



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

**CORRECTED COPY:** Replaces March 25, 2015, survey cover letter dated April 9, 2015

April 15, 2015

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

Provider #: 135136

Dear Mr. Gannon:

On **March 25, 2015**, we conducted an on-site revisit to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **February 28, 2015**. However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- F250-Provision of Medically Related Social Service-42 CFR §483.15(g)(1)**
- F272-Comprehensive Assessments-42 CFR §483.20(b)(1)**
- F279-Develop Comprehensive Care Plans-42 CFR §483.20(d), 42 CFR §483.20(k)(1)**
- F280-Right to Participate Planning Care-Revise CP-42 CFR §483.20(d)(3), 42 CFR §483.10(k)(2)**
- F323-Free of Accident Hazards/Supervision/Devices-42 CFR §483.25(h)**
- F329-Drug Regimen is Free From Unnecessary Drugs-42 CFR §483.25(l)**
- F514-Res Records-Complete/Accurate/Accessible-42 CFR §483.75(l)(1)**

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

answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your copy of the Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 22, 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 the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

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

Steve Gannon, Administrator  
April 15, 2015  
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As noted in the Bureau of Facility Standards' letter of **February 4, 2015**, following the survey of **January 16, 2015**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on **July 16, 2015**, if substantial compliance is not achieved by that time. The findings of non-compliance on **March 25, 2015**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS. On **February 17, 2015**, CMS notified the facility of the intent to impose the following remedies:

- DPNA made on or after April 16, 2015.
- A 'per instance' civil money penalty of \$2000.00.

**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, it will provide you with a separate formal notification of that determination.**

If you believe the deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 0009; phone number: (208) 334-6626, Option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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

Steve Gannon, Administrator

April 15, 2015

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This request must be received by **April 22, 2015**. If your request for informal dispute resolution is received after **April 22, 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,

A handwritten signature in cursive script that reads "Nina Sanderson".

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

NS/dmj

Enclosures

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

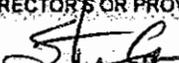
PRINTED: 04/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

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  R-C 03/25/2015
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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><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the revisit for the annual federal recertification and complaint survey of your facility.</p> <p>The surveyors conducting the survey were: Arnold Rosling, RN, BSN, QIDP, Team Coordinator Lorene Kayser, LSW, QIDP</p> <p>The survey team entered the facility on March 23, 2015 and exited on March 25, 2015.</p> <p>Survey Definitions: ADLs = Activities of Daily Living BIMS = Brief Interview for Mental Status BP/bp = Blood Pressure C-Diff = Clostridium Difficile COPD = Chronic Obstructive Pulmonary Disease c/o = Complained/Complained DON = Director of Nursing MDS = Minimum Data Set assessment MG = Milligram ML = Milliliter PRN/pm = As Needed RN = Registered Nurse R/T/rt = Related To SOB = Short of Breath TID/tid = Three Times Daily 1:1 = One on One Staffing</p> <p>F 250 SS=D 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</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.</p> <p>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> <p>RECEIVED APR 22 2015 FACILITY STANDARDS</p>	
		F 250	F-250  Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:	4/20/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 4/21/15
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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
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F 250	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and observation it was determined the facility had failed to ensure the provision of medically-related social service provided to help 1 of 1 (# 15) sampled residents. The deficient practice created the potential for harm if the resident experienced psychosocial changes due lack of social services intervention when a diagnostic procedure had to be delayed. Findings included:</p> <p>1. Resident #15 was admitted to the facility on 5/23/15 with diagnoses of chronic obstructive pulmonary disease (COPD).</p> <p>The resident's most recent quarterly assessment, dated 12/5/14, documented the resident:</p> <ul style="list-style-type: none"> <li>- was cognitively intact;</li> <li>- had mild depression; manifested by changes in energy levels and restlessness;</li> <li>- required minimal assistance from staff for ADL cares;</li> <li>- did have difficulty breathing: with exertion; sitting at rest; and lying flat;</li> <li>- received oxygen continuously; and</li> <li>- did not receive any psychoactive medications.</li> </ul> <p>The most recent physician recapitulation orders documented the resident received Sertraline 50 mg tablet each morning (Zoloft)(order date 2/17/15) and Lorazepam (Ativan) 0.5 mg two tablets three times a day as needed (order date 1/18/15).</p> <p>The most recent resident care plan provided by the facility, dated 1/19/15, did not document any</p>	F 250	<p>F-250 continued...</p> <p>Resident # 15 Anxiety care plan intervention section revised by the MDS Coordinator or LN designee, to include interventions for non-pharmacological psychosocial support approaches by 04/17/2015.</p> <p>By 04/15/2015, The Social Services Director provided 1:1 in-services education by the Administrator or Designee regarding F- 250 with emphasis on the importance of:</p> <ul style="list-style-type: none"> <li>• When a Resident diagnostic procedure has to be delayed by the physician, that psychosocial changes in Resident (e.g. anxiety) will be addressed by the Social Services Director or Designee; that Social Service Director's conversation with the Resident is documented; and that the resident's Anxiety care plan Intervention Section," also includes interventions for non-pharmacological psychosocial support approaches.</li> </ul> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p>	
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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 250	<p>Continued From page 2</p> <p>areas of concern with the resident's psychosocial status. The care plan for, "Resident has episodes of anxiety (panic) as evidenced by verbalization of fearfulness, 0-3 x's (times) per day triggered by intermittent shortness of breath r/t severe respiratory disease." The only intervention psychosocial support was, "Listen to pt's (patient) concerns &amp; identify cause (pt is often concerned about her O2 sat % (oxygen saturation percentage).) Assist pt in resolving concerns."</p> <p>The resident had a "Preoperative History and Physical" completed on 12/23/14 which documented possible cancer of the breast. The resident was to have a right breast biopsy and excision on 1/16/15.</p> <p>On 1/21/15, a physician's progress note documented the resident was "here today with increasing anxiety and hypertension... She had been scheduled to have surgery... last Friday but it was canceled because her surgeon was ill... this has been rescheduled for next Friday. However, last Saturday, she seemed to develop some slight cold symptoms. She has experienced greater anxiety and dyspnea although her oxygen saturations have been good. Her pressure has been noted to be high although she usually does not have a history of hypertension. She was given a dose of Clonidine on Saturday and then on Sunday was started on Ativan 1 mg 1 tid p.r.n. in an attempt to control the anxiety. However, she still complains of anxiety and her pressure is still high. She also has a sensation of dyspnea. For her severe emphysema, she is currently on... (listed multiple medications for COPD)"</p> <p>The physician documented the objective evaluation of, "She seems somewhat sedated,</p>	F 250	<p>F-250 continued...</p> <p>However, all residents who have anxiety related to a delay in a diagnostic procedure by their physician may have the potential to be affected by this deficiency; hence by 04/17/2015 all current Resident(s) who have a scheduled diagnostic procedure will be reviewed by the Administrator or designee and Director of Nurses or LN designee;</p> <p>To ensure all current Resident(s) experiencing psychosocial changes related to a delayed diagnostic procedure by the physician (i.e. anxiety) will be address by the Social Services Director or Designee, that the conversation with the Resident is documented, and that the "Anxiety care plan Intervention Section," includes interventions for non-pharmacological psychosocial support approaches.</p> <p>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:</p> <p>To ensure that the deficient practice does not recur, starting on 04/17/2015</p> <p>All current Resident(s) who have a scheduled diagnostic procedure will be reviewed by the Interdisciplinary Team (IDT) during the scheduled IDT stand up meeting. Resident(s) experiencing psychosocial changes related to a delayed diagnostic procedure by the physician (i.e. anxiety) will be addressed by the Social Services Director or Designee, that the conversation with the Resident is documented, and that the "Anxiety care plan Intervention Section," also includes interventions for non-pharmacological psychosocial support approaches.</p>		

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F 250	<p>Continued From page 3</p> <p>presumably from the Ativan. She also has some trouble with her hearing. She was not dyspnic..."</p> <p>The physicians assessment was, "The patient has anxiety which is probably causing hypertension... Her dyspnea is probably making anxiety worse. The Ativan is not effective in controlling her anxiety..."</p> <p>The Nursing progress notes were reviewed and documentation revealed: 1/16/15, evening, "Pt c/o of SOB, anxiety, O2 sat at 94%, bp 210/120, pt encouraged to deep breath and try to calm down. (Physician name) answering service called and message left..." 1/16/15 at 11:45 p.m. "MD called facility at 2200 (10:00 p.m.) new order for Clonidine 0/1 mg now, recheck BP in 30 minutes. Medication given at 2200 per order, BP rechecked 22:30 - 186/98. Pt s/sx anxiety r/t increase B/P .... B/P 148/78 at this time..." 1/17/15 at 6:00 a.m. "Pt states feeling much better this AM. Will continue to monitor." 1/19/15 at 2:30 p.m. "Vital signs BP 155/81... Res medicated for (increased) anxiety X 2 (with) eff(ective) results. Res is slightly confused r/t Ativan. Co-operative with cares.. Res needs more assist lately with ADLs that she usually can perform independently..." 1/20/15 at 2:45 p.m. "...Had 2 episodes of (increased) anxiety managed with Ativan and 1 : 1 (with) res... Res sleeping more. Resident tries to come down to meals to visit and tries to eat (decreased) appitate (sic) today..." 1/22/15 at 1:30 p.m. "...Had 1 episode of (increased) anxiety. Ativan eff..." 1/23/15 at 2:00 p.m. "...Had 1 episode of (increased) Anxiety. Ativan eff..."</p>	F 250	<p>F-250 continued...</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>Monitoring will be done through:</p> <p>The Administrator or designee and the Director of Nurses or LN designee will review at least three (3) Residents with diagnostic procedures delayed by the physician to ensure;</p> <ul style="list-style-type: none"> <li>Resident(s) experiencing psychosocial changes related to a delayed diagnostic procedure by the physician (i.e. anxiety) will be address by the Social Services Director or Designee, that conversation with the Resident is documented, and that "Anxiety care plan Intervention Section," includes interventions for non-pharmacological psychosocial support approaches.</li> </ul> <p>Monitoring will start on 04/20/2015 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee and the Director of Nurses or LN designee will present to the quarterly QA&amp;A Committee meeting any findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>

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F 250	Continued From page 4 There were no entries in the social services progress noted during this timeframe. There was no documentation the psychosocial impact of the resident's procedure being delayed had been identified or assessed, or any updates to the resident's care plan with non-pharmacological approaches to the onset of the resident's anxiety.  On 3/24/15 at 9:35 a.m., the social worker stated she talked with the resident at the time regarding her increased anxiety, but did not have any documentation of that interaction. The social worker was not able to describe which, if any, interventions the facility had put in place when the resident's surgery was delayed, other than medication changes. The social worker stated she was aware the resident was started on an anti-depressant medication but had no involvement with psychoactive medications.  On 3/24/15 at 9:50 AM, the facility was informed of the above findings. No additional information was provided.	F 250			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine;	F 272	F-272  Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:  Resident # 17 is no longer a Resident in the facility.  Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:	4/20/15	

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F 272	<p>Continued From page 5</p> <p>Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure completion of comprehensive assessments for 1 of 10 sample residents (#17). Failure to ensure complete and thorough Care Area Assessment (CAA) documentation created the potential for unassessed needs and/or inaccurate care planning. Findings include:</p> <p>CMS' Resident Assessment Instrument Version 3.0 Manual CH 4: CAA Process and Care</p>	F 272	<p>F-272 continued...</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, by 04/17/2015 to address residents who may have the potential to be affected by this deficiency; all current Residents with triggered areas in the comprehensive MDS will be reviewed by the Director of Nurses or LN designee to ensure that the "Care Area Assessment (CAA) includes further assessment(s) of the triggers or gives direction as to where additional assessment information could be located in the record.</p> <p>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:</p> <p>To ensure that the deficient practice does not recur;</p> <p>· Although the MDS Coordinator had formal MDS training, by 04/15/2015, the MDS Coordinator will be provided 1:1 in-service education by the Director of Nurses or LN designee on F-272 with emphasis on the importance of the "Care Area Assessment (CAA) to include further assessment(s) of the triggers or gives direction as to where additional assessment information could be located in the record.</p>	
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F-272	<p>Continued From page 6</p> <p>Planning May 2013 Page 4-14 documents the process and steps for completing a CAA as follows:</p> <p>"Step 2: Analysis of Triggered CAAs: Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions. While reviewing the CAA, consider what MDS items caused the CAA to be triggered. This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in MDS data. Review of CAAs helps staff to decide if care plan intervention is necessary, and what types of intervention may be appropriate.</p> <p>Using the results of the assessment can help the interdisciplinary team (IDT) and the resident and/or resident's representative to identify areas of concern that:</p> <ul style="list-style-type: none"> <li>* Warrant intervention;</li> <li>* Affect the resident's capacity to help identify and implement interventions to improve, stabilize, or maintain current level of function to the extent possible, based upon the resident's condition and choices and preferences for interventions;</li> <li>* Can help to minimize the onset or progression of impairments and disabilities; and</li> <li>* Can help to address the need and desire for other specialized services (e.g. palliative care, including symptom relief and pain management).</li> </ul> <p>Use the information gathered thus far to make a clear issue or problem statement. An issue or problem is different from a finding (e.g., a single piece of information from the MDS or a test result). The chief complaint (e.g., the resident has a headache, is vomiting, or is not participating in activities) is not the same thing as an issue or</p>	F-272	<p>F-272 continued...</p> <ul style="list-style-type: none"> <li>• Starting on 04/17/2015 all scheduled completed Comprehensive MDS Care Areas Assessment (CAA) Documentation notes will be reviewed by the Interdisciplinary Team (IDT) during the scheduled IDT stand up meetings to ensure that the "Care Area Assessment (CAA) includes further assessment(s) of the triggers or gives direction as to where additional assessment information could be located in the record.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b></p> <p>Monitoring will be done through:</p> <p>The Administrator or designee and the DNS or LN designee will review at least three (3) completed Comprehensive MDS Care Areas Assessment (CAA) documentation notes to ensure that areas triggered include further assessment(s) of the triggers or gives direction as to where additional assessment information could be located in the record.</p> <p>Monitoring will start on 04/20/2015 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee and the DNS or LN designee will present to the quarterly QA&amp;A Committee meeting any findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>	

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F 272	<p>Continued From page 7</p> <p>problem statement that clearly identifies the situation. Trying to care plan a chief complaint may lead to inappropriate, irrelevant, or problematic interventions."</p> <p>Resident #17 was admitted on 2/25/15 with diagnoses that included type 2 diabetes, sepsis and atrial fibrillation.</p> <p>The 3/11/15 admission MDS documented the resident had a BIMS score of 13 and required extensive of one staff for transfers (3/2). The CAA Summary form, dated 3/10/15, referred to CAA Documentation Notes for Communication, ADL function, Urinary incontinence, Falls, Nutritional Status and Pressure ulcers. The Nutritional Status CAA included specifics related to the resident's nutritional needs. The rest of the CAAs only stated what triggered the CAA, the resident's co-morbidities related to her diagnoses, who attended the care conference, and that care planning, "continued to direct staff care and support of the resident during their stay at the facility." The CAAs did not include further assessment or give direction as to where additional assessment information could be located in the record.</p> <p>When interviewed on 3/24/15 at 2:00 PM, the MDS nurse stated she still had more to learn about the CAA documentation.</p>	F-272		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>	F 279	<p>F-279</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p>	4/20/15

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F 279	<p>Continued From page 8</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure a resident's care plan accurately reflected the need for an assistive device for transfers. This was true for 1 of 3 (# 18) newly admitted residents. Lack of specific information regarding the need for a mechanical lift placed the resident at risk for injury during transfers. Findings include:</p> <p>Resident #18 was admitted to the facility 2/16/15 with diagnoses of rehabilitation for Guillain -Barre Syndrome.</p> <p>The resident's admission MDS assessment, dated 3/1/15, documented the resident required extensive assistance of two staff for transfers.</p> <p>The resident's admission care plan, dated 2/16/15, documented the resident required</p>	F 279	<p>F-279 continued...</p> <p>On 03/25/2015, Resident # 18's "risk for fall" care plan was revised by the MDS Coordinator to reflect the use of a mechanical lift (hoyer lift) for transfer.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567.</p> <p>However, all residents who use a mechanical lift (hoyer lift) for transfer may have the potential to be affected by this deficiency; hence by 04/17/2015 all Resident(s) who use a mechanical lift (hoyer lift) for transfer, will have their fall risk care plan reviewed by the Director of Nurses or LN designee to ensure the particular Resident(s) fall risk care plan reflects the use of a mechanical lift (hoyer lift) for transfer.</p> <p>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:</p> <p>To ensure that the deficient practice does not recur, starting on 04/17/2015, the Therapy Director or Therapist designee will provide the MDS Coordinator or LN designee a list of new Residents who use a mechanical lift (hoyer lift) for transfer, to ensure that the particular Resident(s) fall risk care plan reflects the use of a mechanical lift (hoyer lift) for transfer.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p>		

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F 279	Continued From page 9 resident extensive assistance of two staff for transfers. The care plan did not include that staff should use a a mechanical lift when assisting the resident with transfers.  An Incident/Accident report dated, 3/10/15, described an incident involving the resident's wheelchair being tipped over when staff transferred the resident with a Hoyer (mechanical) lift.  On 3/24/15 at 3:00 PM the DON confirmed a Hoyer lift was needed to assist the resident with transfers and stated she would get back to the surveyor. No further information was provided. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 279	F-279 continued...  Monitoring will be done through: The Administrator or designee and the DNS or LN designee will review at least three (3) Residents who use a mechanical lift (hoyer lift )for transfer, to ensure that the particular Resident(s) fall risk care plan reflects the use of a mechanical lift (hoyer lift) for transfer.  Monitoring will start on 04/20/2015 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.  The Administrator or designee and 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- 280 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:	4/20/15
(F 280) SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  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.	(F 280)	Res. #16, was interviewed by the Administrator and Social Services Director on 4/8/2015, and based upon the conversation, Resident # 16 agreed to have a room change. A follow up interview was done by the Social Services Director to ensure that Resident # 16 is currently comfortable with the noise level of her roommates TV at night in her new room and Resident # 16 did not voice any further concern with noise in her new room, therefore Resident # 16 care plan for sleep concerns with regards to prior room mate watching TV loudly at night was resolved on 4/13/2015.	

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(F 280)	Continued From page 10  This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interview, it was determined the facility failed to ensure residents' care plans accurately reflected their current status. This was true for 2 of 10 sample residents (#s 15 and 16). This failure created the potential for disharmony between roommates and a lack of sleep for Resident #16. Findings included:  At 12:20 PM on 3/23/15 a resident, who chose to remain anonymous, reported to the surveyor that Resident #16 was having difficulty sleeping at night because her roommate's TV was often left on with the volume turned up.  The Annual MDS assessment for Resident #16, dated 1/23/15, indicated she was cognitively intact with a BIMS score of 15.  When interviewed at 1:55 PM on 3/23/15, Resident #16 confirmed that Resident #15 was often awake during the night with the volume of the TV loud enough to prevent or disturb Resident #16's sleep. Residents #15 and #16 shared a room with a partial dividing wall between the rooms. [Note: Each resident's TV was mounted near the ceiling on either side of the dividing wall.] Resident #16 stated this had been an ongoing issue. She stated it had been brought to the attention of the facility's administration more than once and at one time the Resident #15 was given head phones to use at night. Things would get better for about a week or so then Resident #15 would go back to having the TV on all night with the volume turned up. Resident	(F 280)	F-280 continued...  Res. # 15, currently has a new roommate that, according to interview by the Social Services Director, neither new roommate nor family are bothered by Resident # 15 noise level of watching TV at night, although by 04/17/2015, Resident #15's care plan was updated to include that she likes watching TV at night, the use of TV head phones at night, and/or how staff will intervene if the TV volume affects the new roommate's ability to sleep through the night.  Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:  This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all Residents who have roommates may have the potential to be affected by this deficiency. Hence by 04/17/2015, the Administrator or designee and the Social Services Director or designee will do an unannounced observation during the night; · To ensure that Residents who are in "shared rooms," are comfortable with the sound level of their roommates TV. · To ensure that Residents who are in "shared rooms," with roommates that watch TV during the night are care planned (both residents) to address interventions for sleep concerns related to TV volume.  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:	
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(F 280)	Continued From page 11 #16's Plan of Care did not address any sleep concerns.  Resident #15 was admitted on 5/23/14 with diagnoses that included severe COPD, hypertension, hypothyroidism and generalized anxiety disorder. The resident's 5/28/14 Admission Plan of Care included a problem identified as, "at risk for lack of sleep at night due to insomnia." The plan did not include any information about the TV being left on at night, the availability of head phones or how staff was to intervene if the TV volume affected the roommate's ability to sleep through the night.  Documentation regarding how this concern was addressed or resolved was not found in either resident's record.  When interviewed on 3/24/15 at 9:15 AM both the social worker and DON acknowledged an awareness of this issue in the past but thought it had been resolved as Resident #15 used headphones at night.  At 3:00 PM on 3/24/15 the administrator was interviewed about the TV situation involving Residents #15 and #16. He said the issue had been addressed in the past and he thought he had some written documentation about it; however, that documentation was not provided to the survey team.	(F 280)	F-280 continued...  A root cause analysis was done by the Administrator and DNS. Therefore to ensure that the deficient practice does not recur, starting on 04/17/2015 a systemic measure will be put into place - an unannounced observation will be performed bi-weekly (at night) by the Administrator or designee; · To ensure that Residents who are in "shared rooms," are comfortable with the sound level of their roommates TV at night. · To ensure that Residents who are in "shared rooms," with roommates that watch TV during the night are care planned (both residents) to address interventions for sleep concerns related to TV volume.  How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through:  The Director of Nursing or LN designee will do an observation (night) at least three (3) Residents who are in "shared room(s);  · To ensure that Resident who are in "shared rooms," are comfortable with the sound level of their roommates TV at night. · To ensure that Residents who are in "shared rooms," with roommates that watch TV during the night are care planned (both residents) to address interventions for sleep concerns related to TV volume.	
(F 323) SS=D	489.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards	(F 323)	Monitoring will start on 04/20/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.	

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{F 323}	<p>Continued From page 12 as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to implement interventions to prevent falls. This was true for 1 of 2 residents sampled for falls (# 17). Failing to ensure the resident's oxygen (O2) tubing was properly placed prior to assisting her to the bathroom created the potential for injury. Findings include:</p> <p>Resident #17 was admitted on 2/25/15 with diagnoses that included type 2 diabetes, sepsis, C-Diff, and atrial fibrillation.</p> <p>The 5-day MDS assessment (PPS), dated 3/4/15 documented the resident required extensive of two staff for transfers (3/3). The 3/11/15 admission MDS documented the resident had a BIMS score of 13 and required extensive of one staff for transfers (3/2). Fall Risk Assessments dated, 2/25, 3/4 and 3/10/15, documented scores of 20, 20 and 16 respectively. Under the Gait/Balance section, the assessment identified balance and gait deficits with standing, walking, muscle coordination, gait pattern, etc. According to the assessment a total score of 10 or above represents the resident is at high risk for falls.</p> <p>The resident's 3/16/15 Plan of Care for falls identified the resident would receive 2/2 with transfers to reduce the risk of falls (ADL</p>	{F 323}	<p>F-280 continued...</p> <p>The Director of Nursing or LN designee will present to the quarterly QA&amp;A Committee meeting any findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p> <p>F-323</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Res. #17 is no longer a resident of the facility.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567, although to address all Residents that may have the potential to be affected by this deficiency;</p> <p>By 04/17/2015, Residents who are a high risk for falls (that are assisted with ambulation and transfer) that use oxygen, will have their fall risk care plan reviewed by the Administrator or designee and Director of Nurses or LN designee, to make certain that the intervention section includes the need to ensure appropriate placement of the O2 tubing when assisting the Resident with ambulation and transfers.</p> <p>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:</p>	4/20/15	

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{F 323}	<p>Continued From page 13</p> <p>performance &amp; staff support may vary according to resident progress with therapy)" and "2/2" assistance with locomotion. It further stated to, "provide resident with safe, clutter free environment to promote safety." A 3/19/15 Plan of Care for the resident being, "at risk for spontaneous fracture secondary to dx [diagnosis] of degenerative joint disease" included an intervention for, "Staff to handle with caution especially during transfers, ADLs assistance and activities." The plan did not specify the need to ensure the O2 tubing was appropriately placed when assisting the resident with ambulation and transfers.</p> <p>An Incident/Accident report dated 3/18/15 at 1:50 PM documented the resident was transferring to toilet when she tripped on the O2 cord (tubing) and fell and hit her back on the oxygen concentrator. She received an abrasion as a result of the fall. Immediate interventions initiated To Prevent Recurrence were documented as "proper transferring." Initial interventions were identified as, "Make [sic] O2 cord is out of the way."</p> <p>The statement from the staff member who was assisting the resident at the time of the fall documented, "Resident call [sic] to use the restroom[.] I sat her on side of bed gait belt and walker ready[.] she stood up and started walking[.] O2 cord was wrapped around foot and walker leg [unreadable] keep walking got to the bathroom door and noticed bedside table was coming with us[.] asked her to stop[.] went to go unwrap O2 from table[.] She started going and between O2 cord an [sic] being in a hurry to go to the bathroom she fell into the sink an [sic] down onto her bottom [and] back on to the oxygen</p>	{F 323}	<p>F-323 continued...</p> <p>A root cause analysis was done by the Administrator and DNS. Therefore to ensure that the deficient practice does not recur, a systemic measure will be put into place:</p> <ul style="list-style-type: none"> <li>Starting on 04/17/2015, Residents who are high risk for falls (that are assisted with ambulation and transfer) with new orders for oxygen will have their fall risk care plan reviewed by the Interdisciplinary Team (IDT) or their designee during their scheduled stand up meeting, to ensure that the intervention section includes the appropriate placement of the O2 tubing when assisting the Resident with ambulation and transfers.</li> </ul> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b></p> <p>Monitoring will be done through:</p> <ul style="list-style-type: none"> <li>The Administrator or designee and Director of Nurses or LN designee will do visual review sampling of three (3) current Residents that are high risk for falls (who are assisted with ambulation and transfer) and who use oxygen, to ensure that the care plan intervention section includes the appropriate placement of the O2 tubing when assisting the Resident with ambulation and transfers.</li> </ul> <p>Monitoring will start on 04/20/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The facility Administrator or designee and Director of Nurses or LN designee will submit to the QA&amp;A Committee any findings and/or corrective actions taken during the quarterly QA&amp;A Committee Meeting.</p>		

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(F 323)	<p>Continued From page 14 machine. Stated her back hurt[,] got vitals and sat her in w/c [wheelchair] an [sic] then to bed[,] got hot pack for her."</p> <p>When asked about the 3/18/15 fall and what interventions had been put into place as a result of that fall on 3/24/15 at 3:00 PM, the administrator stated the facility had five working days to complete the report and were still in the process of investigating the incident.</p> <p>The facility failed to ensure the resident's safety during transfer and ambulation through promotion of an environment that was safe and clutter free.</p>	(F 323)	<p>F-323 continued...</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>	
(F 329) SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>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 drugs.</p>	(F 329)	<p>F- 329</p> <p>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #2 - On 03/23/2015 the physician declined the GDR recommendation for the Trazodone.</p> <p>Resident # 15 - On 04/13/2015, The Social Services Director met with the Resident to ensure that her anxiety was addressed, that aside from her pharmacological Intervention the non-pharmacological psychosocial support approaches are also effective.</p> <p>Resident #15 - On 04/14/2015, Resident physician was contacted by the Director of Nurses to clarify the indication for Zoloft, as per clarification by the physician the indication for Zoloft is panic disorder(anxiety related to panic disorder). During the conversation with the physician, a telephone order was also given by the physician to discontinue the ativan.</p>	4/20/15

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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 329)	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to request a gradual dose reduction (GDR) as recommended by the pharmacist, justify the use of an antidepressant and an anti-anxiety medication for a resident, and failed to have an interdisciplinary team (IDT) process to review residents who were receiving psychoactive medications. This was true for 2 of 3 sample residents (#2 &amp; 15) reviewed for psychoactive medications. The deficient practice had the potential for harm if residents were over-medicated or inappropriately medicated. Findings include:</p> <ol style="list-style-type: none"> <li>1. Resident #2 was admitted to the facility 11/4/14 with diagnoses of rehabilitation for a fractured ankle and depressive disorder.</li> </ol> <p>The Admission MDS, dated 11/17/14, documented the resident received an antidepressant medication for the 7 days of the assessment period.</p> <p>The March 2015 recapitulation Physician Orders documented the resident received Trazodone 50 mg orally at bedtime every night for depression.</p> <p>The Monthly Behavior Monitoring Flowsheet identified the resident's depression was manifested by insomnia. The Flowsheet for the first 23 days of March 2015 documented the resident slept 7 to 8 hours a night. On 3/23/14 at</p>	(F 329)	<p>F-329 continued...</p> <p>By 04/17/2015, the Administrator or designee will provide in-service education to the Social Services Director, Activity Director, and Dietary Manager regarding F-329 with emphasis on importance of attending the Psychotropic behavior committee meeting.</p> <p>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</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 psychotropic medication, hence by 04/17/2015 the Administrator or designee and Director of Nursing or LN designee sent the copies of the most recent Pharmacist Consultant GDR requests, and/or copies of the most recent Psychotropic Behavior Committee meeting minute(s) to the Resident(s) physician, and also placed in the Resident(s) medical record.</p> <p>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:</p> <p>A root cause analysis was done by the Administrator and DNS. Therefore to ensure that the deficient practice does not recur, a systemic measure to be put into place will be a "GDR checklist," formulated on 04/17/2015 by the Administrator or designee that the Psychotropic Behavior Committee or their designee could use during their scheduled GDR meeting to ensure that;</p>	
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{F 329}	<p>Continued From page 16</p> <p>12:05 PM, the resident stated she had no issues sleeping at night and family was with her most days.</p> <p>A 2/25-26/15 pharmacy Consultation Report, sent to the resident's physician recommended a GDR of the Trazodone dose from 50 mg to 25 mg at bedtime. As of 3/24/15, the facility had not received a response from the physician regarding the recommendation.</p> <p>On 3/24/15 at 2:55 PM, the DON stated the information from the Consultant Report was sent to the physician. It could not be determined exactly when the information was sent; however, the fax date stamp was 3/11/15 at 2:54 PM, 13 days after the recommendation was made. The DON stated the physician was in court during that month.</p> <p>The resident continued on the Trazodone with no documentation as to why there was a 28 day delay in the physician being involved with reducing the medication.</p> <p>2. Resident #15 was admitted to the facility on 5/23/1 with a diagnosis of COPD.</p> <p>The most recent Quarterly MDS, dated 12/5/14, documented the resident was not receiving any psychotropic medications.</p> <p>March 2015 recapitulation Physician Orders documented the resident received Sertraline (Zoloft) 50 mg tablet each morning with an order start date of 2/17/15, and Lorazepam (Ativan) 0.5 mg two tablets three times a day as needed with an order start date of 1/18/15.</p>	{F 329}	<p>F-329 continued...</p> <p>Copies of the Pharmacist Consultant GDR requests, and/or copies of the Psychotropic Behavior Committee meeting minute(s) are sent to the Resident(s) physician, and also placed in the Resident(s) medical record.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</b></p> <p>Monitoring will be done through the Administrator or designee and Director of Nurses or LN designee who will review at least three (3) Residents on Psychotropic medication to ensure that;</p> <ul style="list-style-type: none"> <li>Copies of the most recent Pharmacist Consultant GDR requests, and/or copies of the most recent Psychotropic Behavior Committee meeting minute(s) are sent to Resident(s) physician, and also placed in the Resident(s) medical record.</li> </ul> <p>Monitoring will start on 04/20/2015 This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee and Director of Nursing or LN designee will submit to the QA&amp;A Committee any findings and/or corrective actions taken during the quarterly QA&amp;A Committee Meeting.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A Committee quarterly meeting.</p>	
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{F 329}	<p>Continued From page 17</p> <p>A 1/21/15 physician office visit note documented the resident was, "here today with increasing anxiety and hypertension... She had been scheduled to have surgery... last Friday but it was canceled because her surgeon was ill... this has been rescheduled for next Friday. However, last Saturday, she seemed to develop some slight cold symptoms. She has experienced greater anxiety and dyspnea although her oxygen saturations have been good. Her pressure has been noted to be high although she usually does not have a history of hypertension. She was given a dose of Clonidine on Saturday and then on Sunday was started on Ativan 1 mg 1 tid p.r.n. [three times a day] in an attempt to control the anxiety. However, she still complains of anxiety and her pressure is still high. She also has a sensation of dyspnea. For her severe emphysema, she is currently on... [listed multiple medication for COPD]."</p> <p>The physician documented an Objective Evaluation of, "She seems somewhat sedated, presumably from the Ativan. She also has some trouble with her hearing. She was not dyspnic..."</p> <p>The physician's Assessment was, "The patient has anxiety which is probably causing hypertension... Her dyspnea is probably making anxiety worse. The Ativan is not effective in controlling her anxiety..."</p> <p>The resident's record did not include any assessment or documentation about the resident's anxiety. There was no documentation that any members of the interdisciplinary team were involved to assist the resident in dealing with her anxiety. The resident was started on Zoloft on 2/17/15 but justification by the physician</p>	{F 329}			

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{F 329}	<p>Continued From page 18 or IDT was lacking in the medical record.</p> <p>The DON was interviewed on 3/23/15 at 2:50 PM. The DON was unable to explain the medical record's lack of documentation as to why the resident was started on the antidepressant Zoloft and why the resident still had Ativan ordered to be given for anxiety when the physician indicated it was not effective. The DON provided no further information.</p> <p>3. During an interview with the DON on 3/23/15 at 2:50, the DON stated she, the pharmacist and the MDS nurse reviewed psychotropic medications on a monthly basis when the consultant pharmacist was at the facility to review each resident's medication regime.</p> <p>The DON produced a form entitled, Psychotropic Behavior Committee Meeting that documented the following resident information: Target Behaviors, Number of Episodes, Comments, and IDT (interdisciplinary team) Determination. The form included signature lines for the pharmacist, physician, DON, and MDS nurse. The DON stated the forms were kept in her office, rather than in each resident's record.</p> <p>The DON confirmed that not all members of the IDT were involved in the psychotropic meeting, most notably social services, activities, and dietary staff. The DON stated the residents' physicians did not attend the meetings and there was no process to share the Psychotropic Behavior Committee Meeting notes with the physician. If a medication change was sought, the pharmacist sent a form letter to the physician for review and determination. As such, the DON was unable to explain how the nonpharmacological interventions</p>	{F 329}			

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{F 329}	Continued From page 19 were developed in consideration of each residents' individual needs, preferences, and goals of treatment; nor how it could be determined the physician held a key role in assuring psychotropic medications were used in the minimal dose, for the minimal duration, in response to specific target symptoms.  The facility offered no further information: 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 observation, record review and staff interview, it was determined the facility failed to ensure each resident's medical record completely and accurately documented care provided. This was true for 5 of 10 sample residents (#s 1, 2, 5, 15 and 18) reviewed for clinical records. This created the potential for medical decisions to be on based on inaccurate information. Findings included:	{F 329}		
{F 514}	SS=E	{F 514}	F- 514  Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:  Resident #1, by 04/17/2015 a copy of the most recent Psychotropic Behavior Committee meeting minute was fax to the physician and then placed in the Resident medical record.  Res. #1, order for Restorative Dining was discontinued by the Physician on 3/31/2015.  Resident #1, on 4/14/15 the oxygen care plan was checked and the cleaning of the concentrator filter weekly is in the intervention section according to the Resident(s) physician order.  Resident #1 Lap buddy had been discontinued on 2/13/2015 when an order for self-releasing seat belt was obtained due to Resident removing the lap buddy.  Resident # 1 fall risk care plan was updated to match physician order for self-releasing seat belt to prevent falling forward due to Resident removing the lap buddy.	4/20/15

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<p>{F 514}</p>	<p>Continued From page 20</p> <p>1. Resident #1 was admitted on 4/30/14 with diagnoses that included late effect hemiplegia, cerebral vascular disease and depression.</p> <p>a) March 2015 recapitulation Physician Orders included Zoloft 100 mg daily for depression and Ativan 0.5 mg twice a day as needed for anxiety. The resident's record did not include evidence of review of these medications related to the behaviors for which they were prescribed. When interviewed on 3/24/15 at 8:15 AM, the DON stated Resident #1's medications were reviewed in February and she had notes related to that meeting in a drawer in her office. She said those notes were not a part of the resident's record. The DON then provided a copy of Psychotropic Behavior Committee Meeting minutes dated 2/26/15 that was signed by the pharmacist, DON, physician and MDS Coordinator. The minutes included a review of the resident's behaviors related to the medications and the recommendations of the interdisciplinary team.</p> <p>b) Resident #1's March 2015 recapitulation Physician Orders included that the resident was to eat all meals at the restorative dining table. The start date of the order was 5/20/14.</p> <p>Resident #1's 12/10/14 Plan of Care for Nutrition included an intervention to assist the resident with meals as needed but did not document the resident was to eat meals at a restorative dining table or that the resident required restorative interventions for dining.</p> <p>During the noon meal on 3/23/15 and the breakfast meal on 3/24/15 the resident was observed to eat her meals independently with set</p>	<p>{F 514}</p>	<p>F-514 continued...</p> <p>Resident #1 seat belt is "self-releasing," for a least restrictive measure and that is why during the dining observation, the Resident is able to unfasten her self-releasing seat belt as intended to ensure least restrictive measure.</p> <p>Resident #2, by 04/17/2015, a copy of the most recent Psychotropic Behavior Committee meeting minute was fax to the physician and then placed in the Resident medical record.</p> <p>Resident #5, by 04/17/2015 a copy of the most recent Psychotropic Behavior Committee meeting minute was fax to the physician and then placed in the Resident medical record.</p> <p>Resident # 15, by 04/17/2015, a copy of the most recent Psychotropic Behavior Committee meeting minute was fax to the physician and then placed in the Resident medical record.</p> <p>On 03/25/2015, Resident # 18's "risk for fall" care plan was revised by the MDS Coordinator to reflect the use of a mechanical lift (hoyer lift) for transfer.</p> <p><b>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</b></p> <p>Resident(s) who have physician orders for Psychotropic medication, Restorative Dining, self-releasing seat belt, oxygen concentrator filter cleaning, mechanical lift (hoyer lift) for transfers may have the potential to be affected by this deficiency.</p>	
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{F 514}	<p>Continued From page 21 up assistance only in the main dining room.</p> <p>On 3/25/15 during the exit conference at 8:30 AM the facility's administrator stated the facility did not have a specific restorative dining table.</p> <p>c) The resident's March 2015 recapitulation Physician Orders included an order, with a start date of 2/27/15, for continuous oxygen to be administered at 2 liters per minute to keep saturation levels greater than 90%. The order included that the oxygen concentrator filter was to be cleaned every week.</p> <p>Resident #1's medical record did not include a Plan of Care regarding the oxygen order.</p> <p>d) Resident #1's March 2015 recapitulation Physician Orders included a 3/4/15 order for the use of a self-releasing seat belt in her wheelchair to prevent falling forward due to the resident removing the lap buddy. However, the orders also included an order, with a start date of 10/21/14, for the lap buddy to prevent the resident from falling forward.</p> <p>During observations on 3/23/15 at 12:10, 12:35 and 3:40 PM and during the breakfast meal on 3/24/15 the resident was observed with a seat belt only. On 3/24/15 the seat belt was noted to be unfastened.</p> <p>During the exit conference on 3/25/15 at 8:30 AM the facility's administrator, DON and other facility personnel were informed of the above concerns. The facility provided no further information.</p> <p>2. Resident #18 was admitted to the facility on 2/16/15 with a diagnoses of rehabilitation for</p>	{F 514}	<p>F-514 continued...</p> <p>Therefore by 04/17/2015, the Administrator or designee and the Director of Nurses or LN designee will ensure that;</p> <ul style="list-style-type: none"> <li>• The most recent minute(s) from the Psychotropic Behavior Committee meeting are sent to the Resident(s) physician, and are also placed in the Resident(s) medical record.</li> <li>• The plan of care for Nutrition includes in the intervention "Restorative Dining" for Resident(s) who have a new physician's order for Restorative Dining.</li> <li>• The Resident(s) fall risk care plan matches current use of self-release seat belt for Resident(s) with new physician order for self-release seat belt.</li> <li>• The Resident(s) oxygen care plan includes the cleaning of the concentrator filter weekly when ordered by the Resident(s) physician.</li> <li>• The Resident(s) fall risk care plan reflects the use of a mechanical lift (hoyer lift) for transfer for Resident(s) that use a mechanical lift (hoyer lift) for transfers.</li> </ul> <p>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:</p> <p>A root cause analysis was done by the Administrator and DNS. Therefore to ensure that the deficient practice does not recur, starting on 4/17/2015 a systemic measure will be put into place:</p>	

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(F 514)	<p>Continued From page 22 Guillain-Barre Syndrome.</p> <p>According to an Incident/Accident report dated 3/10/15 at 8:10 AM, the resident was being transferred into his wheelchair with a mechanical lift. The resident's chair tipped when the lift sling was released and the resident fell backwards.</p> <p>The resident's medical record progress notes for all departments were reviewed. There was no documentation that the resident had a fall on 3/10/15.</p> <p>The DON was interviewed on 3/24/15 at 3:45 PM. No further information was provided.</p> <p>3. Resident's #2, #5 and #15 were on psychotropic medications. On 3/23/15 at 2:50 PM the DON was interviewed about the process for reviewing the residents need for psychotropic medications. During the interview it was found the DON had a form and documented the discussions of the staff at the meetings. When asked where the information was located in the medical record the DON stated the forms were in a file in her office and not in the medical records of the residents. Review of the medical records for all three resident's revealed there was no documentation of the meetings and recommendations that came out of the meetings in the medical records.</p> <p>On 3/25/15 at 9:15 AM, the DON provided copies of the forms to the surveyors. The forms had not been in the medical records for review.</p>	(F 514)	<p>F-514 continued...</p> <ul style="list-style-type: none"> <li>• A " Psychotropic Behavior Committee meeting minute checklist," formulated on 04/17/2015 by the Administrator or designee that the Psychotropic Behavior Committee will be used to ensure that the most recent copies of the scheduled Psychotropic Behavior Committee meeting minutes are sent to the Resident(s) physician, and also placed in the Resident(s) medical record.</li> <li>• By 04/17/2015 the Administrator or designee formulated a checklist for residents who have physician order for Restorative Dining to be used by the Interdisciplinary team (IDT) during their scheduled stand-up meetings to ensure that care plans for Nutrition include in the intervention "Restorative Dining" for Resident(s) who have a new physician's order for Restorative Dining.</li> <li>• A " Self-releasing seat belt checklist," formulated on 04/17/2015 by the Administrator or designee to be used by the Interdisciplinary team (IDT) during their scheduled stand-up meetings to ensure that Resident(s) fall risk care plans match current use of self-releasing seat belt for Resident(s) with new physician orders for self-releasing seat belt.</li> <li>• An "Oxygen Concentrator Filter Cleaning checklist," formulated on 4/17/2015 by the Administrator or designee will be used by the Interdisciplinary team (IDT) during their scheduled stand-up meetings to ensure that Resident(s) oxygen care plans include cleaning of the concentrator filter weekly when ordered by the Resident(s) physician.</li> </ul>	

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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  R-C 03/25/2015
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)
{F 514}	<p>Continued From page 22 Gullain-Barre Syndrome.</p> <p>According to an Incident/Accident report dated 3/10/15 at 8:10 AM, the resident was being transferred into his wheelchair with a mechanical lift. The resident's chair tipped when the lift sling was released and the resident fell backwards.</p> <p>The resident's medical record progress notes for all departments were reviewed. There was no documentation that the resident had a fall on 3/10/15.</p> <p>The DON was interviewed on 3/24/15 at 3:45 PM. No further information was provided.</p> <p>3. Resident's #2, #5 and #15 were on psychotropic medications. On 3/23/15 at 2:50 PM the DON was interviewed about the process for reviewing the residents need for psychotropic medications. During the interview it was found the DON had a form and documented the discussions of the staff at the meetings. When asked where the information was located in the medical record the DON stated the forms were in a file in her office and not in the medical records of the residents. Review of the medical records for all three resident's revealed there was no documentation of the meetings and recommendations that came out of the meetings in the medical records.</p> <p>On 3/25/15 at 9:15 AM, the DON provided copies of the forms to the surveyors. The forms had not been in the medical records for review.</p>	{F 514}	<p>F-514 continued...</p> <ul style="list-style-type: none"> <li>• A "Mechanical Lift checklist" formulated on 4/17/2015 by the Administrator or designee to be used by the Interdisciplinary team (IDT) during their scheduled stand-up meetings to ensure that Resident(s) fall risk care plans include mechanical lift (hoyer lift) for residents that are transferred using a mechanical lift (hoyer lift).</li> </ul> <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 Administrator or designee and Director of Nursing or LN designee will review;</p> <ul style="list-style-type: none"> <li>• At least three (3) Residents who have physician order for psychotropic medication to ensure that the scheduled Psychotropic Behavior Committee meeting minutes are sent to the Resident(s) physician, and also placed in the Resident(s) medical record.</li> <li>• At least three (3) Residents to ensure that the plan of care for Nutrition includes in the intervention "Restorative Dining" for Resident(s) who have a physician's order for Restorative Dining.</li> <li>• At least three (3) Residents to ensure that Resident(s) fall risk care plan matches current use of self-releasing seat belt for Resident(s) with physician order for self-releasing seat belt.</li> <li>• At least three (3) Residents to ensure that Resident(s) oxygen care plan includes cleaning of the concentrator filter weekly when ordered by the Resident(s) physician.</li> </ul>

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

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