 96-14, from the Bureau of Facility Standards, stated, "The issue arose when the Board of Nursing received information that long term care facility staff were signing medications as given at the time of the medication preparation, not after the resident actually received the medication. ...the Board's expectation, and the accepted standard of practice, is that licensed nurses document those things they have done, not what they intend to do." During medication pass on 1/13/15 between 8:55 AM - 9:35 AM, LN #2 was observed to pre-initial	F 281	F-281 continued... <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i> LN #2 will be provided with a 1:1 in-service education by the Director of Nursing or LN designee by 02/20/2015, regarding F-281 on the importance of initialing after medication is passed and not prior to administration. LN #2 & LN #3 will be given a 1:1 in-service education by the Director of Nursing or LN designee by 02/20/2015 on F-281 with regards to on the importance of using the second drop of blood for testing and using a cotton ball to wipe away the first drop of blood instead of alcohol swab when obtaining glucose level. <i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i> This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, to address residents who may have the potential to be affected by this deficiency, the Director of Nursing or LN designee will in-service by 02/20/2015; · All License Nurses regarding F-281 on the importance of initialing after medication is passed and not prior to administration. · All License Nurses regarding F-281 on the importance of using the second drop of blood for testing and using a cotton ball to wipe away the first drop of blood instead of alcohol swab when obtaining glucose level.		

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F 281	<p>Continued From page 11</p> <p>medications for three different residents as follows:</p> <p>a) Resident #2's - Norco and Robltussin DM; b) Resident #11's Tylenol; and, c) Resident #12's Oxycodone.</p> <p>On 1/13/15 at 8:50 AM, LN #2 was interviewed regarding the pre-initial of medications. She stated she was nervous and remembered to initial medications after giving them when she came to the fourth resident.</p> <p>On 1/13/15 at 1:40 PM, LN #2 was again observed to pre-initial Resident #12's Oxycodone.</p> <p>2. Clinical Nursing Skills, 7 7th edition, 2010, by Potter and Perry, pages 1155 and 1156, stated, "... 9 Choose puncture site. Puncture site should be vascular... 11 Clean site with antiseptic swab, and allow it to dry completely ... Alcohol can cause blood to hemolyze. ... 14 Wipe away first droplet of blood with cotton ball... First drop of blood may contain more serous fluid than blood cells. ... 15 Lightly squeeze puncture site (without touching) until large droplet of blood has formed... 16 Obtain test results. ... "</p> <p>The facility's policy and procedure for Obtaining a Fingerslick Glucose Level, in the Steps in Procedure section, documented, "Obtain a blood sample by using a sterile lancet (a spring-loaded lancet or manual lancet). Discard the first drop of blood if alcohol is used to clean the fingertips because alcohol may alter the results."</p> <p>On 1/13/15 at 12:10 PM, LN #2 was observed as she performed a BG check for Resident #2. The LN used a single alcohol swab to clean the</p>	F 281	<p>F-281 continued...</p> <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>To ensure that the deficient practice does not recur, by 02/20/2015 the Director of Nursing or LN designee will do a Medication Administration Skill Check focusing on ensuring that;</p> <ul style="list-style-type: none"> All Licensed Nurse(s) sign their initial in the Medication Administration Record (MAR) after medication is passed and not prior to administration. All Licensed Nurse(s) are using the second drop of blood for testing and using a cotton ball to wipe away the first drop of blood instead of alcohol swab when obtaining glucose level. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through;</p> <ul style="list-style-type: none"> The DNS or LN designee will perform visual observation of at least three (3) of the medication passes to ensure that the Licensed Nurse(s) sign their initials in the Medication Administration Record (MAR) after medication is passed and not prior to administration. The DNS or LN designee will perform visual observation of at least three (3) glucose level checks to ensure that the Licensed Nurse(s) are using the second drop of blood for testing and using a cotton ball to wipe away the first drop of blood instead of alcohol swab. <p>Monitoring will start on 02/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p>	
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F 281	Continued From page 12 resident's fingertip and used the first blood droplet to check the BG level. The result was 227. On 1/13/14 at 4:40 PM, LN #2 stated she normally used the first droplet. The surveyor referred to the facility's policy and procedure for obtaining a fingerstick glucose. LN #2 stated, "I will try to work on that." 3. On 1/15/15 at 12:20 PM, LN #3 was observed as she performed a BG check for Resident #8. She used a single alcohol swab to clean the resident's fingertip, wiped the first droplet of blood with an alcohol swab and used the second droplet to check the BG level. The result was 269. LN #3 was interviewed on 1/15/15 at 12:40 PM, and stated her normal procedure was to use alcohol swabs. She stated she was not aware that alcohol could alter the results. On 1/15/15 at 3:35 PM, the DON was informed of the above observations. The DON stated she would put out an education inservice with the policy and procedure attached for her nursing staff immediately. The facility offered no further information.	F 281	F-281 continued... The DNS or LN designee will present to the quarterly QA&A Committee meeting any findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	F-309 SS=D §483.25) - Provide Care/Services for Highest Well Being <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i>	2/28/2015	

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F 309	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to follow residents' physician orders related to compression stockings and nutritional supplements. This was true for 2 of 11 sampled residents (#s 1 & 5). Additionally the facility failed to monitor behaviors for a resident with dementia (#5) receiving an antidepressant. This created the potential for harm if the residents did not receive the care or services for their current needs. Findings included:</p> <p>1. Resident #1 was admitted to the facility on 4/30/14 with diagnoses which included hemiplegia and cerebrovascular disease.</p> <p>The resident's 1/1/15 recapitulation Physician Orders included an order to wear compression stockings during the day and off at bedtime with a start date of 4/30/14.</p> <p>The resident's 5/20/14 Risk for Hypertension Care Plan documented in the Intervention section to wear compression hose during the day and off at night.</p> <p>During observations on 1/13/15 at 12:30 p.m. and at 6:30 p.m. the resident was observed not wearing compression stockings.</p> <p>On 1/15/15 at 4:30 p.m., the DON was informed of the above concern. The facility provided no further information.</p> <p>2. Resident #5 was admitted to the facility on 8/27/09 with diagnoses which included muscle</p>	F 309	<p>F-309 continued...</p> <p>The License Nurse(s) identified during the survey assigned for Res. #1 on 01/15/2015 at 12:30 pm-6:30 pm will be provided with a 1:1 in-service education by the Director of Nursing or LN designee with regards to F-309 on the importance of following physician's order related to compression stockings.</p> <p>Res. #5, On 02/01/2015 the February Medication Administration Record was reviewed by the Director of Nursing to ensure that the 8 oz Nutritional supplement matches the 12/30/2014 physician's order on the frequency as TID.</p> <p>With regards to Res. # 5 behavior monitor for her anti-depressant, by 02/20/2015 All License Nurses will be provided with an in-service education by the Director of Nursing or LN designee regarding F-309 with emphasis on the importance of complete and accurate documentation in the Behavior Monitoring Flow sheet's (BMF) during their shift.</p> <p><i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i></p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. Although, to address other Residents that may have the potential to be affected by this deficiency;</p> <p>By 02/20/2015, a visual observation will be done by Director Nursing or LN designee to ensure that all current Residents with physician orders for compression stockings are being implemented according to physician's order.</p>		

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F 309	Continued From page 14 weakness and dementia. The resident's medical record included an order to "Increase supplement to 8 oz nutritional supplement..." three times a day. The order was signed by the physician at 9:00 p.m. on 12/30/14. The resident's 1/1/15-1/13/15 Medication Record documented the resident had received the 8 ounce house supplement 2 times each day. On 1/15/15 at 6:25 p.m., the DON was informed of the above concern. No further information was provided. On 1/16/15 at 2:15 p.m., the Administrator and the DON were informed of the above concerns. The facility offered no further information. The DON and the Administrator were informed of the above concerns on 1/16/15 at 2:15 p.m. The facility provided no further information.	F 309	F-309 continued... · By 02/20/2015, all current Residents with orders for nutritional supplements will be reviewed by the Director of Nursing or LN designee to ensure they are transcribed in the Medication Record as ordered by the physician. · All Behavior Monitoring sheets will be reviewed by the Director of Nursing or LN designee 02/20/2015, to ensure that they are filled out completely and appropriately. <i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i> To ensure that the deficient practice does not recur, through root cause analysis that was done by the Director of Nursing and Administrator, it was determined that previous citations in F309 were related to other systems. Thus focus will be on the below educational areas.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and resident, family and staff interview, it was determined the facility failed	F 323	· By 02/20/2015 all License Nurses will be in-serviced by DNS or designee regarding F-309 about the importance of ensuring appropriate implementation of compression stockings when ordered by the physician. · By 02/20/2015 a 1:1 in-service education to the Health Information Manager regarding F-309 on the importance of following the physician's order when completing an entry. Starting on 02/23/2015, The IDT Team or designee during their scheduled stand up meeting will; · Review at least a sampling of five (5) Behavior Monitor Flow Sheets (BMF) to ensure completion and accuracy.	

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NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202	
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F 323	<p>Continued From page 15</p> <p>to implement interventions to prevent falls. This was true for 2 of 9 sampled residents (#s 3 & 4). Resident #4 was harmed when she fell twice after being given a medication for sleep, and needed staples for a laceration to the back of her head. The resident suffered additional harm when identified fall interventions were not implemented, the resident fell again, and sustained a laceration to her knee which required emergency treatment. The potential for harm was created when Resident #3 fell as a result of not having her call light within reach. Findings included:</p> <p>1. Resident #4 was admitted to the facility on 9/25/14 with diagnoses that included rehabilitation care, chronic ulcer of the skin, ulcer of lower limb, and edema.</p> <p>The Nursing Admission Assessment, dated 9/25/14, documented the resident had fallen in the past 30 days, had muscle weakness, an unsteady gait, used a walker and required others to propel her when in a wheelchair.</p> <p>The Fall Risk Assessments, dated 9/25, 10/2, 10/8, and 10/11 documented the resident was not considered at high risk for potential falls.</p> <p>A Fall Risk Care Plan, initiated on 9/25/14, documented interventions to observe gait for unsteadiness, report observed medication side effects to MD, call light within reach, assist with transfers, provide necessary assistance with transfer, keep area free of clutter, encourage participation to extent able, and needed two person extensive assistance for transfers.</p> <p>The resident's Admission MDS, dated 10/8/14, documented the resident was cognitively intact</p>	F 323	<p>F-309 continued...</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through:</p> <p>The DNS or LN designee will do visual observation and/or review;</p> <ul style="list-style-type: none"> · Sampling of three (3) current Residents to ensure that physician orders for compression stockings are being implemented according to physician's order. · Sampling of three (3) current Residents with orders for nutritional supplements to ensure they are transcribed in the Medication Record as ordered by the physician. · Sampling of three (3) current Residents with Behavior Monitoring sheets to ensure that they are filled out completely and accurately. <p>Monitoring will start on 02/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The DNS or LN designee will present any findings and/or corrective actions taken to the Administrator his/her designee and to the QA&A Committee, during their quarterly QA&A meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	

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F 323	<p>Continued From page 16 with a BIMS score of 15. The resident had impairment on one side when assessed for functional limitation in range of motion, and needed extensive assistance of 1 person for bed mobility, transfer, walk in room, and toilet use. The MDS noted that "never or 1 day" during the look-back period the resident had difficulty with sleep.</p> <p>A Physician's Telephone order, dated 10/9/14, documented an order for Ambien 5 mg one tab PO (per oral) Q (every) HS (hour of sleep) for the diagnosis of insomnia and was signed by the physician.</p> <p>The October 2014 Medication Record documented the resident received Ambien nightly 10/9/14 through 10/25/14, and was discontinued on 10/27/14.</p> <p>A care plan for the problem, "resident is attempting to self transfer," dated 10/9/14, and marked x 2 weeks, documented interventions to include education concerning call light and using request assistance. A line was drawn diagonally through the care plan and marked resolved. No documentation was found as to why the care plan was in effect for only two weeks, why it had been resolved, the date it was resolved, or initials of who discontinued the care plan.</p> <p>Patient Fall Scene Investigation & Incident Reports (FSI), dated 10/11/14 and 10/25/14, documented the following:</p> <p>a) An FSI, dated 10/11/14 at 1:00 AM, documented an unwitnessed fall on 10/11/14 at 12:00 AM (midnight). The FSI documented staff responded to a loud noise and found the resident</p>	F 323	<p>F-323 SS= G §483.25(h) - Free of Accident Hazards/Supervision/Devices</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>Res. #4, Ambien was discontinued on 10/27/2014.</p> <p>Res. #4 " Pt attempting to self transfer," was a temporary x 2 week short term care plan. That is why a diagonal line was drawn through it and was marked resolved after it was transcribed to the long term care plan. The MDS Coordinator will be provided a 1:1 in-service education by the Director of Nursing or LN designee by 02/20/2015 with regards to F-323 with emphasis on the importance of:</p> <ul style="list-style-type: none"> · Documenting in the short term temporary care plan the reason for resolving it i.e. if it discontinued or if it is due to bringing it forward in the long term care plan. · Dating when care plan is resolved. · Initialing when discontinued. <p>Res. #4, bed alarm was discontinued on 12/15/2014.</p> <p>Res. #4 continues to be alert and oriented and is able to make decisions i.e. with regards to exercising her right to self determination for example: asking for or not asking for assistance, or using or not using her call light.</p> <p>Res. # 3, the Nurse assigned to the resident who did not marked the box for "none apparent injury," is no longer an employee of the facility. There was no injury related to Res. # 3 fall incident on 12/25/2014.</p>	2/28/2015	

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F 323	<p>Continued From page 17</p> <p>lying on the floor with a laceration to her head, which was bleeding. She was transported to a local hospital where the laceration to her scalp was sutured with 8 staples and she returned to the facility. The FSI documented the resident got up to change her TV, but did not use her call light, which was within reach. The New Interventions section documented, "Education w/patient on importance of getting help when trying to get up." The Root Cause section documented, "Patient attempted to self transfer." The initial interventions to prevent future falls documented, "Education with patient on importance of asking for help."</p> <p>A Physician's Telephone Order, dated 10/11/14, documented a bed alarm was added for safety.</p> <p>A care plan for the problem, "resident is attempting to self transfer," dated 10/11/14, marked x 2 weeks, documented interventions to orient/educate the resident concerning call light use, encourage to use call light, request staff assistance, and bed alarm to alert for staff assistance.</p> <p>A Fall Risk Assessment, dated 10/11/14, documented the resident was not considered at high risk for potential falls.</p> <p>b) An FSI, dated on 10/26/14 at 1:00 AM, documented an unwitnessed fall on 10/25/14 at 11:35 PM. The FSI documented the resident was found on the floor of her bathroom in a sitting position with a large open wound to her right knee which was bleeding. The resident was transported to a local hospital. The New Interventions section documented, "None at this time. [Name of resident] expressed concerns</p>	F 323	<p>F-323 continued...</p> <p>Res. # 3, a visual observation will be done by the Administrator by 02/20/2015, to ensure that all current residents call lights are within reach.</p> <p><i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i></p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. Although, to address other Residents that may have the potential to be affected by this deficiency;</p> <ul style="list-style-type: none"> - By 02/20/2015, a Behavior Monitor Flow Sheet will be initiated for any resident who has an order for Ambien to ensure that hours of sleep and side effect are being monitored every shift. - By 02/20/2015 the Administrator or designee will inspect all Residents that have bed alarms to ensure that the bed alarms are functional. - By 02/20/2015 visual observation on all three shifts will be done by the Administrator or designee to ensure that call lights are within reach on all current residents who use a call light. <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>To ensure that the deficient practice does not recur, by 02/20/2015 all License Nurses will be in-serviced by the Director of Nursing or LN designee on F-323 regarding the following measures put into place:</p>		

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F 323	<p>Continued From page 18</p> <p>re: functions of call light - she was educ. [ated] re: call light above door of her room and how to tell if it's on by looking at wall (light) in her room. She did demonstrate appropriate use of call light." The Root Cause section documented, "Pt. attempted to self ambulate to the restroom and did not use her call light which was on her bed. Pt. was under the influence of Ambien and may not have been fully awake." The initial interventions to prevent future falls documented, "[Name of resident] shown how to determine if call light is on. Order for Ambien discontinue obtained from physician."</p> <p>A Nursing Note, dated 10/25/14 at 11:35 PM, documented, "Pt [Patient] found on floor sitting against wall in her bathroom. Staff reacted within seconds to a crash heard down 100 Hall. Pt was severely lacerated (10 cm x 10 cm) on right knee. EMS was activated by 2340 [11:40 PM]. Pt transported to [a local hospital] @ [at] 2405 [12:05 AM] by ambulance."</p> <p>A local hospital ER (Emergency Room) report, dated 10/26/14 at 12:24 AM, documented the resident had a right anterior knee skin tear with exposed subcutaneous tissue. The report documented the resident had a "full thickness skin tear...flap too far retracted to allow suturing...X-rays negative...will hold Coumadin x 2 days and recheck Monday." The report documented dressing to the right knee and the resident returned to the facility.</p> <p>The FSI further documented the resident received Ambien at 9:00 PM and was observed sleeping at 10:30 PM. The root cause documented the resident was under the influence of Ambien and may not have been fully awake.</p>	F 323	<p>F-323 continued...</p> <ul style="list-style-type: none"> · That a behavior Monitor Flow Sheet will be initiated for any resident who has an order for Ambien to ensure that hours of sleep and side effects are being monitored every shift. · Orders for bed alarms to include every shift check to ensure that the bed alarm is in place and is functioning. · Rounds will be performed every shift by Administrator or designee to ensure call lights are in reach on all current residents who use a call light. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through:</p> <ul style="list-style-type: none"> · The Director of Nurses or LN designee will review at least three (3) Residents on Ambien to ensure that hours of sleep and side effect are being monitored every shift. · The Director of Nurses or LN designee will do visual observation of at least three (3) Residents to ensure that bed alarm is in place and functional on residents who have orders for bed alarm. · The Director of Nurses or LN designee will do visual observation of at least three (3) Residents who use a call light to ensure their call light is with in reach. <p>Monitoring will start on 02/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p>	

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F 323	<p>Continued From page 19</p> <p>The interventions added to prevent falls were to educate the resident on how to determine when the call light was on and to discontinue the order for Ambien.</p> <p>The DON documented on the FSI, the resident stated, "I got up and went into the bathroom...walker tipped on me." The DON documented the resident was able to use her call light appropriately and was encouraged to seek staff assistance with transfer.</p> <p>A care plan for the 10/25/14 fall, documented interventions to observe the resident for three days for signs and symptoms of complaint of injury, notify physician with any concerns, nurse to re-educate resident and answer questions regarding how to tell if call light is on.</p> <p>A care plan, dated 10/27/14, for not utilizing the call light for toileting assistance and transfers, self transferring, and Ambien use, documented interventions to discontinue the Ambien in favor of Melatonin, educate resident in call light use, encourage to utilize (call) light and staff assistance for transfers and ambulation, and to monitor the resident for one week for effectiveness of discontinued Ambien related to confusion at night.</p> <p>On 1/13/15 at 4:15 PM, one of the the resident's family stated, "things were bad at first...things are better now, they check on her more."</p> <p>On 1/14/15 at 11:20 AM, the surveyor interviewed Resident #4 regarding the 10/11 and 10/25 falls. She stated the falls could have been due to a combination of medications and she did not use her call light. The resident stated, "For a while</p>	F 323	<p>F-323 continued...</p> <p>The facility Director of Nursing or LN designee will submit to the Administrator or designee and to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	

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F 323	<p>Continued From page 20</p> <p>there, I was taking sleep medication and I didn't know about it."</p> <p>On 1/16/15 at 10:45 AM, the DON was interviewed regarding the 10/11 and 10/25 falls. She stated a bed alarm was added 10/11, after the first fall. The surveyor asked the DON if the bed alarm was working when the resident fell on 10/25, since a NN documented staff had responded to "a crash." She stated she would check into it. The DON stated, after the second fall on 10/25, the LN on duty thought the Ambien could have caused the fall. The LN documented this as being the root cause on the FSI, and Ambien was discontinued on the 10/27. The DON explained the resident was re-educated in call light use and encouraged to utilize the call light for staff assistance with transfers or ambulation.</p> <p>On 1/16/15 at 12:50 PM, the DON provided a copy of the TAR for the month of November 2014 which documented bed alarm checks. When asked if the bed alarm was on and working for the 10/25/14 fall, the DON responded, "I can't answer that."</p> <p>The facility failed to provide an increase in supervision to keep the resident from falling after a sleep medication was added to the resident's medication regimen. Resident #4 was harmed when she fell and required 8 staples to a laceration to her head. The facility was unable to determine why the bed alarm did not alert staff the resident had gotten out of bed.</p> <p>2. Resident #3 was admitted to the facility on 12/9/14 with acute myocardial infarction (heart attack), encephalopathy (abnormal brain function) and a urinary tract infection.</p>	F 323		

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F 323	Continued From page 21 A 12/25/14 Incident/Accident Report (IA) documented the resident was "found on floor next to bed. PT [patient/resident] says trying to get up..." The area to document injuries was blank. The Root Cause section of the IA documented the resident needed to get up and the call light was "clipped to wall outlet." Interventions identified to prevent future falls documented the call light needed to be within reach. On 1/15/15 at 4:50 PM the DON stated, "It is expected the call light is within reach at all times." The Administrator was present and stated the facility had provided staff training, after the incident, to ensure residents' call lights were always within reach.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents who used oxygen receive the	F 328	F- 328 SS=D §483.25 (k) - Treatment/Care for Special Needs <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i> Upon identification during the survey, Res. # 2 O2 nasal cannula was put back to the Resident nose. In regards to Res. #2, the LN #2 was provided with a 1:1 in-service education regarding F-328 with emphasis on the importance of putting O2 back on residents after breathing treatments. Res. #2 oxygen order was clarified with the physician by the Director of Nursing on 02/12/2014, new clarified oxygen order is "Oxygen 2 LPM via nasal cannula continuous to keep O2 sats >90 %."	2/28/2015

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F 328	<p>Continued From page 22</p> <p>liter flow ordered by the physician. This was true for 1 of 9 residents (#2) reviewed for oxygen therapy. This deficient practice created the potential for more than minimal harm should residents have a drop in oxygen saturations causing them to become anxious, confused and experience respiratory distress. Findings included:</p> <p>Resident #2 was admitted to the facility on 11/4/14 with multiple diagnoses including rehabilitation care, fracture of left ankle, and diabetes mellitus.</p> <p>On 1/13/15 at 8:40 AM, the surveyor observed the resident to have labored breathing when conversing with the surveyor. The resident was not wearing oxygen but did have a concentrator sitting against the wall near her bed with oxygen tubing wrapped neatly on top of the concentrator. The surveyor immediately alerted LN #2 who was outside the resident's room. LN #2 stated, "I just gave her a breathing treatment and should have put her oxygen back on at 2 liters (L)." The surveyor asked LN #2 to please check the oxygen saturations, which were 83%. LN #2 immediately turned on the oxygen at 2 L and placed the nasal cannula in the resident's nose. LN #2 then checked the oxygen saturations which were 92%. LN #2 stated, "The order for oxygen is to titrate to keep sats [saturation levels] greater than 90%."</p> <p>The January 2015 Physician Orders (recapitulation orders) documented a 11/4/14 order for oxygen at 2 liters per minute via nasal cannula titrate to keep sats greater than 90% for the diagnosis of dyspnea (shortness of breath). NOTE: The oxygen order did not give a range for</p>	F 328	<p>F-328 continued...</p> <p><i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i></p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. Although, to address residents who may have the potential to be affected by this deficiency;</p> <ul style="list-style-type: none"> · A visual observation will be done by the Director of Nursing or LN designee by 02/20/2015 to ensure that following the resident's breathing treatments their oxygen nasal cannula is put back to the Resident nose. · A review of all oxygen orders will be done by the Director of Nursing or LN designee by 02/20/2015 to ensure that oxygen orders have a range for titration. <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>To ensure that the deficient practice does not recur;</p> <p>The Director of Nursing or LN designee will provide an in-service education to all License Nurses by 02/20/2015 with regards to F-328 with emphasis on the importance of:</p> <ul style="list-style-type: none"> · Ensuring that after the resident's breathing treatments their oxygen nasal cannula is put back to the Resident nose. · Making sure that oxygen orders have a range for titration. 		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135136	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2015
NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 23 titration and was not PRN (as needed). The January 2015 Treatment Record documented day and night shift oxygen saturation levels. On 1/16/15 at 9:10 AM, the DON was made aware of the labored breathing observation on 1/13/15. The DON looked at the oxygen order on the recapitulation orders and stated, "It is a continuous order." On 1/16/15 at 2:15 PM, the Administrator and DON were informed of the oxygen therapy concern. No further information was provided.	F 328	F-328 continued... Starting on 02/23/2015, new oxygen orders will be reviewed by the Interdisciplinary Team (IDT) or their designee during their scheduled stand-up meeting to ensure that oxygen orders have a range for titration. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i> Monitoring will be done through: · The DNS or LN designee will do a visual observation of at least (3) residents receiving breathing treatments to ensure that following residents breathing treatments their oxygen nasal cannula is put back to the resident nose. · The DNS or LN designee will review at least (3) oxygen orders to ensure that oxygen orders have a range for titration. Monitoring will start on 02/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The Director of Nursing or designee will submit to the Administrator or his/her designee and to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A Committee Meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		

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F 329	<p>Continued From page 24 drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure 3 of 6 sample residents (#s 1, 4, & 5) were free from unnecessary medications. The facility failed to monitor behaviors related to psychopharmacological use, failed to implement a physician ordered gradual dose reduction and failed to ensure residents were free from unnecessary medication. This practice placed residents at risk for unanticipated declines or newly emerging or worsening symptoms. Findings included:</p> <p>1. Resident #5 was admitted to the facility on 8/27/09 with diagnoses which included muscle weakness and dementia.</p> <p>The resident's 1/1/15 recapitulation Physician Orders included an order for Lorazepam (anxiolytic) 0.6 mg daily for anxiety with a start date of 5/18/13. A handwritten note on a different page documented, "when current Lorazepam exhausted change to Lorazepam 0.25 ..." The start date was documented as 12/10/14. The hand written entry was not initialed or signed.</p> <p>The resident's Medication Record for 1/1/15-1/14/15 documented the resident had received 0.5 mg Lorazepam every day.</p> <p>The Medication Regimen Reviews signed by the</p>	F 329	<p>F- 329 SS=D §483.25(l) - Drug Regimen is Free from Unnecessary Drugs</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>Res. #5, Resident is currently on a gradual dose reduction for Lorazepam, on 02/09/2015 physician ordered for 0.25mg PO every other morning for two weeks for 8 dose then stop if doing okay with taper.</p> <p>Res. #5, The handwritten note on the 01/01/15 recapitulation that the surveyor identified as not initialed or signed by the License Nurse was actually signed by the License Nurse with her full first name and last name, it was signed on that bottom of that particular page and that could be why the surveyor may have not noticed the signature. Although, the License Nurse will still be provided with a 1:1 in-service education by the Director of Nursing by 02/20/2015 regarding F-239 with emphasis on the importance of initialing or signing on hand written physician orders being brought forward when doing recapitulation.</p> <p>Res. # 5, By 02/20/2015 the MDS Coordinator will revise the behavior care plan to identify separate problems i.e. Depression and Anxiety:</p> <ul style="list-style-type: none"> Resident behavior care plan for the use of anxiolytic that will include how specific behaviors of restlessness or anxiety are exhibited, how the resident is resistant to care, and how long to wait prior to re-approaching the resident and the observation for side effects of the anxiolytic will also be added in the intervention section. Depression care plan will be revised to include how expression(s) of sadness are exhibited. 	2/28/2015

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F 329	<p>Continued From page 25</p> <p>pharmacist documented a recommendation to decrease Lorazepam to 0.25 mg on 11/22/13, 3/17/14, 4/28/14, 6/23/14, 7/25/14 and 11/25/14.</p> <p>A 11/25/14 Consultation Report from the pharmacist documented the medication review committee recommended the Lorazepam be reduced to 0.25 mg. The physician had accepted the recommendation and signed the report on 12/8/14.</p> <p>On 1/15/15 at 6:25 p.m., the DON stated she would check if the Lorazepam had been reduced to 0.25 mg. No further information was provided by the facility such as the number of 0.5 mg doses left.</p> <p>Additionally it was unclear when Lorazepam was to be administered. The resident's 9/29/11 (revised 10/17/14) "Psych/Soc" care plan identified the use of psychoactive medications for behaviors of sadness and restlessness. The intervention section identified to monitor side effects of an antidepressant, but did not include any information related to an anxiolytic (relieving anxiety). The resident's care plans for behaviors of abusive to staff and refusal of care did not identify the use of an anxiolytic.</p> <p>The resident's 1/1/15 recapitulation Physician Orders included orders for Citalopram (antidepressant) 10 mg daily for depression with a start date of 5/18/13.</p> <p>The resident's 9/29/11 (revised 10/17/14) Care Plan for psychoactive medications for anxiety and depression documented in the problem section expressions of sadness and restlessness.</p>	F 329	<p>F-329 continued...</p> <p>By 02/20/2015 All License Nurses will be provided with an in-service education by the Director of Nursing or LN designee regarding F-329 with emphasis on the importance of complete and accurate documentation in the Behavior Monitoring Flow sheet's (BMF) during their shift.</p> <p>Res. #5, Behavior care plan of physical abusiveness to staff was resolved on 01/29/2015 by the MDS Coordinator as resident is currently no longer abusive to staff.</p> <p>Res. #1, By 02/20/2015 All Licensed Nurses will be provided with an in-service education by the Director of Nursing or LN designee regarding F-329 with emphasis on the importance of complete and accurate documentation in the Behavior Monitoring Flow sheet's (BMF) during their shift.</p> <p>Res. #4, Ambien was discontinued on 10/27/2014.</p> <p><i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i></p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. Although, this deficiency has the potential to impact any resident receiving a psychotropic medication, hence by 02/20/2015 the Director of Nursing or LN designee;</p> <ul style="list-style-type: none"> · Will review each current resident on a psychotropic medication to ensure complete and accurate documentation on the behavior monitoring flow sheet. · Will review all Behavior care plans to ensure that they are modified to define how behaviors are exhibited, and that interventions are resident specific. 		

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F 329	<p>Continued From page 26</p> <p>The goal section documented the medication would be effective as evidenced by a decrease in anxiety as exhibited by sadness and restlessness.</p> <p>The intervention section documented the medications would be assessed: for effectiveness, need for a psychiatric evaluation or social service consult, side effects of medication, and a dose reduction. The Intervention or the goal section did not include how expressions of sadness were exhibited (statements of being worthless, thoughts of dying, crying etc.). Additionally there was no specific behaviors identified for how restlessness or anxiety was exhibited (rocking in wheelchair, wringing hands, tapping foot etc.).</p> <p>The resident's 9/28/09 resistant to care plan had a goal to improve behaviors. The interventions included to redirect the resident when upset, allow resident to verbalize and to reapproach at a later time.</p> <p>The care plan did not include how the resident was resistant to care such as refusing carrot (hand contracture device), resisting peri care etc. Additionally the care plan did not include how long to wait prior to re-approaching the resident.</p> <p>The Behavior Monitoring Flowsheet's (BMF) for November and December 2014 and January to current date of 1/13/15 had spaces for each shift (day evening and night) to document restlessness, sadness and non-compliance with the carrot.</p> <p>The BMF for 1/1- 1/13/15 documented the resident exhibited no incidents of restlessness 12</p>	F 329	<p>F-329 continued...</p> <ul style="list-style-type: none"> Will review each resident on psychotropic medications to make sure that the resident or responsible party is notified of the prescribed psychotropic medication. <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>Systematic measure that will be put in place will be starting on 02/23/2015,</p> <p>The IDT Team or their designee during their scheduled stand up meeting will;</p> <ul style="list-style-type: none"> Review new order(s) of psychotropic medication to ensure that Behavior Care Plans are in place to define how behaviors are exhibited and that the Behavior Monitor Flow sheet (BMF) is updated, and that interventions are resident specific. Review new order(s) of psychotropic medication to make sure that resident or responsible party is notified of the prescribed psychotropic medication. Review at least a sampling of five (5) Behavior Monitor Flow Sheets to ensure completion and accuracy. 	

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F 329	<p>Continued From page 27</p> <p>out of 13 days and the intervention of 1 on 1 was not effective 6 of the days. The night shift documented no days with behaviors and 13 days the intervention of 1 on 1 was not effective. BMF's for 11/15 and 12/15 had similar documentation.</p> <p>Note: The intervention of 1 on 1 did not clarify how long the 1 on 1 was or how to implement the intervention (look at photographs, discuss pets, etc.).</p> <p>The resident's 9/28/09 "Psych/Soc" care plan identified behaviors of physical abuse of staff exhibited by hitting and kicking. The goals were to decrease incidents of hitting and kicking and to "to have less episodes of depression evidenced by relaxed and contented periods..."</p> <p>Interventions included to ask the resident to explain the needs for the abuse and to remain calm and "adopt a non-critical approach and state boundaries on behavior in a firm, but gentle manner."</p> <p>The facility did not provide any documentation of the number of times the behaviors of hitting and kicking were exhibited.</p> <p>The facility failed to document behaviors exhibited and provide clear indication for the use of the antidepressant or the anxiolytic. On 1/15/15 at 6:25 p.m. the MDS Coordinator and the DON stated the care plan interventions were not resident specific and the BMS were inaccurate.</p> <p>2. Resident #1 was admitted to the facility on 4/30/14 with diagnoses which included hemiplegia and cerebrovascular disease.</p>	F 329	<p>F-329 continued...</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through the Director of Nursing or LN designee who will:</p> <ul style="list-style-type: none"> Review at least three (3) new orders of psychotropic medications to ensure That Behavior Care Plans are in place to define how behaviors are exhibited and that the Behavior Monitor Flow sheet (BMF) is updated, and that interventions are resident specific. Review at least three (3) new orders of psychotropic medications to make sure that the resident or responsible party is notified of the prescribed psychotropic medication. Reviewed at least three (3) Behavior Monitor Flow Sheets to ensure completion and accuracy. <p>Monitoring will start on 02/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Director of Nursing or LN designee will submit to the Administrator or designee and to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>		

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F 329	<p>Continued From page 28</p> <p>Resident #1's Care Plan , related to delusions regarding her spouse, documented the following interventions with a start date of 9/15/14 to: reward positive behavior with positive feedback, compliment resident and/or spend time with the resident, identify if behavior is due to an unmet need, remain calm, adopt a non-critical approach and state boundaries on behavior in a firm but gentle manner and allow resident time and space to regain control.</p> <p>The resident's 1/15 recapitulation Physician Orders included an order for Zoloft (antidepressant) 25 mg every day for depression with a start date of 6/10/14.</p> <p>BMFs' for the resident identified the resident had a diagnosis of depression and received Zoloft.</p> <p>BMFs for 1/15-1/12/15 had a space to document "sadness" daily for day, evening and night shift. The day shift section documented 1 day with 2 incidents of sadness and no interventions implemented. The evening shift documented 5 of the 12 days no behaviors were exhibited but an intervention of 1 on 1 was implemented 12 days. BMS for 11/14 and 12/14 had similar documentation</p> <p>On 1/15/15 at 6:25 p.m., the DON stated the BMF's were not accurate. When asked what information was used to determine if a dose reduction would be attempted, the DON stated the BMFs. When asked how the facility ensured behaviors documented by staff accurately reflected behaviors exhibited by the resident, the DON stated the care plans and BMFs needed to ensure resident specific behaviors were</p>	F 329			

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F 329	<p>Continued From page 29</p> <p>identified. The DON stated the delusions for Resident #1 could be documented in the Nurses Notes. It was unclear how the treatment team would be able to determine if a dose reduction was warranted if the BMFs were inaccurate.</p> <p>On 1/16/15 at 2:15 p.m., the Administrator and the DON were informed of the above concerns. The facility provided no further information.</p> <p>3. Resident #4 was admitted to the facility on 9/25/14 with diagnoses that included rehabilitation care, chronic ulcer of the skin, ulcer of lower limb, and edema.</p> <p>The resident's Admission MDS, dated 10/8/14, documented the resident was cognitively intact with a BIMS score of 15 and had trouble falling asleep, staying asleep, or sleeping too much, with frequency documented as "never or 1 day" in a two week period.</p> <p>A Physician's Telephone order, dated 10/9/14, documented an order for Ambien 5 mg one tab PO (per oral) Q (every) HS (hour of sleep) for the diagnosis of insomnia and was signed by the physician.</p> <p>The medical record documented the resident fell on 10/11/14, two days after the resident was started on Ambien. The resident fell again on 10/25/14. The root cause determined Resident #4 was under the influence of Ambien and may not have been fully awake.</p> <p>The October 2014 Medication Record documented the resident received Ambien 10/9/14 through 10/25/14, and was discontinued</p>	F 329			

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F 329	Continued From page 30 on 10/27/14. A Nurses Note (NN), dated 10/27/14 at 8:00 PM, documented, "Received new order to D/C (discontinue) Ambien and start Melatonin. Family notified." No documentation was found in the resident's medical record which indicated the resident was restless, had trouble falling asleep, staying asleep or had insomnia. No documentation was found that a monitor for sleep had been initiated. On 1/14/15 at 11:20 AM, the surveyor interviewed Resident #4 regarding the 10/11 and 10/25 falls. She stated the falls could have been due to a combination of medications and she did not use her call light. The resident stated, "For a while there, I was taking sleep medication and I didn't know about it." On 1/16/15 at 10:45 AM, the DON was made aware the resident's medical record did not contain documentation that the resident or her family had been made aware she had been prescribed Ambien for sleep. The DON stated she would check for documentation. The facility failed to ensure Resident #4 was free from unnecessary medication. The facility did not ensure the resident needed a medication for sleep, and did not adequately monitor its use. On 2/2/15 at 3:45 PM, the Administrator was informed of the concern with unnecessary medication. No further information was provided by the facility.	F 329			
F 371	483.35(i) FOOD PROCURE,	F 371			

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F 371 SS=E	<p>Continued From page 31</p> <p>STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, it was determined the facility failed to ensure food was prepared and served under sanitary conditions. This affected 11 of 12 sample residents (#s 1-9 and 11-12) and had the potential to affect all residents who dined in the facility. This failure created the potential for contamination of food and exposed residents to potential disease causing pathogens. Findings included:</p> <p>On 1/15/15 at 11:35 AM, Dietary Aide #1 was observed washing dishes in the kitchen without a facial restraint to cover his beard. The Dietary Manager (DM) was present and was asked if the Dietary Aide should have a beard restraint on. She stated she had heard "both" ways, that a beard restraint was required and that it was not required. The DM was informed a beard restraint was required.</p> <p>The 2009 FDA Food Code, Chapter 2, Part 2-4, Hygiene Practices, Hair Restraints, subpart 402.11, Effectiveness, indicates, "(A) Except as provided in ¶ (B) of this section, food employees</p>	F 371	<p>F- 371 SS= E</p> <p>§483.35(i) - Food Procure, Store/Prepare/Serve - Sanitary</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>The employee that was witnessed without a beard restraint was provided a 1:1 in-service education by the Dietary Manager in regards to F-371 on the importance of the requirement for food employees to wear a beard restraint for employees who have a beard.</p> <p><i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i></p> <p>There are no other food employees who currently have beards. Although, all residents may have the potential to be affected by this deficiency, therefore the Administrator on 02/13/2015 verified with the Dietary Manager to ensure that beard restraints are available in the kitchen.</p> <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>Through root cause analysis the DNS and Administrator determined that the previous citations in F-329 were related to other systems, thus focus will be on the below areas of not using a beard restraint by a food employee.</p> <p>To ensure that the deficient practice does not recur;</p> <p><i>Should read F371 per the w/ admin 2/25/15</i></p>	2/28/2015	

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F 371	Continued From page 32 shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (B) This section does not apply to food employees such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff if they present a minimal risk of contaminating exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles."	F 371	F-371 continued... · By 02/20/2015, all Dietary staff (food employees) will be in-serviced by the Dietary Manager or designee regarding F-329, with reference to the importance of the requirement for food employees who have beards to wear beard restraints. · Starting on 02/20/2015, New Dietary Staff (food employees) will be in-serviced by the Administrator or designee regarding F-329, with reference to the importance of the requirement for food employees to wear beard restraints if they have beards. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i> Monitoring will be done through: The Dietary Manager or designee will do visual observation to ensure that dietary staff on duty that have beards are using beard restraints. Monitoring will start on 02/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The Dietary Manager or designee will submit to the Administrator or designee and to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A Committee Meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441			

should read F-371 per TC w/ admin 2/25/15
Asst. Dir.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2015
NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202	
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F 441	<p>Continued From page 33</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to follow standard infection control practices to prevent the spread of infection for 3 of 6 sampled residents (#s 3, 5 & 6). The facility failed to ensure dirty laundry was not placed on the floor, and a neck cushion was cleaned after it was found on the floor before being placed under the resident's head. This placed residents at risk for infection. Findings included:</p> <p>1. On 1/12/15 at 1:50 PM, dirty compression stockings and a wadded up towel were found on the shower floor in Resident #5's room.</p> <p>On 1/12/15 at 2:00 PM, CNA #6 stated, "Whoever put her in bed last night must have left them on</p>	F 441	<p>F- 441 SS=D §483.65 - Infection Control, Prevent Spread, Linens</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>Res. #5: On 1/12/2015 upon identification, the dirty compression stockings and wadded up towel found on shower floor were removed and placed in the soiled linen bin.</p> <p>Res. #6: On 1/12/2015 upon identification, the wet wadded up wash cloth found on shower floor was removed and placed in the soiled linen bin.</p> <p>Res. #3: On 1/12/2015 upon identification, the neck support pillow was properly cleaned & sanitized and returned to the resident.</p> <p><i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i></p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. Although, to address other residents who may have the potential to be affected by this deficiency:</p> <ul style="list-style-type: none"> By 02/20/2015, the Administrator or designee will do a visual observation of all resident bathrooms to ensure that there are no soiled linens on the shower floor. By 02/20/2015 the Administrator or designee will do a visual observation on 3 different meal times to ensure that any resident item that is dropped on the dining room floor will be properly cleaned & sanitized before returning to the resident. 	2/28/2015

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F 441	<p>Continued From page 34</p> <p>the floor." CNA #6 picked them up and stated, "I'm working on it," and placed the dirty linen in a plastic bag.</p> <p>2. On 1/12/15 at 1:55 PM, a wet, wadded up washcloth was found on the shower floor of Resident #6's room.</p> <p>On 1/12/15 at 2:10 PM, CNA #5 was interviewed regarding the washcloth on Resident #6's shower floor. She stated, "I'm not sure when it got there, but it shouldn't be there and should have been put in the dirty clothes linen."</p> <p>On 1/12/15 at 4:45 PM, the DON was made aware of the observations. No further information was provided by the facility.</p> <p>3. Resident #3 was admitted to the facility on 12/9/14 with diagnoses which included acute myocardial infarction, encephalopathy and a urinary tract infection.</p> <p>During the evening meal observation on 1/13/15 at 6:20 p.m. the pillow Resident #3 used to support her neck was observed on the dining room floor. Numerous CNAs were observed to walk by the pillow and leave it on the floor. The Dietary Manager picked up the pillow and placed it behind the resident's neck.</p> <p>On 1/16/15 at 10:30 a.m., LN #4 stated the pillow should have been sanitized before placing it behind the resident's neck.</p> <p>On 1/16/15 at 2:15 p.m., the Administrator and DON were informed of the above concern. The facility provided no further information.</p>	F 441	<p>F-441 continued...</p> <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>Through root cause analysis the DNS and Administrator determined that previous citations in F-441 were related to other systems, thus focus will be on the below areas as it relates to proper and timely removal of soiled linen from resident shower floors and cleaning / sanitizing any resident item dropped on the dining room floor before returning it to the resident.</p> <p>Therefore, to ensure that the deficient practice does not recur, the Infection Control Nurse or LN designee:</p> <ul style="list-style-type: none"> By 02/20/2015 will In-service all Staff on the subject of F-441 emphasizing the significance of ensuring that there are no soiled linens on the resident shower floor. By 02/20/2015 will In-service all Staff on the subject of F-441 emphasizing the significance of proper cleaning / sanitization of items dropped by residents on the dining room floor before returning it to the resident. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through:</p> <ul style="list-style-type: none"> The Infection Control Nurse or LN designee will do a visual observation of at least three (3) resident bathrooms to ensure that there are no soiled linens on the shower floor. 	

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F 514 F 514 SS=E	Continued From page 35 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to accurately document information in residents' medical records. This was true for 6 of 11 residents sampled (#s 1, 2, 4-6 and 8) for clinical records. This created the potential for medical decisions to be on based on inaccurate information. Findings included: 1. a) Resident #5 was admitted to the facility on 8/27/09 with diagnoses which included muscle weakness and dementia. The resident's medical record included an order to "increase supplement to 8 oz nutritional supplement..." three times a day. The order was signed by the physician at 9:00 p.m. on 12/30/14. The resident's 1/1/15 recapitulation Physician	F 514 F 514	F-441 continued... The Infection Control Nurse or LN designee will do a visual observation on three (3) different meal times to ensure that any resident item that is dropped on the dining room floor will be properly cleaned & sanitized before returning to the resident. Monitoring will start on 02/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The facility Infection Control Nurse or LN designee will submit to the Administrator or designee and to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A Committee Meeting. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting. F- 514 SS=E §483.75(L) (1) - Res. Records-Complete/Accurate/Accessible <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i> Res. #5, On 02/01/2015 the February Medication Record was reviewed by the Director of Nursing to ensure that the 8 oz Nutritional supplement for Res. # 5 matched the 12/30/2014 physician's order on the frequency as TID. Res. #5, By 02/20/2015 All License Nurses will be provided with an in-service education by the Director of Nursing or LN designee regarding F-329 with emphasis on the importance of complete and accurate documentation in the Behavior Monitoring Flow sheet's (BMF) during their shift.	2/28/2015

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F 514	<p>Continued From page 36</p> <p>Orders documented the resident was to receive 8 ounces of the house supplement two times a day with a start date of 7/31/14.</p> <p>On 1/15/15 at 4:50 p.m. the DON was informed the 1/1/15 recapitulation Physician Orders had not been revised to include the resident was to receive the supplement 3 times a day.</p> <p>b) Resident #5's 11/14-1/15 Behavior Monitor sheets for restless behaviors documented no behaviors, however an intervention of 1 to 1 was implemented.</p> <p>The resident's 1/1/15 recapitulation Physician Orders included an order for Lorazepam (anxiolytic) 0.5 mg daily for anxiety with a start date of 5/18/13. A handwritten note on a different page documented, "when current Lorazepam exhausted change to Lorazepam 0.25 ..." The start date was documented as 12/10/14. The hand written entry was not initialed or signed.</p> <p>On 1/16/15 at 9:10 a.m., the DON stated the physician should sign and date any changes on recapitulation orders.</p> <p>2. Resident #1 was admitted to the facility on 4/30/14 with diagnoses which included hemiplegia and cerebrovascular disease.</p> <p>Resident #1's Behavior Monitor sheets for 11/4-1/15 documented numerous days with no behaviors of sadness, however, an intervention of 1 to 1 was implemented.</p> <p>On 1/15/15 at 6:25 p.m. the DON stated the Behavior Monitors for Resident #1 and #5 were inaccurate.</p>	F 514	<p>F-514 continued...</p> <p>Res. #5, The handwritten note on the 01/01/15 recapitulation that the surveyor identified as not initialed or signed by the License Nurse was actually signed by the License Nurse with her full first name and last name; it was signed on the bottom of that particular page and that could be why the surveyor may not have noticed the signature.</p> <p>Although, the License Nurse will still be provided with a 1:1 in-service education by the Director of Nursing by 02/20/2015 regarding F-514 with emphasis on the importance of, when doing recapitulation, initialing or signing handwritten physician orders being brought forward.</p> <p>Res. #1, By 02/20/2015 All License Nurses will be provided with an in-service education by the Director of Nursing or LN designee regarding F-514 with emphasis on the importance of complete and accurate documentation in the Behavior Monitoring Flow sheet's (BMF) during their shift.</p> <p>Res. # 4, the License Nurse identified as having made a handwritten note on January 2015 recapitulation physician orders will be provided with a 1:1 in-service education by the Director of Nursing or LN designee by 02/20/2015 regarding F-514 on the importance of including the diagnosis for prescribed medications.</p> <p>Res. # 4, By 02/20/2015 The Health Information Manager will be provided a 1:1 education by the Director of Nursing or LN designee regarding F-514 on the importance of making sure that the physician recapitulation orders are dated when signed by the physician.</p>		

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F 514	<p>Continued From page 37</p> <p>On 1/16/15 at 2:15 p.m. the DON and Administrator were informed of the above concerns. The facility provided no further information.</p> <p>3. Resident #4 was admitted to the facility on 9/25/14 with multiple diagnoses which included rehabilitation care, chronic ulcer of the skin, ulcer of lower limb, and edema.</p> <p>The resident's January 2015 recapitulation Physician Orders included handwritten orders which were not initialed, did not include a diagnosis, and did not include the date the physician signed the recapitulation orders. The handwritten orders, dated 12/24/14, for dressing changes were as follows: *Left shin 2 x week, Xeroform Mepilex Border with lite Coban; *Right knee 2 x week, Xeroform with Mepilex Border; and, *Bacitracin dressing to Left 2nd Toe Q [every] D [day]."</p> <p>4. Resident #6 was admitted on 9/5/12 and readmitted on 12/4/14 with multiple diagnoses which included dementia, depression and anxiety.</p> <p>The resident's January 2015 recapitulation Physician Orders included handwritten orders which did not include a diagnosis, and were not dated or signed by the physician. The handwritten orders were as follows:</p>	F 514	<p>F-514 continued...</p> <p>Res. #6, The handwritten note on the 01/01/15 recapitulation that the surveyor identified as not dated or signed by the License Nurse was actually signed by the License Nurse with her full first name and last name, it was signed on the bottom of that particular page and that could be why the surveyor may not have noticed the signature. Although, the License Nurse will still be provided with a 1:1 in-service education by the Director of Nursing by 02/20/2015 regarding F-514 with emphasis on the importance of initialing or signing then dating and also putting the order date of when medication was originally ordered by the physician, when orders are being brought forward on the recapitulation.</p> <p>Res.# 6: By 02/20/2015 The Health Information Manager will be provided a 1:1 education by the Director of Nursing or LN designee regarding F-514 on the importance of making sure that the physician recapitulation orders are dated when signed by the physician.</p> <p><i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i></p> <p>To address other residents that may have the potential to be affected by this deficiency, by 02/20/2015 the Director of Nursing or LN designee will review all current residents' recapitulation orders to ensure that:</p> <ul style="list-style-type: none"> Physician's orders are brought forward in the recapitulation as transcribed by the physician. Physician recapitulation orders are dated and signed by the physician. 		

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F 514	<p>Continued From page 38</p> <p>*Clonidine 0.2 mg tab PO [per oral] TID [three times daily]; and, *Metoprolol 25 mg Q D."</p> <p>The December 2014 recapitulation Physician Orders documented the above mentioned orders for Clonidine and Metoprolol with start dates of 12/23/13 and diagnosis of hypertension for both medications.</p> <p>On 1/16/15 at 9:30 AM, the DON stated, "There is no date, no diagnosis, and no route for the Metoprolol" for Resident #s 4 and 6.</p> <p>On 1/16/15 at 2:15 PM, the Administrator and the DON were made aware of the above mentioned concerns. The facility provided no further information.</p>	F 514	<p>F-514 continued...</p> <p>The License Nurse who is assigned to do the monthly recapitulation is initialing or signing then dating and also putting the order date of when medication was originally ordered by the physician, when orders are being brought forward on the recapitulation.</p> <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>Through root cause analysis, to ensure that the deficient practice does not recur, by 02/20/2015 a "Recap Watch Team" will be created by the facility who will review a sampling of five (5) current residents recapitulation every month to ensure that:</p> <ul style="list-style-type: none"> · Physician's orders are brought forward in the recapitulation as transcribed by the physician. · Physician recapitulation orders are dated and signed by the physician. · The Licensed Nurse who is assigned to do the monthly recapitulation is initialing or signing then dating, and also putting the order date of when medication was originally ordered by the physician, when orders are being brought forward on the recapitulation. <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through: The Director of Nursing or LN designee will review at least five (3) Residents physician recapitulation to ensure that:</p>		

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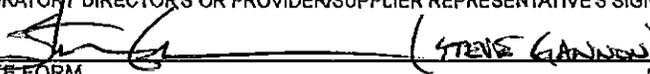
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F 514	<p>Continued From page 38</p> <p>*Clonidine 0.2 mg tab PO [per oral] TID [three times daily]; and,</p> <p>*Metoprolol 25 mg Q.D."</p> <p>The December 2014 recapitulation Physician Orders documented the above mentioned orders for Clonidine and Metoprolol with start dates of 12/23/13 and diagnosis of hypertension for both medications.</p> <p>On 1/16/15 at 9:30 AM, the DON stated, "There is no date, no diagnosis, and no route for the Metoprolol" for Resident #s 4 and 6.</p> <p>On 1/16/15 at 2:15 PM, the Administrator and the DON were made aware of the above mentioned concerns. The facility provided no further information.</p> <p>Continuation from page 39...</p> <p>This additional page was added to allow room for the complete Plan of Correction for F-514 to be added to the 2567.</p>	F 514	<p>F-514 continued...</p> <ul style="list-style-type: none"> · Physician's orders are brought forward in the recapitulation as transcribed by the physician. · Physician recapitulation orders are dated and signed by the physician. · The License Nurse who is assigned to do the monthly recapitulation is initialing or signing then dating, and also putting the order date of when medication was originally ordered by the physician, when orders are being brought forward on the recapitulation. <p>Monitoring will start on 02/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Director of Nursing or LN designee will submit to the Administrator or his/her designee and to the QA&A Committee any findings and/or corrective actions taken during the quarterly QA&A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001635	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/16/2015
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State Licensure/Complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Sherri Case, Team Coordinator, LSW/BSW, QIDP Rebecca Thomas ,RN, BSN</p> <p>The survey team entered the facility on January 12, 2015 and exited on January 16, 2015.</p>	C 000	Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.	
C 147	<p>02.100,05,g Prohibited Uses of Chemical Restraints</p> <p>g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician.</p> <p>This Rule is not met as evidenced by: Please refer to F-329 as it relates to unnecessary medication.</p>	C 147	C 147 - Please see response to F-329.	2/28/2015
C 325	<p>02.107,08 Food Sanitation</p> <p>08. Food Sanitation. The acquisition, preparation, storage, and serving of all food and drink in a facility shall comply with Idaho Department of Health and Welfare Rules, Title 02, Chapter 19, "Rules Governing Food Sanitation Standards for Food Establishments (UNICODE)."</p>	C 325	C 325 - Please see response to F-371.	2/28/2015

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  (STEVE GANNON)	TITLE ADMINISTRATOR	(X6) DATE 2/16/15
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001635	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/16/2015
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NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE (STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 325	Continued From page 1 This Rule is not met as evidenced by: Refer to F371 regarding a beard restraint not worn in the kitchen.	C 325	C-664 02.150,02, a Required Members of Committee <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i>	2/28/2015
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of the Infection Control Meeting minutes and staff interview, it was determined the facility failed to ensure a representative from each department was included and participated in the Infection Control Meetings. This failure had the potential to affect all residents, staff and visitors to the facility. Findings included: The Infection Control Protocol was reviewed on 1/15/15 at 6:00 PM with LN #4, the Infection Control Coordinator. She provided the sign-in sheets from the Quarterly Infection Control Meetings. Upon review of the sign-in sheets, it was determined the following departments were not represented: *Pharmacist for the May 2, 2014 meeting; and, *Medical Director, Pharmacist and Housekeeping/Maintenance for the August 2014 meeting. On 1/15/15 at 6:00 PM, LN #4 was interviewed regarding the missing members and stated she was new to the position and was in the process of being trained. She stated she would make sure there was a representative from each department and that they signed an attendance record for all	C 664	By 02/20/2015 the Pharmacy Consultant, Medical Director, Housekeeping/Maintenance Director will be provided a 1:1 in-service education regarding the importance of signing in the Quarterly Infection Control Committee meeting sign-in sheet. <i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i> There were no residents affected by this deficiency as the deficiency only pertains to the missed signing of the Pharmacy Consultant, Medical Director, Housekeeping/Maintenance Director on the Quarterly Infection Control committee meeting sign-in sheet. <i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i> By 02/20/2015, all Infection Control Committee Members will be provided an in-service education by the Administrator regarding C-664 with emphasis on the importance of making sure they sign the Quarterly Infection Control meeting sign-in sheet. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i> Monitoring will be through; The Administrator will review the quarterly Infection Control meeting sign-in sheets to ensure that all members of the committee signed the sheet.	

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE (STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202
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C 664	Continued From page 2 future quarterly meetings. On 1/16/15 at 12:15 PM, the Administrator and the DON were made aware of the above mentioned concern. No further information was provided by the facility.	C 664	C 664 continued... Monitoring will start on 02/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The Administrator will discuss the findings and/or corrective actions taken with the QA&A Committee during the quarterly QA&A Committee Meeting.	
C 671	02.150,03,b Handling Dressings, Linens, Food b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Please refer to F-441 as it relates to dirty linen.	C 671	Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting. C 671 - Please see response to F-441.	2/28/2015
C 745	02.200,01,c Develop/Maintain Goals/Objectives c. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; This Rule is not met as evidenced by: Please refer to F-281 as it relates to professional standards.	C 745	C 745 - Please see response to F-281.	2/28/2015
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please refer to F-280 as it relates to care plan revisions.	C 782	C 782 - Please see response to F-280.	2/28/2015
C 786	02.200,03,b,ii Body Alignment, Exercise, Range of Motion	C 786	C 786 - Please see response to F-246.	2/28/2015

Bureau of Facility Standards

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C 786	Continued From page 3 ii. Good body alignment and adequate exercises and range of motion; This Rule is not met as evidenced by: Please refer to F246 as it relates to proper body alignment.	C 786		
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F309 and F328 as it relates to following Physician's Orders.	C 788	C 788 - Please see responses to F-309 and F-328.	2/28/2015
C 790	02.200,03,b,vi Protection from Injury/Accidents vi. Protection from accident or injury; This Rule is not met as evidenced by: Please refer to F-323 as it relates to accidents/falls.	C 790	C 790 - Please see response to F-323.	2/28/2015
C 879	02.203 Resident Records 203. PATIENT/RESIDENT RECORDS. The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices. This Rule is not met as evidenced by: Refer to F514 as related to complete and accurate medical records.	C 879	C 879 - Please see response to F-514.	2/28/2015



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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FILE COPY

February 18, 2015

Steve Gannon, Administrator
Quinn Meadows Rehabilitation & Care Center
1033 West Quinn Road,
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Gannon:

On **January 16, 2015**, an unannounced on-site complaint survey was conducted at Quinn Meadows Rehabilitation & Care Center. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey.

The identified resident and five other residents were observed during the survey process for quality of life, quality of care, room and daily life reviews, progress notes, social worker notes, physician notes, minimum data set assessment and care area assessments.

The following documents were reviewed:

- Incident and Accident Reports from August 2014 through January 12, 2015;
- Grievances from August 2014 through January 12, 2015;
- Resident Council Meeting minutes from August 2014 to January 2015; and,
- Hospital Reports, wound clinic notes, physician orders, skin assessment sheets, physical therapy notes and social worker notes for the identified resident.

Interviews were conducted with the following:

- Administrator;
- Director of Nursing;
- Business Office Manager;
- A Licensed Social Worker;

- Physical Therapy Director;
- A family member of the identified resident;
- Quality of Life Resident Group Interview on January 13, 2015, with four residents in attendance;
- Quality of Life Assessment Resident Interviews during the Recertification Survey; and,
- Quality of Life Assessment Resident Interview with the identified resident.

The complaint allegations, findings and conclusions are as follows:

Complaint #6802

ALLEGATION #1:

The complainants stated the resident had two falls at the facility, which occurred on October 11, 2014 and October 26, 2014. The resident was transferred to a local hospital. On October 11, 2014, the resident had a 4 cm laceration with hematoma to scalp, right elbow laceration and right wrist bruise. After the October 26, 2014 fall, the resident experienced hallucinations and severe diarrhea. As a result of the October 26, 2014 fall, the resident needed to reside at the facility for a longer period. The facility called one family member; however, no other family members were contacted. As a result of the fall, the resident was unable to participate in PT for two weeks. After each fall, the facility did not communicate regarding preventative measures to prevent subsequent falls or treatment of costs. The complainants stated the resident's stay at the facility was extended and her health was compromised due to the above mentioned falls.

FINDINGS #1:

Review of the identified resident's medical record, Incident and Accident reports, grievances and hospital reports documented the resident fell on October 11, 2014 and October 25, 2014. The identified resident was evaluated and treated at a local hospital after each incident. Based on records reviewed, staff interviewed, residents interviewed and a family member interview, the allegation was substantiated and the facility was cited at F323 and F329. Please refer to F323 and F329 for additional information.

CONCLUSIONS:

Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainants stated the resident's treasured turquoise and coral wristwatch was misplaced during transport from the facility to the hospital. The complainants stated the watch has disappeared, they have checked with the hospital and they are unable to find it.

FINDINGS #2:

A review of the facility's grievances did not include a grievance from the identified resident. The identified resident's facility inventory sheet did not document a turquoise and coral wristwatch. The local hospital's medical record department was contacted and reported they do not inventory the emergency department patients' belongings. The identified resident was interviewed and stated she had not filed a grievance concerning her wristwatch.

Based on interviews and records reviewed, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainants stated the identified resident was charged for the ambulance transport.

FINDINGS #3:

Interviews were conducted with the facility's Administrator, Director of Nursing Services and the Business Office Manager. The facility provided documentation that they (the facility) were in process of paying for the ambulance costs. Therefore, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainants stated the identified resident suffered a serious reaction to the IV therapy antibiotics prescribed by a local wound care center.

FINDINGS #4:

Based on review of the identified resident's record, the local wound clinic physician's orders, progress notes, medication administration records and an interview with the Director of Nursing Services, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Steve Gannon, Administrator
February 18, 2015
Page 4 of 4

ALLEGATION #5:

The complainants stated the facility's Social Services Director (SSD) informed the family on November 13, 2014; the family must make arrangements for the resident to go home or to another facility by November 21, 2014. The SSD stated the facility was required to provide only 48-hour notice of discharge.

FINDINGS #5:

The Business Office Manager was interviewed and stated the resident was originally given a 48-hour notice of Medicare Non-Coverage. However, the facility rescinded the 48-hour notice since the family did not feel the identified resident was ready to go home.

Based on records reviewed and staff interviewed, it was determined the allegation was substantiated. However, a deficient practice did not exist since the facility rescinded the 48-hour notice.

CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

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

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.I.D.P., David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option #2. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



NINA SANDERSON, L.S.W., Supervisor
Long Term Care

NS/dmj