



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

PHILIP COPY

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

June 15, 2015

Mark S. High, Administrator  
Life Care Center of Idaho Falls  
2725 East 17th Street  
Idaho Falls, ID 83406-6601

Provider #: 135091

Dear Mr. High:

On **June 5, 2015**, a survey was conducted at Life Care Center of Idaho Falls 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. 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) and on or before the "Opportunity to Correct." **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.

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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 Plan of Correction (PoC) for the deficiencies must be submitted by **June 29, 2015**. Failure to submit an acceptable PoC by **June 29, 2015**, may result in the imposition of civil monetary penalties by **July 18, 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; and
- 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*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **July 10, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **July 10, 2015**. A change in the seriousness of the deficiencies on **July 10, 2015**, may result in a change in

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the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **July 10, 2015** includes the following:

Denial of payment for new admissions effective **September 5, 2015**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 5, 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 provide you with a separate formal notification of that determination.**

If you believe these 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, 83720-0009; 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. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **June 5, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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:

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<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 **June 29, 2015**. If your request for informal dispute resolution is received after **June 29, 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,



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

NS/dmj  
Enclosures

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

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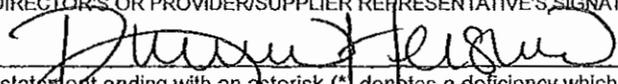
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/05/2015
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF IDAHO FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406
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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 annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN Kendra Deines, RN, BSN Lorraine Hutton, RN</p> <p>The survey team entered the facility on June 1, 2015 and exited on June 5, 2015</p> <p>This report reflects changes resulting from the Informal Dispute Resolution (IDR) process completed on August 11, 2015</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed</p>	F 000	<p>Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</p>	
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 226	<p><b>Root Cause:</b></p> <p>(1) The facility failed to have the definition of a bruise of unknown origin outlined as stated in CMS letter dated May 2014 in reporting procedure. (2) A certified nursing assistant placed inaccurate terminology for the accurate autonomy placement on the discovered bruise (this witness statement was present in the investigation report (IDA) and was not part of</p>	7/10/15

RECEIVED  
IDR  
FACILITY COMPLAINTS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ED	(X6) DATE 09-02-15
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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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F 226	<p>Continued From page 1</p> <p>by: Based on record review and staff interviews, it was determined the facility failed to operationalize its policies and procedures for the identification, investigation, and reporting of abuse, neglect, or mistreatment for 1 of 15 sampled residents (Resident #8). This failure had the potential for harm when the resident had an unwitnessed fall, then a bruise was found on the resident's trunk 11 days later and a conclusion was made that the bruise was related to the fall without adequate investigation. In addition, the potential abuse was not reported to the state agency. Findings include:</p> <p>Resident #8 was admitted to the facility in 2009 with multiple diagnoses including dementia.</p> <p>An Incident/Accident report dated 2/24/15 documented the resident was "sitting in geri-chair in activity area when staff overheard resident fall from chair" and sustained a skin tear to the left leg. The Incident/Accident Data Entry Questionnaire documented CNA #14 witnessed the fall. The CNA stated on her witness form, "I was charting, and heard [the resident] fall out of her wheelchair and onto the floor." The report documented, "ROM [range of motion] without concerns and/or signs and symptoms of pain...no additional injuries observed." Increased supervision and body pillow for the wheelchair was initiated as new interventions.</p> <p>An Incident/Accident report dated 3/7/15 documented a bruise was found to the "pelvic area." The witness statement by CNA #13 stated, "I went to change [the resident] I noticed a bruise on her vagina that was not there the night before because I worked and changed her all night."</p>	F 226	<p>the resident's medical record) stating the bruise was discovered on the resident's "vagina". LPN observation followed by RN assessment completed placed accurate bruise formation on pelvic bone left of midline. (3) The facility completed the investigation to the discovered bruise but failed to report the discovery and investigation to CMS agency.</p> <p><b>Specific Resident:</b></p> <p>Resident #8 had head to toe skin assessment completed to ensure no bruises of unknown origin were present on the trunk area. No areas of concern and/or bruising discovered.</p> <p><b>Other Residents:</b></p> <p>Resident's within the facility that have a bruise of unknown origin discovered as defined in Idaho State Informational letter #2014-04 will have report called into the CMS agency and the follow up investigation completed and sent to CMS agency within 5 business days after notification.</p> <p><b>Systemic Change:</b></p>	

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F 226	<p>Continued From page 2</p> <p>This was the only witness statement in the investigation and all other mentions of the bruise in the report referred to the "pelvic area." The Incident Follow-up and Recommendation Form documented when the bruise was found vital signs, skin, pain, and environment were assessed for areas of concern. Upon follow-up it was determined, "Resident with previous fall on 2/27/15. Resident had rolled and/or climbed over side of geri-chair. Bruise root cause related to crawling and/or making contact with armrest in geri-chair." At this time it was also documented that the family and doctor were notified of the "bruise to pelvic/peri area."</p> <p>Note: Idaho State Informational Letter #2014-04 states, "Incidents that must be reported:...Resident injuries of unknown origin. These are injuries whose source was not observed by any person or the source of the injury could not be explained by the resident; and, the injury includes bruising on the head, neck, or trunk...Injuries found immediately after a fall need not be reported as 'unknown origin.'" The bruise found on 3/7/15 was not reported to the state agency and investigation to rule out abuse was not completed.</p> <p>On 6/4/15 at 11:05 a.m., the DON was asked about any further investigation of the bruise. She said, "I talked to the nurse manager and we determined it was from the fall. The documentation wasn't adequate. It should have been more in depth. The nurse manager was interviewed but it wasn't documented. I never suspected abuse at all." When asked if the bruise could have been caused by something other than the fall, she acknowledged it could have had another cause.</p>	F 226	<p>(1) The facility updated the definition of bruise of "unknown origin" as defined in Idaho State Informational Letter #2014-04. (2) DON and ED educated on Idaho State Informational letter #2014-04 and reporting bruising discovered on the trunk area of unknown origin. (3) LN staff educated on investigation of bruises of unknown origin, documentation of investigation included in the medical record and the reporting guidelines to CMS agency.</p> <p><b>Monitoring:</b></p> <p>(1) Regional Director of Clinical Services and/or Regional Vice President to audit incident reports related to bruising of unknown origin to the trunk area to ensure proper reporting completed to CMS agency monthly X3 months. (2) ED to audit incident reports weekly X4 weeks and then monthly X2 months to monitor bruises of unknown origin to the trunk area are accurately reported to state agency and investigation documentation is present in the medical record. Results of</p>	

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F 226	Continued From page 3  On 6/5/15 at 10:30 a.m., the DON provided surveyors with the article "Can one accurately date a bruise? State of the science" from 2007. The article was faxed to the facility on 6/4/15. The information in the article did not resolve the issue of inadequate investigation of potential abuse.  On 6/4/15 at 5:45 p.m., the Administrator and DON were notified of this issue. No further information was provided by the facility on the issue.	F 226	audits will be brought to monthly CQI meeting with further education and/or audits to be determined based on trends identified.  <b>Specific Resident</b>  The meal serving line procedure was changed to include the dietary aide calling out the resident dislikes off of the resident meal card to the line cook prior to placing the food on the plate.	7/10/2015
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure meals provided met the resident's preference. This affected 1 of 13 (#4) sampled residents. The facility's failure created the potential for weight loss when his meal preferences were not honored. Findings included:  Resident #4 was admitted to the facility on 5/19/15 with multiple diagnoses including decubitus ulcer and dementia.	F 242	<b>Other Resident</b>  All residents would be affected by this deficient practice.  <b>Systemic Changes</b>  Dietary staff have been in-serviced on the new procedure of calling out and recognizing resident dislikes prior to dishing up the meals on the tray. This procedure will continue during each meal time to assure that resident dislikes are not served.  <b>Monitoring</b>  CDM and/or designee will conduct	7/10/15

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F 242	Continued From page 4  The resident's admission MDS assessment dated 5/26/15, documented the resident was severely cognitively impaired with a BIMS of 3.  On 6/2/15 at 1:50 PM, the resident was observed on his bed, in his room, with his lunch plate on a tray table in front of him. The plate contained baked beans, which the resident had not eaten.  The resident's meal card was reviewed on 6/2/15 and it documented dislikes, "Beans of any kind..."  On 6/3/15 at 2:40 PM, the Dietary Manager (DM) was interviewed about the beans and she stated, "That's one they should have looked at more closely."  On 6/3/15 at 5:00 PM, the Administrator and DON were informed of the issue. No further information was provided by the facility.	F 242	a daily audit to assure that this new practice is occurring daily X2 weeks weekly X3 months. Random weekly audit by ED will also occur X3 months with results of the audits to be reported in monthly CQI meeting with further education audits to be determined based on trends identified. Monitoring/audits will begin on 6/29/2015.  Root Cause:  (1) During investigation it was determined that the facility failed to obtain MD clarification orders for colostomy care as stated in the resident's care plan. (2) Facility had new Nurse Manager whom had not received the knowledge and/or understanding of obtaining MD clarification orders for colostomy care with clear documentation that cares were completed in the resident's medical record.	
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.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure necessary care of a colostomy for 1 of 13	F 309	MD clarification orders obtained on resident #5 and placed on treatment record. Plan of care reviewed and is accurately reflecting MD ordered colostomy care.  Other Residents:	7/10/15

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F 309	Continued From page 5 (Resident #5) sampled residents. This failure created the potential for harm if the resident developed complications due to improper care of the colostomy. Findings include:  Resident #5 was admitted to the facility on 2/24/15 with multiple diagnoses which included the use of a colostomy related to a sacral stage IV pressure ulcer.  The resident's colostomy care plan included the interventions, initiated 3/6/15, "Change colostomy per MD order" and "Colostomy care each shift."  Review of physician recapitulation orders did not reveal any orders for changing the colostomy bag.  On 6/4/15 at 1:55 p.m., the DON stated "There are no orders for the care of the colostomy. The care plan refers to the order but there are no orders."  On 6/5/15 at 11:30 p.m., the Administrator and DON were notified of this issue. No further information was provided by the facility.	F 309	Residents within the facility that have a colostomy present will have clarification orders obtained from following MD, colostomy care documentation present in their medical record and reflected accurately in resident's care plan.  <b>Systemic Change:</b>  (1) Nurse Manager education completed related to obtaining MD clarification orders for colostomy cares and ensuring documentation is present in the medical record to confirm cares were completed as care planned. (3) LN staff education provided on ensuring documentation of colostomy care is present in the medical record and being completed as determined in resident's care plan  <b>Monitoring:</b> DON and/or designee to complete a weekly audit on all resident's with colostomy to ensure MD clarification orders are obtained, documentation is present in the medical record that MD orders are followed for colostomy care, and care plan accurately states the colostomy cares being provided. Audit will be conducted weekly X4 and then monthly X2. Results of audits will be brought to monthly CQI meeting with further education and/or audits to be determined based on trends identified.	7/10/15	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.				

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F 314	Continued From page 6  This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, it was determined the facility failed to provide appropriate interventions to prevent pressure sores for 1 out of 1 sampled residents (#8). The failure created the potential for harm if the resident developed pressure sores when the facility failed to implement foam boots as a preventative measure. Findings include:  Resident #8 was admitted to the facility in 2009 with multiple diagnoses including dementia and failure to thrive.  The resident's 4/2/15 Annual MDS documented the risk of pressure sore development.  The resident's physician's order dated 1/27/14 documented, "Foam boots to be worn at all times while in bed."  On 6/2/15 at 2:10 p.m., the resident was observed lying in bed without foam boots on.  At 4:10 p.m., CNA #1 acknowledged the resident did not have foam boots on when she came on her shift at 2:00 p.m..  On 6/4/15 at 5:45 p.m., the Administrator and DON were notified of this issue. No further information was provided by the facility.	F 314	<b>Root Cause:</b>  Facility staff failed to execute process for pressure sore prevention (placement of foam boots per MD order from 2:10pm-4:10pm) as witnessed from state auditor on 6/2/2015 on resident # 8.  <b>Specific Resident:</b>  Resident #8 had foam boots replaced at time of witnessed non-compliance with MD ordered foam boots.  <b>Other Residents:</b>  All resident's with MD orders for foam boots will have foam boots present per MD order and/or resident's choice as reflected in resident's individualized care plan.  <b>Systemic Change:</b>  All direct care staff educated to ensure that MD ordered foam boots are in place per MD order.  <b>Monitoring:</b>  In-House audit completed on all resident's with MD ordered foam boots to ensure boots are in place as ordered. Care plan audits completed on all resident's with MD ordered foam boots for accuracy.  Treatment Nurse and/or DON to	7/10/15	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive				



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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF IDAHO FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406		
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F 315	<p>Continued From page 8</p> <p>clothing manipulation and incontinence cares. Under cognitive/behavior patterns associated with the ability to retrain, the 3/17 assessment documented the resident could comprehend and follow directions, could recognize urinary urge sensation and could learn to control the urge to void. The 3/17 assessment documented a precipitant to incontinence was, "rushing to the toilet," and identified the resident as a candidate for a scheduled voiding program.</p> <p>The resident's Incontinence Care Plan, with a target date of 6/19/15, documented the Problem, "Resident is experiencing incontinent episodes of bowel and bladder as evidenced by - Bladder incontinence pattern, frequent incontinent of bladder, occasionally incontinent of bowels..."</p> <p>The Approaches included:          * "[Resident uses] toilet for elimination. Provide transfer pole in bathroom."          * "Assist resident to toilet before/after meals; Q [every] HS [bedtime], Q 4 hours at night and prn [as needed]."          * "Requires staff assistance for transfers to toilet, clothing, &amp; incontinent product management."</p> <p>Resident #12 was observed on 6/4/15 at 4:15 pm napping in a recliner in his room. Two staff approached the resident and woke him stating, "Harold let's go to the bathroom." Staff assisted him to a standing position and into his wheelchair. They then wheeled him into the bathroom. Using a transfer pole, the resident stood and transferred himself to the toilet with support from the two staff. The resident's adult briefs were dry.</p> <p>The resident's Monthly Flow Reports for Bladder (Flow Reports) documented mixed bladder incontinence in April 2015. For example:</p>	F 315	<p><b>Systemic Changes:</b></p> <p>Direct Care staff educated on different toileting programs and the clear definition of the programs. (2) Documentation requirements and accuracy of toileting programs educated to direct care staff and knowledge tested for understanding once education was completed. Education provided to direct care staff to ensure toileting programs are followed as care planned. (3) Care plans reviewed and adjusted to ensure facility clearly identified resident's toileting needs to maintain the highest possible level of continence.</p> <p><b>Monitor:</b></p> <p>Staff Development Coordinator to monitor RITA documentation three times a week X2weeks, twice a week X2 weeks and monthly X2 to ensure accurate charting that clearly defines toileting program for resident.</p> <p>Staff Development Coordinator to monitor toileting program provided to the resident accurately for 10% of facility</p>	

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F 315	<p>Continued From page 9</p> <p>* Out of 30 day shifts and 90 voids on day shift in April, 12 voids were incontinent. Out of 31 day shifts and 96 voids in May 2015, 7 were incontinent. Between June 1 and June 3, 2015, the resident voided 8 times on day shift, 1 of which was incontinent.</p> <p>* Evening shift voids were similar to day shift voids in April, May and June.</p> <p>* Night shift documentation for April, May and June 2015 documented the resident was incontinent 21 of 30 shifts in April, 21 of 31 shifts in May, and 2 of 2 night shifts in June.</p> <p>The Flow Reports also contained boxes for each shift of the month in which staff were to document the type of bladder program the resident received or participated in when voiding. The categories of programs were listed as: "Bladder Retraining," "Prompted Voiding," "Scheduled Voiding," "Pelvic Floor Muscle Exercises," "Check and Change," and "Incontinent and toileted every 2 hours and PRN."</p> <p>Note: Per an interview with the resident's RN manager on 6/4/15 at 4:50 pm, the resident's bladder program, as listed on his care plan, should have been documented as, "Scheduled voiding."</p> <p>Documentation on the April, May and June 2015 Monthly Flow Report for Bladder infrequently documented, "Scheduled Voiding." April's Flow Report documented the resident was, "Prompted to Void" on 4 day shifts, 2 evening shifts, and 22 night shifts. "Scheduled Voiding" was documented on only 11 shifts, all of which were evening. "Check and Change" was documented on 2 day shifts, 12 evening shifts, and 7 night shifts. "Incontinent and toileted every 2 hours &amp; PRN" was documented on 4 day shifts, 13</p>	F 315	<p>wide residents 3 times a week X2 weeks, twice weekly X2 weeks and monthly X2. Results of audits will be brought to monthly CQI meeting with further education and/or audits to be determined based on trends identified.</p>		

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F 315	<p>Continued From page 10 evening shifts, and 5 night shifts. May's Flow Reports were similar.</p> <p>On 6/4/15 at 5:00 pm, the resident's RN manager acknowledged that due to the inconsistent documentation, it was difficult to determine that staff knew what the resident's toileting program was and/or if the incontinence care plan was followed.</p> <p>2. Resident #8 was admitted to the facility in 2009 with multiple diagnoses including adult failure to thrive and dementia.</p> <p>The resident's 4/2/15 Annual MDS coded the resident had severely impaired cognitive skills, was fully dependent on staff for toileting, and was always incontinent of urine.</p> <p>The resident's bowel/bladder care plan (initiated 10/22/14) documented the intervention to "check and change [the resident's adult briefs] every two hours and pm."</p> <p>An Incident &amp; Accident report dated 2/24/15, documented Resident #8 fell at 4:00 p.m., and the last time the resident was toileted before the fall was at 12:00 p.m., 4 hours prior to the fall. The I&amp;A did not document how missed toileting opportunities would be addressed for the resident.</p> <p>The resident's Bladder Monthly Flow Report for February 2015 documented the resident was not checked and changed 8 out of 28 days.</p> <p>Similar findings were found on the Bladder Monthly Flow Report for the following months: *March-8 out of 31 days and *April-6 out of 30 days.</p>			

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F 315	Continued From page 11  On 6/4/15 at 9:00 a.m., the DON acknowledged the Incident & Accident report from 2/24/15 documented the resident was not toileted for 4 hours.  On 6/5/15 at 10:55 a.m., the DON acknowledged the documentation showed the resident was not checked and changed on the dates in question.  On 6/4/15 at 5:45 p.m., the Administrator and DON were notified of this issue. No further information was provided by the facility.			
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 oxygen therapy was accurately administered. This affected 1 of 5 (#4) residents sampled for oxygen therapy. This practice created the potential for harm if residents developed hypoxia from lack of oxygen. Findings	F 328	<b>Root Cause of Deficiency:</b>  Facility failed to execute process related to accurate administration of oxygen specific to MD order. During the investigation it was determined that LN staff did not have proper knowledge of identifying placement for proper liter flow on facility concentrators.  <b>Specific Resident:</b>  Resident #4's oxygen was adjusted to the correct liter flow at the time inaccuracy discovered.	7/10/15

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F 328	<p>Continued From page 12 included:</p> <p>Resident #4 was admitted to the facility on 5/19/15 with multiple diagnoses including hypertension.</p> <p>The resident's Physician Telephone orders, dated 5/21/15, documented, "Oxygen at 2 L[iters] min[ute] via NC [nasal cannula]."</p> <p>The resident's May and June 2015 MARs documented an order with a diagnosis of hypoxia, dated 5/21/15, "Oxygen at 2 L/Min continuous via NC."</p> <p>The resident's Respiratory care plan, dated 5/28/15, documented an intervention of, "O2 [oxygen] per MD orders."</p> <p>The resident's Progress notes, dated 5/23/15 at 9:46 PM, 5/25/15 at 9:44 PM, and 5/26/15 at 2:48 PM, documented the resident received oxygen at 1 liters per minute. The Progress notes, dated 5/27/15 at 2:28 PM, documented the resident received oxygen at 3 liters per minute. The Progress notes, dated 5/2/15 at 3:17 PM, documented the resident received oxygen at 2.5 liters per minute.</p> <p>On 6/2/15 at 8:55 AM, 9:50 AM, 11:00 AM, 12:05 PM, and 1:50 PM, the resident was observed in his bed with a nasal cannula in his nose with the room air concentrator on and set at 1.5 liters per minute.</p> <p>On 6/2/15 at 2:55 PM, Unit Manager #3 was shown the resident's room air concentrator and she said the oxygen level was not quite at 2 liters. She said the bubble which showed the liter flow,</p>	F 328	<p><b>Other Residents:</b></p> <p>Residents residing in the facility receiving supplemental oxygen will received MD ordered liter flow with accurate documentation.</p> <p><b>Systemic Changes:</b></p> <p>(1) DON obtained manual of facility oxygen concentrator and reviewed placement of identification ball for proper administration of liter flow. It was determined that the ball is to be placed center of the line specific to the ordered liter flow. (2) Education provided to direct care staff related to the proper placement/reading of the liter flow on facility concentrators and reflecting accurate documentation of liter flow to reflect MD order.</p>		

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F 328	Continued From page 13 "needs to be in the middle" of the 2 liters mark and it was not. She immediately adjusted the liter flow to 2 liters per minute.  On 6/3/15 at 5:00 PM, the Administrator and DON were informed of the issue. No further information was provided by the facility.	F 328	<b>Monitoring:</b>  DON and/or designee to ensure proper liter flow being administered to resident's per MD order for supplemental oxygen from facility concentrator (correct placement of identification device) and accurate documentation reflecting oxygen flow in medical record. Twice a week X4 weeks and weekly X8 weeks. Results of audits will be brought to monthly CQI meeting with further education and/or audits to be determined based on trends identified.		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS  The facility must provide special eating equipment and utensils for residents who need them.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to consistently provide special eating equipment for a resident who needed it. This was true for 1 of 13 sampled residents (#4). This deficient practice had the potential to harm the resident if his nutritional status declined. Findings included:  Resident #4 was admitted to the facility on 5/19/15 with multiple diagnoses including muscle weakness and lack of coordination.  The resident's 5/26/15 admission MDS assessment documented the resident had range of motion impairments to both upper extremities.  The resident's 5/28/15 Nutrition care plan was reviewed on 6/2/15 and it did not document the resident used adaptive utensils with meals.  The resident's 5/20/15 Occupational Therapy (OT) Plan of Treatment evaluation documented	F 369	<b>Root Cause:</b>  Resident was admitted to the facility and brought his personal assistive device for meals with him to the facility which was given to an unidentified facility staff member. This device was given to the kitchen for resident's use with meals which resulted in failure to follow facility procedure related to adaptive equipment use during meals.	7/10/15	

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F 369	<p>Continued From page 14</p> <p>under the goals section, "Self Feeding: ...The patient will effectively utilize adaptive utensil to feed self..."</p> <p>The resident's OT progress notes documented the following:</p> <p>-5/23/15, "Resident had built-up handled bendable spoon at table but reported that it didn't work very well. Will attempt to adapt or modify for increased I [sic] with feeding task...Continue with POC [Plan of Care];"</p> <p>-5/25/15, "OT provided reassessment of pt [patient] ability to self feed. Pt refused of adaptive spoon, despite OT demonstration of use for scooping of foods, and pt education regarding benefit of AE [Adaptive Equipment] to reduce food spillage. Pt opted to use standard spoon for self feeding of cereal, flexing forward to position mouth close to bowl, then scooping food to mouth. Pt exhibited approx[imately] 50 [percent] food spillage.;" and,</p> <p>-5/30/15, "Resident used built-up bendable spoon for meal. Completed approx 50 [percent]."</p> <p>On 6/2/15 at 1:50 PM, the resident was observed on his bed, in his room, eating his lunch meal. The resident had a red handled adaptive built-up curved spoon which he used to eat his meal.</p> <p>On 6/2/15 at 2:15 PM, the resident's meal tray card was requested and reviewed. It did not document the resident used adaptive utensils.</p> <p>On 6/2/15 at 5:40 PM, the resident was observed in his wheelchair in the main dining room. The resident's tray contained a regular spoon and fork and did not contain an adaptive built-up curved spoon. The resident's meal tray card did not document the resident used adaptive utensils.</p>	F 369	<p><b>Specific Resident:</b></p> <p>Clarification obtained for resident # 4 for use of assistive devices with meals. (2) Care plan updated to reflect resident's preference using adaptive equipment with meals and communication sent to dietary services. (3) Occupational therapy alerted to resident's preference using adaptive equipment with meals and will continue to be included in resident's plan of treatment.</p> <p><b>Other Residents:</b></p> <p>Residents residing in the facility that require adaptive equipment will receive devices as reflected in resident's care plan directly related to resident's need.</p> <p>House wide audit completed on all facility resident's whom use assistive devices with meals to ensure accurate resident preference for devices and MD order, care plan and tray card accurate.</p>	

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F 369	<p>Continued From page 15</p> <p>On 6/3/15 at 10:35 AM, Certified Occupational Therapy Assistant (COTA) #10 was interviewed about the resident's adaptive spoon. He said when he had worked with the resident there were times when the resident would use the adaptive spoon and sometimes he would not.</p> <p>On 6/3/15 at 10:50 AM, OT #11 was interviewed about the adaptive spoon. She said the spoon was the resident's personal spoon and it was brought when the resident was admitted. When asked if she had written an order for the spoon, she said she was told she did not need to write an order for it since it was brought in by the resident. Note: A Diet Order and Communication form was not found in the resident's medical record regarding the adaptive spoon.</p> <p>On 6/3/15 at 1:00 PM, the resident was observed on his bed, in his room, eating his lunch meal. The resident's tray had a regular knife, fork and spoon and did not have an adaptive spoon. The resident's meal tray card did not document the resident used adaptive utensils.</p> <p>On 6/3/15 at 2:40 PM, the Dietary Director (DD) was interviewed about the issue. When asked what utensils dietary staff were to use when there was no documentation on the meal tray card and she said a "regular knife, fork and spoon." When asked about the resident's adaptive spoon, she said she was just made aware of it on 6/2/15. She said there had been some confusion, since the resident's red handled spoon was brought in by the resident, rather than one of the facility's black handled spoons. She said the spoon had not been on the meal tray card because there had not been a diet order and communication form</p>	F 369	<p><b>Systemic Changes:</b></p> <p>Education provided to facility staff related to proper identification of items brought in from home for resident's continued use; staff educated include dietary staff, direct care staff, therapy staff and admission staff. (2) Therapy staff educated on communication with Nursing Department and Dietary Department to ensure needed adaptive equipment is on tray card, available and offered for resident use at all meals.</p> <p><b>Monitoring:</b></p> <p>Dietary Manager and/or designee to audit assistive devices with meals and ensure device available to the resident as ordered/care planed and on tray card. Weekly X4 and monthly X2 to monitor adaptive equipment with meals is provided and used per resident's preference/MD order. Results of audits will be brought to monthly CQI meeting with further education and/or audits to be determined based on trends identified.</p>	7/10/2015

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F 369	Continued From page 16 sent to the dietary department, which was the normal process to add adaptive equipment to the tray cards. She said some of the dietary staff were aware of the spoon since it had been washed and had been placed on the resident's tray on multiple occasions.  On 6/3/15 at 3:25 PM, the DON informed the surveyor she would get an order for the adaptive spoon. At 3:33 PM, the DON further informed the surveyor, speech therapy had started to work with the resident to see if the spoon was still appropriate for the resident.  On 6/3/15 at 5:45 PM, the Administrator and DON were informed of the issues. No further information was provided by the facility.			
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS  The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the consulting physician failed to write, sign, and date progress notes for each visit for 1 out of 13 (#5) sampled residents. This had the potential for harm when the facility did not	F 386	<b>Root Cause Analysis:</b>  Facility failed to obtain progress notes from consulting physician related to wound care on resident # 5. Root cause determined to be related to lack of knowledge in medical records regarding consulting physician's progress notes when visit completed.  <b>Resident Specific:</b>  Resident #5 will have progress notes present in medical record to summarize cares provided during the visit of wound consultation. *Resident #5 had all progress notes related to medical physician (Dr. Baker) present in medication record. *Resident #5 has discharged from facility.	7/10/15

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F 386	<p>Continued From page 17 have physician visit notes regarding the resident's stage IV pressure sore.</p> <p>Resident #5 was admitted to the facility on 2/24/15 with multiple diagnoses including a stage IV pressure sore.</p> <p>On 6/3/15 at 1:00 p.m., surveyors observed the resident's wound specialist visit the resident to assess the sacral stage IV pressure sore.</p> <p>On 6/3/15 at 1:10 p.m., surveyors asked LN #2 for the wound specialist visit notes. She stated he had visited "several times" but did not find any notes in the resident's chart. She stated she would continue to look. At 1:15 p.m., LN #2 said she had called the physician's office to get "notes and other records including today's note." At 5:00 p.m., LN #2 said she was still waiting for the physician's office to send her visit notes.</p> <p>Evidence of physician visit notes by the wound specialist were never provided to the surveyors within the timeframe of the survey.</p> <p>On 6/4/15 at 5:45 p.m., the Administrator and DON were notified of this issue. No further information was provided by the facility.</p>	F 386	<p><b>Other Residents:</b></p> <p>Residents residing in the facility that requiring medical physician services will have progress notes present in medical record to summarize cares provided at time of visit.</p> <p><b>Systemic Changes:</b></p> <p>(1) Education provided to Nurse Managers, Treatment Nurse and Medical records staff related to obtaining progress notes from MD after visit completion. (2) Discussed documentation of resident's visits with consulting wound specialist to ensure the facility maintains accurate documentation of care provided and/or assessment completed to the resident with MD signature for accuracy and completion present.</p> <p><b>Monitor:</b></p> <p>Medical Records and/or designee to monitor that progress notes are received from MD within regulated time frame after visit completed and is placed in medical record. Audit to be completed weekly X4 and bi-monthly X4</p>	7/10/15
F 514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</p>			



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

PRINTED: 08/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/05/2015	
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF IDAHO FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406		
(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 514	<p>Continued From page 19</p> <p>The I&amp;As documented that two of the 7 falls, plus the 1/11/15 fall, involved the resident's electronic recliner:</p> <p>* 10/1/14 I&amp;A documented, "... discovered resident on floor recliner was elevated to standing position. Resident stated he was going to the bathroom. Call light within reach but not activated." New interventions included, "Resident to have remote control to the chair removed [due to] resident's confusion/dementia he is unable to understand the proper function... removing remote from the resident's reach will allow the chair to remain a stationary chair and increase safety in use." The I&amp;A documented this decision was made with the resident's wife/POA's input.</p> <p>* 10/25/14 I&amp;A documented the resident was discovered by staff sitting on the floor with his back to the recliner. Resident stated he saw people grabbing at his feet and slid onto the floor. 15 minute checks and non-skid socks were implemented.</p> <p>* 1/11/15 I&amp;A documented staff entered room to discover resident sitting on the floor in front of his recliner with the recliner chair tipped over onto the resident's back. During LN assessment, the resident complained of new/different pain and was sent to the hospital where he was admitted for pain management.</p> <p>The 1/11/15 I&amp;A further documented, "Resident's preference continues to be sleeping in recliner despite facility's concerns and education provided. Spouse aware of concerns. Spouse refusing to have a non-electric recliner placed at facility's cost... Spoke with spouse [related to] ongoing concerns [with] injury [related to] non-compliance. Spouse in agreeance to have</p>	F 514	<p>checking progress notes for updates.</p> <p><b>Resident Specific:</b></p> <p>Resident # 12 had chart review to assess present documentation related to safety concerns and/or communication with spouse/family related to changes needed/required to current plan of care. No changes discovered. Resident # 1 medication review completed. MD office contact and informed to update changes to medication list as inaccurately reflected in progress note for upcoming MD assessment.</p> <p><b>Other Residents:</b></p> <p>Residents residing in the facility requiring communication with family and/or responsible part in relation to facility safety concerns will have documentation of conversations present in their medical record. (2) Residents that have active medications listed on MD progress notes will have medications reviewed at time of assessment and reconciled for accuracy with facility active medication record.</p>	

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F 514	<p>Continued From page 20 recliner unplugged... while in recliner. Suspected root cause [related to] self-operation of tilting up recliner chair.</p> <p>There was no documentation in the resident's medical record between 10/1/14 and 1/11/15 documenting the facility's concerns with the resident's electric recliner or conversations with the POA regarding the concerns and possible solutions.</p> <p>During an interview on 6/4/15 at 8:30 am, the DON stated that she, the social worker and the resident's RN manager had discussed their concerns regarding the resident's safety relating to his electric recliner. The DON stated the residents wife was adamant that the recliner not be removed or replaced because the recliner was a comfort to the resident and he would become quite upset with the change. On 6/4/15 at 4:50 pm, the resident's RN Manager confirmed the resident's attachment to the chair and problems related to moving or changing the chair. The RN Manager indicated the resident's psychosis with hallucination was long term (starting when the resident was young) and still active. The resident was seeing a psychiatrist who had been adjusting the resident's antipsychotic medications and it was anticipated that removing the electric chair from the resident's room would cause the resident emotional/psychological stress.</p> <p>When asked if the information regarding the resident's attachment to the chair, concerns with removing the chair from his room, and conversations with the wife about the same were documented in the medical record between October 2014 and January 2015. The DON and RN manager stated they would look for</p>	F 514	<p><b>Systemic Changes</b></p> <p>(1) LN education provided for documentation requirement for family contact related to resident safety concerns and/or follow up requirements related to maintaining resident's safety and documenting in the medical record. (2) Progress notes to be reviewed upon arrival for accuracy of listed medications and MD notified of changes required to update medication list in office system. (3) MD will be given a copy of recent medication administration record at time of visit to ensure current medications are accurate at time of MD visit.</p> <p><b>Monitoring:</b></p> <p>DON and/or designee to complete weekly audits X16 to ensure documentation is completed related to family/resident contact related to education and/or concerns in relation to resident safety.</p> <p>Medical Records and/or designee to review progress notes received from MD (if medications listed on progress note) to ensure medication list</p>

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F 514	<p>Continued From page 21 documentation. On 6/4/15 at 5:15 pm the DON stated no documentation was found.</p> <p>2. Resident #1 was admitted to the facility on 9/11/14 with multiple diagnoses including dementia.</p> <p>The resident's physician orders discontinued 2 medications on 2 different dates: *discontinue Spironolactone on 3/18/15 and *discontinue Marinol on 3/19/15 (order said to discontinue "14 days" from 3/5/15).</p> <p>The resident's physician visit notes dated 4/6/15 documented spironolactone and Marinol were current medications. This was documented 19 days after spironolactone was discontinued and 18 days after Marinol was discontinued.</p> <p>On 6/4/15 at 10:50 a.m., the DON confirmed these orders had been discontinued on the dates in question and that the physician note was wrong.</p> <p>On 6/4/15 at 5:45 p.m., the Administrator and DON were notified of this issue. No further information was provided by the facility about this issue</p>	F 514	<p>is accurate with current facility active medication regime. Audits to be completed weekly X16. Results of audits will be brought to monthly CQI meeting with further education and/or audits to be determined based on trends identified.</p>	7/10/2015

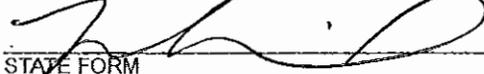
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001400</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/05/2015</b>
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C 000	16.03.02 INITIAL COMMENTS  The following deficiencies were cited during the State licensure survey of your facility.  The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN Kendra Deines, RN, BSN Lorraine Hutton, RN	C 000	<b>RECEIVED</b>  JUN 30 2015  FACILITY STANDARDS  <b>Root Cause:</b>  Facility failed to ensure mandatory attendance present at quarterly infection control meetings. Root cause of deficiency related to lack of education and knowledge of required attendees at quarterly infection control meeting.	
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 staff interview and review of the Infection Control Meeting Minutes, it was determined the facility failed to ensure a representative from required departments attended Infection Control Meetings. This affected 13 of 13 sampled residents (#s 1-13) and had the potential to affect all residents who resided in the facility. Findings included:  Review of Infection Control Meeting Minutes revealed: *The October 2014 meeting did not have housekeeping or maintenance representatives; *November 2014 meeting did not have dietary, housekeeping, or maintenance representatives; *December 2014 meeting did not have the Medical Director, housekeeping, or maintenance representative; *January 2015 meeting did not have the Administrator, dietary, housekeeping, or maintenance representative;	C 664	<b>Residents:</b>  All residents residing in the facility have the potential to be affected by lack of department attendees at quarterly infection control meetings.  <b>Systemic Change:</b>  (1) Education provided to facility staff that are required to attend quarterly infection control meeting. (2) Facility developed infection control meeting attendance log to clearly define departments in attendance which include medical director, administrator, pharmacist, dietary services supervisor, director of nursing, housekeeping services representative and maintenance services representative.  <b>Monitoring:</b>	

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

*Executive Director*

(X6) DATE

6-25-15

Bureau of Facility Standards

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C 664	Continued From page 1  *February 2015 meeting did not have the Administrator, housekeeping, or maintenance representative; *March 2015 meeting did not have the DON, dietary, housekeeping, or maintenance representatives.  On 6/4/15 at 5:45 p.m. the Administrator and the DON were informed of these findings. No further information was provided by the facility.	C 664	Regional Director of Clinical Services and/or Regional Vice Present to audit quarterly X3 to ensure all required members in attendance for monthly infection control meeting with documentation present to confirm attendance. Results of audits will be brought to monthly CQI meeting with further education and/or audits to be determined based on trends identified.	7/10/2015
C 735	02.154,02,d Current History and Physical and Findings  d. The physician shall provide the facility with medical information necessary to care for the patient/ resident which includes at least a current history and physical or medical findings completed made no longer than five (5) days prior to admission or within forty-eight (48) hours after admission. The information shall include diagnosis, medical findings, activity limitations, and rehabilitation potential. This Rule is not met as evidenced by: Based on record review and staff interviews, it was determined the physician failed to provide the facility with medical information important for care of 1 out of 13 (#13) sampled residents, when there was no evidence in the clinical record of the resident's H&P dated within 5 days of admission and no evidence of a physician assessment within 2 days after admission. Findings include:  Resident #13 was admitted to the facility on 4/16/15 with multiple diagnoses including dementia.	C 735	<b>Specific Resident</b>  Resident #13 has all documentation including date and signed H&P and all physician visits documented in her medical record.  <b>Other Resident</b>  All residents have the potential to be affected.  <b>Systemic Changes</b>  HIM educated in the standard practice of having all history and physicals dated and signed five (5) days prior to admission or within forty-eight (48) hours after admission. Systematically HIM will perform an admission audit on each newly admitted resident to the facility to assure that all history and physicals are properly dated	

Bureau of Facility Standards

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C 735	<p>Continued From page 2</p> <p>a. On 6/3/15 at 3:15 p.m., the ADON said the resident went out to see the primary physician on 5/5/15 (approximately 19 days after admission to the facility).</p> <p>On 6/3/15 at 3:25 p.m., Medical Records and the ADON said two physicians reviewed the discharge summary but neither ever physically saw the resident after the resident was admitted.</p> <p>b. Record review revealed 2 discharge summaries, on 4/1/15, when the resident was discharged from the hospital to a local Transitional Care Unit (TCU) and 4/16/15, when the resident was discharged from the TCU to the facility.</p> <p>On 6/3/15 at 3:15 p.m., the ADON said the TCU's discharge summary was requested on 6/2/15 (approximately 46 days after the resident was admitted to the facility).</p> <p>On 6/4/15 at 5:45 p.m., the Administrator and DON were notified of these issues. No further information was provided by the facility.</p>	C 735	<p>and signed within the guidelines. Following physician visits will be scheduled by the facility and will be routed and audited by the HIM to assure that physician visits are within the allowable guidelines.</p> <p><b>Monitoring</b></p> <p>ED will monitor this process weekly X4 and then every 2 weeks X3 month. Monitoring/audits will begin on 6/29/2015. Results of audits will be brought to monthly CQI meeting with further education and/or audits to be determined based on trends identified.</p>	7/10/2015