



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK--ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T -- Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: tsb@idhw.idaho.gov

July 31, 2015

Troy Thayne, Administrator
Safe Haven Care Center Of Pocatello
1200 Hospital Way,
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Thayne:

On **June 19, 2015**, a survey was conducted at Safe Haven Care Center of Pocatello 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.) **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.

Troy Thayne, Administrator
July 31, 2015
Page 2

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 **August 13, 2015**. Failure to submit an acceptable PoC by **August 13, 2015**, may result in the imposition of civil monetary penalties by **September 2, 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*.

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

A 'per instance' civil money penalty of **\$3,000**.

(THIS REMEDY IS GENERALLY RESERVED FOR SITUATIONS OF SERIOUS NONCOMPLIANCE AS DESCRIBED IN THE STATE OPERATIONS MANUAL §7510) (42 CFR §488.430)

Troy Thayne, Administrator
July 31, 2015
Page 3

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 19, 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.

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

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

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

- **BFS Letters (06/30/11)**

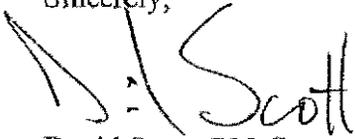
2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **August 13, 2015**. If your request for informal dispute resolution is received after **August 13, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Troy Thayne, Administrator
July 31, 2015
Page 4

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 black ink that reads "David Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

David Scott, RN, Supervisor
Long Term Care

DJS/djm
Enclosures

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 136071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 000	INITIAL COMMENTS The following deficiencies were cited during a complaint investigation survey of your facility. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Linda Hukill-Neil, RN Lorraine Hutton, RN The survey team entered the facility on June 15, 2015 and exited on June 19, 2015. Survey Definitions: ADL = Activities of Daily Living ADON = Assistant Director of Nursing BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CNA = Certified Nurse Aide DON = Director of Nursing CDM = Certified Dietary Manager LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS - Minimum Data Set NA = Non certified nurses aide POC = Plan of Care TAR = Treatment Administration Record	F 000	F 157 1- The facility administrator spoke personally with resident #17's guardian and gave him an update on the investigation and the investigation process. The previous administrator and DON did not enforce policies or procedures to notify family or guardians. Nursing staff has been in-serviced on proper notification of accidents and investigations. Resident #8's seatbelt was removed and placed on a 1:1. 2- All residents who have a change of condition or experience an incident have the potential to be affected. 3- An Accident Investigation committee has been established and will meet daily, five days a week to review the previous days' accidents and/ or unusual occurrences. The committee will do root cause analysis and will initiate investigations as necessary Residents' family or guardian will be notified immediately following an incident/accident or a significant change of condition. Nurses who are	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X6) DATE 9-10-15

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.

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 157	<p>Continued From page 1</p> <p>status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on grievances, incident and accident reports, medical record review, and staff interviews, it was determined the facility did not ensure residents' legal representatives or family members were notified when there were accidents involving residents which resulted in injury and/or had the potential for requiring physician intervention. This was true for 2 of 17 (#s 8 & 17) residents reviewed for family notification of changes. This deficient practice had the potential to cause harm when family members were not notified of the residents'</p>	F 157	<p>found to not follow the reporting policy will be subject to disciplinary action.</p> <p>4.- The Incident/Accident committee will review daily, 5 times per week all incidents and accidents to include verifying that families and/or responsible parties are notified on a perpetual basis. Accidents and incidents will be trended and reviewed at each monthly QA meeting in order to identify any problems related to timely notification.</p> <p>5- Compliance date: 09/15/15</p>		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 157	<p>Continued From page 2</p> <p>incident and accidents, were not given the opportunity to be with their family member or share information with the emergency personnel at the hospital. Findings included:</p> <p>1. Resident #17 was admitted to the facility on 8/28/12, and readmitted on 4/7/15, with multiple diagnoses which included dementia without behavioral disturbances, anoxic encephalopathy, and mood disorder.</p> <p>The resident's 4/21/15 readmission MDS assessment documented: *BIMS of 3 - cognition severely impaired; *Locomotion on- and off the unit - extensive assistance with one person assistance; *Bed mobility, transfer, and dressing - extensive assistance with 2-person assistance; and, *No limitation in range of motion for bilateral limbs.</p> <p>Resident #17's Mobility Care Plan documented: *Focus - Self-care deficit of mobility related to anoxic brain injury, impaired cognition, and impaired mobility. Interventions - "...requires limited to extensive assist with 1-2 persons with mobility/transfers. May use Vander Lift as needed...uses a W/C for long distances, She is able to propel herself very short distances. Staff to assist as needed...alarm to bed and WC to alert staff when [resident's name] attempts to self transfer."</p> <p>The resident's Nursing Progress Notes documented: 4/18/15 at 4:00 PM - "Res [resident] found alert orient [sic] X [times] 1 on her mat on the floor...Denied discomfort. No injuries noted...Res</p>	F 157		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 157	<p>Continued From page 3</p> <p>had reportedly had increased days of altered mental status during the week where the Cymbalta & Abilify were in a bubble pack in the med cart, possibly given, MD ordered to hold Cymbalta & Abilify."</p> <p>4/19/15 at 11:30 AM - "Res was able to get out of front door of facility [and] rolled halfway down the driveway. Her W/C hit the curb and she fell onto the grass. Once upon the scene VS [vital signs] obtained...Asked resident what happened. She reported "I fell." C/O [complains of] pain in her back et [and] pelvic area - EMTs called - Res alert [and] able to answer questions...EMTs arrived [and] assessed. Res transported to [hospital] ER [emergency room]. Assistant DON, acting DON, administrator, [and] PCP [primary care provider] notified - transport to ED [emergency department]..."</p> <p>4/19/15 at 3:30 PM - "Res returned to [facility]from hospital]. No new orders received...x-rays were obtained [and] results are noted as WNL [within normal limits]..."</p> <p>4/19/15 at 4:30 PM - "(Guardian) notified of fall and trip to ED..."</p> <p>The facility's Suggestion/Grievance/Compliment form with Resident #17's name, the month of April, no day or year, and completed by the Social Worker, documented the following: "[Resident #17's Guardian] is upset because [Resident #17] fell and he wasn't contacted in a timely manner. He's upset about the lack of notable signs posted on the front doors which would protect anyone from letting residents outside. He wants to know how we will prevent this from happening in the future. He's upset because he wasn't given any updates after this incident as far as an official report of the incident</p>	F 157		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 157	<p>Continued From page 4 and intervention itself..."</p> <p>The facility had a nine-page Incident/Accident report, dated 4/19/15, for Resident #17 that documented:</p> <ul style="list-style-type: none"> -The resident on 4/19/15 at 11:00 AM was able to get out the front facility door, rolled halfway down the drive, hit the curb, and fell into the grass. -The physician was notified at 11:15 AM and new orders were received to transport the resident to the emergency room. -The area for family member/resident representative notification was blank. <p>Note: There was no Incident and Accident report or documented investigation for the 4/18/15 fall indicating the resident's representative had been contacted.</p> <p>On 6/19/15 at 11:08 AM, when LSW #1 was interviewed about Resident #17's 4/18 and 4/19/15 incident and accidents, she stated she received a text message alert the day after the resident went out the front door and that the resident's Guardian was upset and needed a call back. The LSW acknowledged the resident's representative should have been contacted immediately. LSW #1 stated she thought it was nursing's responsibility to notify resident representatives and complete a thorough investigation with input from the IDT (Interdisciplinary Team).</p> <p>On 6/19/15 at 4:30 PM, the Administrator and staff managers were informed of the concerns with failure to notify family members or a legal representative immediately of a resident's change of condition and/or incidents and accidents.</p>	F 157		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCA TELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCA TELLO, ID 83201		
(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 157	<p>Continued From page 5</p> <p>2. Resident #8 was admitted to the facility with diagnoses of ischemic stroke with occlusion, hemiplegia affecting right side, below knee amputation, osteoarthritis, and chronic pain.</p> <p>The previous Quarterly MDS assessment, dated 4/9/15, and the current Quarterly MDS assessment, dated 6/16/15, coded the resident required extensive assistance of two people for transfers; was not steady when moving from a seated to standing position; had no impairment in the upper extremities; had impairment on one side of the lower extremities.</p> <p>The facility's Change in a Resident's Condition or Status policy documented, "Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's condition or status."</p> <p>A 3/4/15 Incident/Accident Report for Resident #8 documented the resident reached down to [pick] something on floor and fell out of his wheelchair. As a result of the fall, the resident sustained a skin tear to the right lower elbow and a lump on right head and upper forehead. The family notification portion of the form was blank.</p> <p>A 3/6/15 an Incident/Accident Report documented the resident was attempting to enter a room and was rocking the wheel chair back and forth to get over the threshold and fell forward out of the chair. The family notification portion of the form documented the family member was notified at 4:00 PM, 4 hours and 40 minutes prior to the 8:40 PM fall.</p>	F 157			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 157	Continued From page 6	F 157	F 221		
F 221 SS=D	<p>A 3/7/15 Incident/Accident Report documented the resident was found on the floor of his room at 1:15 PM. The family notification portion of the form documented family was not notified until 5:57 PM, almost 5 hours after the fall occurred.</p> <p>On 6/19/15 at 4:30 PM, the Administrator and staff managers were informed of the concerns with failure to notify family members or a legal representative immediately of a resident's change of condition and/or incidents and accidents.</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and medical record review, it was determined the facility improperly used physical restraints on residents, failed to evaluate the use of less restrictive devices/restraints, and failed to adequately assess residents' condition with a seatbelt in place. This was true for 2 of 4 (#s 3 & 8) residents sampled for the use of physical restraints. This deficient practice created the potential for harm should residents experience contractures, decreased mobility, and/or the development of pressure sores from inability to off load. Findings include:</p>	F 221	<p>1-The use of the gait belt was unauthorized by the facility. The belt was removed from resident #8. The aide who restrained resident #3 was educated and disciplined. Resident # 8 was able to remove his seatbelt, but had an injury to his hand that was wrapped up that prevented him from unlatching the seatbelt after the initial assessment. Nursing staff was educated on proper reassessment when there is a change of condition.</p> <p>2- All residents with restraints have the potential to be affected. An audit has been completed of all residents to identify those who have restraints.</p> <p>3- All residents with restraints will be reviewed weekly during Restraint Meeting. The restraint committee will review for appropriate signatures, update and/or change Care Plans as necessary, and review any care provider notes, and any changes of condition. Audits will be completed twice weekly for two weeks on all residents to identify those with restraints that are not ordered, then once weekly for 2</p>		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 136071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 221	Continued From page 7 The facility's policy and procedure, General Guidelines for the Use of Physical Restraints, documented: * Restraints will only be used after alternative methods have been tried unsuccessfully and upon the written order of a physician that specifies the circumstances for the use of the restraint. * If a resident's behavior is such that it will result in injury to himself or herself or others and any form of physical restraint is utilized, it shall be in conjunction with a treatment procedure designed to modify the behavioral problems for which the resident is restrained or, as a last resort, after failure of attempted therapy. * Designated facility staff must explain the potential risks and benefits of all options under consideration including using a restraint, not using a restraint and alternatives to restraint use. * The use of restraints is identified on the resident's care plan and includes: The medical symptoms that warrant the need for the restraint; the symptoms that are being treated; type of restraint used; when the restraint is to be used; the plan for the release of the device for exercise and toileting every 2 hours for a period of not less than ten (10) minutes; the plan for monitoring every 30 minutes; and how the use of the restraint will assist the resident in reaching his/her highest level of physical and psychosocial well-being. 1. Resident #3 was admitted to the facility on 2/18/15 with multiple diagnoses, including dementia with behavioral disturbances, decubitus buttocks ulcer, neurogenic bladder, and chronic kidney disease.	F 221	months by the Restraint Committee. 4- Data of restraints will be brought to the monthly QA meeting for review and oversight for a minimum of 3 months or until otherwise resolved. 5- Compliance Date: 9/15/15		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 221	<p>Continued From page 8</p> <p>The resident's admission MDS assessment, dated 3/14/15, documented: *BIMS score of 3 - Cognition severely impaired; *Total assist of 1 person for locomotion on- and off unit; and, *Total assist of 1 person for dressing, eating, toilet use, and personal hygiene.</p> <p>The resident's 1:1 Shift Behavior Narrative by NA #2, dated 5/4/15 for evening shift from 4:00 PM to 10:00 PM, documented: 4:15 PM - "Res was crying and wanted to go home." 4:30 PM - "Res wanted to go to the front desk to ask some questions." 5:00 PM - "Sitting in the halls talking to everyone." 5:30 PM - "Res went to the bathroom and voided 100." 6:00 PM - "Res was really hungry asked for help while eating 100% and drank 740cc." 6:45 PM - "Res is watching [television] kicking back wanting a candy bar." 7:00 PM - "Res went to the bathroom voided 300." 8:00 PM - "took Res outside because kept yelling." 9:00 PM - "Res voided, and she has been sitting in bed watching TV."</p> <p>The facility's Occurrence Report for Resident #3 completed on 5/4/15 at 10:00 PM, with date of occurrence as 5/4/15 and time of 7:00 PM, documented: "...res was secured to chair with gait belt..."</p> <p>The facility's investigation of the 5/4/15 occurrence documented:</p>	F 221			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 221	<p>Continued From page 9</p> <p>*Committee Review: Resident #3's 1:1 had improperly used a gait belt. The facility initiated an abuse/neglect investigation and the 1:1 was sent home pending the investigation's outcome. The resident was unaware of any occurrence when interviewed about the event. No injury to the resident was detected. The use of the gait belt was considered a restraint. The occurrence was reported to the State Agency [Idaho Department of Health & Welfare - Bureau of Facility Standards].</p> <p>*1:1 Staff (NA #2) Statement Form: "I had put my gait belt loosely around [Resident #3's] waist so she wouldn't slide out of her chair like the seat belts that some residents wear. She had been screaming so I tried to redirect her by telling her to drink some water or punch because two of us had already taken her to the bathroom so if she drank some water or punch I'd gladly take her because she hadn't drank [sic] anything for awhile. I've seen others do this and thought it was okay. I did explain to her what I was doing and she [was] okay. There was [sic] other employees around me and none of them told me that it was wrong."</p> <p>*Staff (CNA #3) Statement Form: "[Resident #3] was yelling for 'help.' I walked around nurses station [Resident #3] said she needed to go to [the] bathroom. [NA #2] said she took her 5 min ago so I said I would try. I went to take [Resident #3] to bathroom when I stood [Resident #3] up she was strapped to her chair w/ [with] a gaitbelt. I asked why she was strapped down. [NA #2] stated she left enough room for her to move around. I told her it was still a restraint. I untied [Resident #3] from the chair and assisted her to [the] bathroom where she emptied 1000 of urin [sic] out."</p>	F 221			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 221	<p>Continued From page 10</p> <p>On 6/16/15 at 8:10 AM, 10:15 AM, and 4:00 PM, and 6/17/15 at 9:15 AM, the resident was observed in her room or the hallway and had a staff member who identified his/her self as Resident #3's 1:1 CNA/NA. He/She was within arm's reach of the resident at all times. The 1:1 CNA/NA would have another staff member care for the resident while the 1:1 took breaks. The resident was never observed without a 1:1 present.</p> <p>On 6/18/15 at 9:50 AM, the DON was interviewed regarding the gait belt use as a restraint. The DON said she originally placed NA #2 on suspension because the gait belt was used as a restraint. The DON was instructed by the facility's Corporate Office that the NA could return to work but required additional training on the appropriate use of a gait belt, which the DON stated was provided.</p> <p>On 6/19/15 at 4:30 PM, the Administrator and several other management staff were informed of the restraint concerns.</p> <p>2. Resident #8 was admitted to the facility with diagnoses of ischemic stroke with occlusion, hemiplegia affecting right side, below knee amputation, osteoarthritis, and chronic pain.</p> <p>The Quarterly MDS assessment, dated 4/9/15, and the current Quarterly MDS, dated 6/16/15, documented the resident had short- and long-term memory impairment; skills for daily decision making were severely impaired; inattention and disorganized thinking; required</p>	F 221			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 221	<p>Continued From page 11</p> <p>extensive assistance of two staff for transfers and toileting; limited assistance of one person for locomotion; unsteady when moving from a seated to standing position; no impairment in upper extremity; impairment on one side of lower extremity; did not receive PT/OT services; and trunk restraint used less than daily.</p> <p>A Physical Therapy Evaluation & Plan Treatment, dated 3/23/15, documented the following risk factors: "Due to the documented physical impairments and associated functional deficits, the patient [resident] is at risk for falls. Add lap belt to wc for safety." The area for the physician's signature was blank.</p> <p>A Physician Telephone Order, dated 4/3/14, documented the resident was to have a lap belt to the chair for safety.</p> <p>The current restraint care plan, dated 5/19/15, documented the resident was at high risk for falls and had weakness. Documented interventions included a self-releasing seat belt; restraint assessment and documentation; observe for decline in function; report adverse reactions to MD; and PT/OT screen as needed.</p> <p>The restraint care plan did not document the medical symptoms which warranted the need for the seatbelt; how often it should be assessed; how often it should be released; duration of time the seatbelt should be released; and how the use of the seatbelt would assist the resident reach his/her highest level of physical and psychosocial well-being.</p> <p>A Nurse's Note, dated 4/5/15, documented,</p>	F 221		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 221	<p>Continued From page 12</p> <p>"Resident [has] belt alarm for safety. Would try to remove it times 4, redirected [him]."</p> <p>The following observations were made on 6/16/15:</p> <p>* 7:50 AM - The resident was sitting in his wheelchair outside of his room by the nurse's cart with the seatbelt securely fastened. The resident had a below the knee amputation (BKA) of his right leg, and his right hand and wrist were immobile and completely covered by a cloth bandage. The resident attempted to reposition himself several times in the wheelchair without success. The resident then pulled on the seatbelt and with a furrowed brow shook his head back and forth from side to side several times.</p> <p>* 9:05 AM - The resident attempted to pick up a small object off of the table and was unable to reach it due to the seatbelt which restricted his movement.</p> <p>* 9:07 AM to 9:15 AM - The resident was removed from the dining room and left in his wheelchair in front of his room where he was observed to pull at the cloth dressing which completely covered his right hand/wrist. He then pulled at the seatbelt and with a furrowed brow shook his head back and forth from side to side several times.</p> <p>* 10:45 AM to 10:55 AM - The resident was in his wheelchair in a sitting area by the front door. The resident pointed to the front door, spoke some unrecognizable words, looked down at and pulled on the seatbelt, pulled on the dressing covering his right hand and with a scowl on his face shook his head back and forth from side to side several times.</p> <p>* 11:05 AM - The resident pointed to the front door and said, "Gold Car," and attempted to</p>	F 221			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 221	Continued From page 13 reposition himself three times without success. The resident then pulled on the seatbelt and with a scowl on his face shook his head back and forth from side to side several times.	F 221	F 226	
F 226 SS=D	On 6/19/15 at 4:30 PM, the Owner, Administrator, Assistant Administrator, DNS, MDS Coordinator, Social Services, and other management staff were informed of the concern. 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on a complaint from the community, staff interview, record review, review of policies and procedures, and investigation reports, it was determined the facility failed to follow its abuse policies and procedures to ensure all allegations of abuse were thoroughly investigated. The facility failed to: * Ensure that all allegations and investigation results were reported to the State Survey Agency/ Bureau of Facility Standards (BFS) in accordance with state law; * Ensure residents and/or resident representatives were informed of the allegations and outcomes of investigations; and, * Ensure all witnesses, including residents, were interviewed and written statements obtained. This was true for 2 of 3 (#s 1 & 11) sampled	F 226	1- Residents #1 and #11 were separated and moved to different rooms. The facility has assigned the Assistant Administrator as the Abuse Coordinator in the facility and the Administrator as the back-up. An abuse binder has been created to log and track allegations of abuse and neglect. The previous administration who has since left the facility assigned the responsibility to the DON (who is no longer at the facility) without informing the assistant administrator 2- All residents have the potential to be affected. 3- Staff will be educated on resident to resident sexual conduct and how to respond and report to the proper authorities including facility management as well as state agencies as appropriate. A review of the abuse log will be completed by Assistant administrator weekly to review the status of all alleged abuse and neglect, and to ensure proper	

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 226	<p>Continued From page 14</p> <p>residents. Failure to thoroughly investigation allegations of abuse placed these two residents, and all other residents who lived in the facility, at risk for physical and/or psychological harm. Findings include:</p> <p>The facility's Abuse Policy, dated 4/2014, documented, "Should a suspected violation or substantiated incident of...abuse (including resident to resident abuse) be reported, the facility administrator, or his/her designee, will promptly notify the following persons or agencies (verbally and/or written) of such incident: The State licensing/certification agency...,The Resident's Representative, The Resident's attending Physician, and The Facility Medical Director."</p> <p>Resident #1 was admitted to the facility on 10/28/13 with multiple diagnoses, including sensorimotor hearing loss, Parkinson's syndrome, and dementia.</p> <p>The Quarterly MDS assessment, dated 5/22/15, coded short- and long-term memory impairment and physical behavior symptoms directed towards others (for example: hitting, kicking, pushing, scratching, grabbing, abusing others sexually).</p> <p>The current Behavior care plan documented concerns related to, "Inappropriate/sexual comments and touching." Interventions included: "Know where Resident #1's hands are at all times; as much as possible avoid placing yourself in a position that would allow for inappropriate contact; female staff to care for Resident #1 as much as possible; immediately inform Resident</p>	F 226	<p>investigations are completed and family/resident, or responsible party are informed of investigative results as appropriate. The Incident/Accident (I&A) committee will meet daily, 5 days a week on a perpetual basis to review all incidents/accidents/abuse/neglect, and initiate investigations. The I&A committee will ensure families and responsible parties are notified and are reported to state agencies as required.</p> <p>4- A review of the Abuse/Neglect log will be completed during the monthly QA meeting for completeness and compliance.</p> <p>5- Compliance date: 9/15/15</p>		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 226	<p>Continued From page 15</p> <p>#1 the behavior is inappropriate; and staff to closely monitor Resident #1 when he is out of his room."</p> <p>The Psychotropic Drug Re-Evaluation and Assessment note, reviewed for 1/8/15 and 5/21/15, documented, "The resident continues to be assigned only female staff due to his continued inappropriate sexual behaviors/comments towards male staff."</p> <p>The Occurrence Report, dated 5/23/15, at 3:00 PM and 9:45 PM, included the names for both Resident #1 and Resident #11 and documented, "1st [sic] hand to hand contact, where Resident #1 tried to pull Resident #11's hand towards [and] into his attends. Later Resident #11 was on the floor by Resident #1's bed. They were holding hands and Resident #1 was rubbing Resident #11's arm." The identified residents are roommates and the incident occurred in their room.</p> <p>A Witness statement, dated 5/24/15, documented: * "1st [sic] occurrence at 1500 [3:00 PM]. I walked into Resident #1's room and seen [sic] Resident #1 attempting to put Resident # 11's hand into [Resident #1's] attend. I seperated [sic] the residents, educated res[idents] and notified nurse on the hall. * "2nd [sic] occurrence - During rounds around [9:45 PM] 2 other aides and I were going to change Resident #11. When we walked over to Resident #1's side and seen [sic] Resident #11 sitting on the floor next to Resident #1's bed and Resident #1's left hand was rubbing Resident #11's right hand. The 2 aides stayed with [the] residents and I went and got the nurse. Alarm</p>	F 226			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 226	<p>Continued From page 16 didn't go off." The Occurrence Report documented the physician and resident representative were notified, however, it did not include the date and time, nor did it specify for which resident. It could not be determined why the facility did not complete an occurrence report for each resident for the incidents at 3:00 PM and 9:45 PM.</p> <p>Note: The behavior care plans implemented prior to and after the incidents on 5/24/15 documented the same interventions. The care plans did not include any increase in supervision for either resident when unattended in their room together.</p> <p>On 6/18/15 at 8:30 AM, when asked who was responsible for investigating allegations of abuse in the facility, the Administrator said he thought it was the Assistant Administrator or the DNS. The DNS, when asked the same question, said she thought it was the Assistant Administrator. The Assistant Administrator, when asked, said it was the DNS.</p> <p>On 6/19/15, LSW #1 stated she received a text message on 5/24/15 at 4:06 PM from the nurse on the men's unit related to the incident. The nurse texted that Resident #1's family had been notified, however the text did not specify whether the facility contacted Resident #11's physician and representative. LSW #1 stated she had not notified Resident #11's family and did not know if anyone else had. When asked if the facility had reported the incidents to the State Agency and conducted an investigation, LSW #1 stated the facility had not. LSW #1 stated, "In hindsight an investigation should have been done. [Resident #1 and Resident #11] should not be roommates."</p>	F 226			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 226	Continued From page 17 The LSW stated Resident #1 had a history of touching or attempting to touch male residents' groin/thigh/penis. On 6/19/15, at 3:30 PM, the Owner, Administrator, Assistant Administrator, DNS, and Management Team were notified related to the identified concern.	F 226	F280 1 Former employees did not communicate information that could be included in the care plan. The Care Plan has been updated to reflect current status of resident. The facility has hired a new Certified Wound Care nurse to help identify and address care plan issues. The nursing staff has been educated to use the proper care plans that address wounds and interventions.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to 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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, it was determined the facility failed to ensure that residents' care plans were revised	F 280	Resident #9's care plan has been reviewed and updated to reflect current wound care needs and interventions. 2- All residents with wounds had their care plans reviewed and updated for accuracy. All residents have the potential to be affected. 3- Weekly skin assessments will be completed on all residents weekly. The wound care nurse will review each skin care assessment weekly and will address all skin issues and obtain orders from the physician for proper treatment. The wound care nurse will update Skin Problem care		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 280	<p>Continued From page 18</p> <p>to address needed care changes. This was true for 1 of 4 residents (# 9) reviewed for pressure ulcers. Resident #9 was admitted to the facility with pressure ulcers that deteriorated, and the resident developed new ulcers while residing at the facility. (Please refer to deficiencies at F309 and F314). Findings included:</p> <p>Resident #9 was initially admitted to the facility on 10/25/10, and readmitted following hospitalization on 3/12/15, 4/14/15, and 5/6/15, with diagnoses that included traumatic brain injury (TBI), insulin dependent diabetes mellitus, diabetic neuropathy, Stage III renal insufficiency, venous insufficiency, left hemiparesis, chronic pain syndrome, bipolar disease, and schizoaffective disorder.</p> <p>The resident's 10/9/14 Quarterly MDS through his 6/3/15 30-day MDS assessments documented the resident's cognitive status varied from alert, oriented, and cognitively intact to confused and unable to correctly answer questions. All 2015 MDS assessments documented the resident required extensive-to-total assistance of at least two staff with bed mobility and transfers, frequently resisted care, was incontinent of bowel and bladder, and had an increasing number of pressure ulcers (PUs).</p> <p>Resident #9's Medical Records, dated March 2015 through April 2015, documented at least five Stage II to Stage IV PUs that either developed in the facility or were present upon readmission but worsened. Three of these PUs remained unresolved at the time of survey.</p>	F 280	<p>plans each time there is a change in the condition of a wound, significant change, or treatment. Audits will be performed by DON/designee on completion and accuracy of wound care plans. This will be completed once a week x one month, then one time every two weeks thereafter until compliance is achieved.</p> <p>4 A review of the audits will be completed during the monthly QA meeting for oversight and compliance.</p> <p>5 Compliance date: 9/15/15</p>	

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 280	<p>Continued From page 19</p> <p>A re-admission 3/12/15 Wound Care Note (WCN) documented, "Resident has a 1.5 cm X 1.5 cm area [Stage I] at risk on left heel [medial side] and a 5.5 cm x 6.5 cm blister on right heel [Stage II]." The clinic ordered bilateral heel medix boots at all times and directed that the resident not wear shoes.</p> <p>The resident's Skin At Risk Care Plan (SARCP), dated 3/13/15, listed potential problem areas as moisture, activity, mobility, and friction/shear. The SARCP did not list the right or left heel PUs or include approaches staff were to follow, such as the ordered medix boots, no shoes, and standard nursing interventions such as floating and/or off loading the heels.</p> <p>The 24 Hour Nursing Admission Care Plan, signed 3/15/15 (3 days after readmission), documented the resident was at risk for skin breakdown. The section titled Skin Issues Upon Admit listed only, "Excoriated Buttocks." Neither heel PU was addressed on the care plan and approaches included only: Skin Assessment upon admit, barrier cream PRN after episodes of incontinence, high-density mattress, and weekly skin assessments. Specific interventions for the heels were not listed.</p> <p>On 4/9/15, a WCN documented the left heel developed two additional reddened areas and was "... very much at risk." The SARCP was not updated to include needed nursing interventions, such as floating heels, Meplex boots, and/or no shoes, to help prevent further breakdown, nor was any other wound care plan developed to address these interventions.</p>	F 280		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 280	<p>Continued From page 20</p> <p>Between 4/16/15 and 4/29/15, WCNs and WPNs (Wound Progress Notes written by facility wound nurse) documented the PUs on both heels continued to worsen and the ulcer on the right heel was undermining. Other than the addition of a mattress overlay and specialized mattresses on 3/24, 4/21, and 4/26, the resident's wound care care plans were not updated to reflect needed nursing interventions. (Please refer to F314 for details).</p> <p>In addition, the resident's medical record revealed that from 3/16/15 to 4/21/15, the resident developed four additional pressure ulcers/wounds:</p> <ul style="list-style-type: none"> * Pressure ulcer/open area on scrotum & intergluteal cleft lesions - onset 3/16/15. * Left lower back/buttock abrasion observed on 3/16/15, later developed into Stage III then Stage IV pressure ulcer. * Suspected deep tissue injury and Stage II pressure ulcer, right buttocks onset 4/21/15. <p>During interviews, the DON, the former Wound Care Nurse, and LN #4, who was the primary charge nurse for Resident #9, stated the resident had multiple behaviors that contributed to his skin breakdown and lack of healing. They stated he had frequent anger outbursts, could be verbally and physically aggressive with staff, and often refused cares such as turning every 2 hours and floating his heels.</p> <p>Resident #9's wound care plans and general care plan were not updated to reflect needed changes in nursing interventions for each new wound or pressure ulcer. The care plans did not address the physician's specific order, dated</p>	F 280		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 280	<p>Continued From page 21</p> <p>4/9/15 to, "Keep off (L) hip buttock area," and on 4/21/15 a wound vac was placed on the resident's left lower back PU. The care plans were not updated to provide instructions to nursing staff on when/how to ensure the wound vac was functioning correctly, when the wound vac dressing would be changed and by whom, and/or what adverse side effects should be monitored. In addition, the care plans failed to provide specific directions to staff regarding resistance to care related to wound healing and/or prevention of of further breakdown.</p> <p>On 4/29/15, the Potential/Actual Impaired Skin Integrity Care Plan was revised to include the following related approaches:</p> <ul style="list-style-type: none"> * Assure [resident] has stable and well fitting footwear [Contradicts 3/12/15 wound clinic order for no shoes] * Cushion to w/c for reducing pressure * Position heels and legs in bed with pillows when requested * Bariatric Bed with Alternating Air Mattress for comfort/pressure relief * Staff to remind/educate resident about laying down between meals to reduce pressure to buttocks * Document episodes of resistance to care <p>Neither the 4/29/15 Potential/Actual Skin Integrity Care Plan nor the resident's general Care Plan listed the actual skin breakdown/pressure ulcers sites or the resident's non-healing wounds. The Care Plans did not specifically address keeping the resident off his left side, not using bed pans, his wound vac treatment - who was to change the wound vac and when, or specifically how to address the resident when he was resistive to</p>	F 280			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 280	Continued From page 22 pressure ulcer and preventative cares.	F 280	F309	
F 309 SS=D	On 6/19/15 at 4:30 PM, the Administrator and DON were informed of the Care Plan issues regarding pressure ulcer care and treatment. 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 observation, staff interview, and record review, it was determined the facility failed to provide care in a manner that allowed residents to reach their highest practicable level of well-being as directed by physician order, determined by assessment, and/or directed by the residents' Plan of Care. This was true for 3 of 15 (#s 7, 10 & 15) residents sampled for the delivery and quality of care. This failure: 1. Resulted in potential harm to Resident #15 when the facility failed to provided 24-hour 1:1 staffing as physician ordered and care planned. 2. Resulted in potential harm to Resident #7 when staff failed to follow the physician's orders for evening blood sugar checks and sliding scale insulin. 3. Resulted in potential harm when nursing staff failed to check Resident #10's blood sugar as frequently as ordered by the physician, and failed	F 309	1 Staff shortages were due previous administration practices. Resident #15 no longer resides in the facility. Facility was short staffed at the time, but has since hired sufficient staff to provide treatments and document care. A new staffing coordinator has been hired to help oversee staffing, and to fill openings in the schedule. LN's were educated on checking and documenting BG's. The facility hired a clinical care coordinator (CCC) to review and audit all BG's to include those of residents #7 and #10. 2- All residents have the potential to be affected by this deficient practices. The CCC is reviewing BG on all residents. 3- The CCC/designee will do weekly audits of the MARs on all residents on BG checks. Staff who are found to not document/treat those with BGs will be disciplined as appropriate. The facility will be able to hold accountable staff who are not documenting care as part of the	

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 309	<p>Continued From page 23 to recheck low blood sugars per physician's orders. Findings include:</p> <p>1. Resident #15 was readmitted to the facility on 8/5/13 with diagnoses including extreme autism/mental retardation, intractable grand mal seizures, and vitamin D deficiency.</p> <p>The resident's last available Nursing Facility PASRR II-B Specialized Services Resident Quarterly Progress Note, dated 12/24//14, documented the PASRR B was needed for specialized services related to his diagnoses of autism and mental retardation. The PASRR B documented, "Requires ... 1:1 staff at all times. Condition will never improve. He is a long term placement."</p> <p>The resident's 11/12/14 annual MDS assessment and his 5/8/15 quarterly MDS assessment coded no speech, rarely/never understands or makes himself understood, short- and long-term memory impairment, severely impaired daily decisions, frequent expressions of physical aggression towards others, daily rejection of care, and daily wandering.</p> <p>Physician Order Reports (Recapitulation Orders), with effective dates of 2/1/15, 3/1/15, 4/1/15, and 5/1/15, documented, "1:1 staffing 24 HR/day R/T falls, impulsive behavior, poor safety awareness... 1:1 to be in arms [sic] length at all times R/T impulsivity, running down hall, trespassing into peers [sic] rooms, lack of safety awareness, seizure DO [disorder]."</p> <p>On 4/1/15 a telephone order from the resident's primary care physician again instructed staff to</p>	F 309	<p>education and quality improvement process. A review of staffing will be completed daily x5 at morning stand up meeting, and staffing coordinator will help provide staff daily for adequate coverage of 1:1's.</p> <p>4- Audits will be brought to the monthly QA for review and oversight.</p> <p>5 Compliance date: 9/15/15</p>		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 309	<p>Continued From page 24</p> <p>provide, "1:1 staffing 24 hrs/day RT [related to] behavior."</p> <p>The resident's Care Plans for February 2015 through May 2015 documented, "1:1 staffing due to lack of safety awareness, impulsive behavior." Interventions included, "1:1 staffing 24 [hours] per day ... 1:1 is to be within arms [sic] length at all times ... "</p> <p>Review of Resident #15's medical record and staffing documentation for 2/20/15 through 6/28/15 revealed the facility provided less than 24 hours of 1:1 staffing on 50 of 54 days between 2/20/15 and 4/15/15. For example:</p> <p>a. On 4/27/15, LN #5 documented, "The middle or end of February [2015] ... this resident had an increase in physical aggression and an increase in 3 - 5 seizures daily. The seizures caused an increase in falls in the hall ways [sic] and at the nurse's station. The gentleman hit his head multiple times. Myself as well as the staff members [sic] wrote multiple incident reports, occurrences and behavior narratives that were given to previous administration. Multiple staff had also approached administration asking for 1:1 status. It was denied ... even though present care plan had him listed on a 24 hour 1:1 status. At this time (beginning of March) I made the decision to place him on 1:1 status while awake, when I had the staff available to do so ..." Note: This written statement was provided as a witness statement for an allegation of abuse investigation. Please refer to F221 for details.</p> <p>b. 1:1 Shift Behavior Narratives dated 2/20/15 to April 2015 documented:</p>	F 309			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 309	<p>Continued From page 25</p> <ul style="list-style-type: none"> * 2/20/15 - 2/28/15 - The facility provided fewer than 16 hours of 1:1 staffing on 1 day and only 16 hours of 1:1 staffing on 6 days, * 3/1/15 - 3/31/15 - The facility provided fewer than 16 hours of 1:1 staffing on 9 days and only 16 hours of 1:1 staffing on 20 days, and * 4/1/15 - 4/15/15 - the facility provided fewer than 16 hours of 1:1 staffing on 3 days and only 16 hours of 1:1 staffing on 11 days. <p>c. NOC (Night) Shift assignment sheets for March 2015 listed nine "1:1 residents" and the staff assigned to them during the night. Resident #15 was not included as a 1:1 resident on these assignment sheets.</p> <p>d. 1:1 Shift Behavior Narratives (SBN), Behavior Narrative Reports (BNR), and Occurrence Reports and/or Incident/Accident Committee (OR) for 2/20/15 - 4/15/15 documented the resident had frequent seizures and behaviors including:</p> <ul style="list-style-type: none"> * OR 3/1/15 3:30 am - seizure with fall, no injuries * OR 3/1/15 4:00 pm - seizure with fall, no injuries * OR 3/2/15 at 2:50 pm - seizure with fall, superficial cut to eyebrow * OR 4/12/15 at 6:00 pm - seizure with fall, hit head <ul style="list-style-type: none"> * BNR 2/22/15 2:45 am - Pushed and shoved aides to get behind nurses station. Trying to steal item from Nurses Cart. * BNR 2/23/15 8:15 pm - Resident "made it into" another resident's room, stealing a cup and taking it back to his own room. * BNR 2/26/15 4:30 pm - Physical aggression 	F 309			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 309	<p>Continued From page 26</p> <p>towards staff, grabbing, pinching, and pushing staff.</p> <p>* SBNs 2/20/15 - 4/15/15 documented 17 days when the resident had at least 1 grand mal seizure, 11 days when the resident was physically aggressive with staff, 7 days when the resident attempted to wander in the halls and into other resident rooms, taking items that were not his.</p> <p>During interviews, the DON stated she was fairly new to the facility and not able to answer specific questions regarding Resident #15's 1:1 staffing or PASRR IIB. She stated the social workers were responsible for the PASRRs and the person responsible for staffing during February and March 2015 was no longer employed at the facility.</p> <p>On 6/16/15 at 5:15 p.m., LSWs #1 and #6 were asked when Resident #15 was changed from 1:1 staffing for 24 hours/7 days per week to 16 hours per 24 hour period. The LSWs provided a copy of a social service note written on 12/2/14 that documented, "[Resident] remains on 1:1 16 hours a day for safety. His behaviors include/intrusive, socially inappropriate, physically aggressive, disruptive, resistive to cares... " She was unable to provide any other documentation regarding when/why supervision was changed to 1:1 16 hours per day.</p> <p>3. Resident #7 was admitted to the facility on 10/10/13 with multiple diagnoses including traumatic brain injury with permanent disability, hiatal hernia, chronic dysphagia with PEG tube feeding, and diabetes mellitus.</p>	F 309			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 309	<p>Continued From page 27</p> <p>Resident #7's recapitulated June 2015 Physician's Orders documented: *10/10/13 - "Lantus 100U [units]/ml 30 units SQ [subcutaneously] QAM [every AM]." *4/16/14 - "Novolog Sliding Scale Insulin BID [twice a day] 150-199=1 u 200-249=3 u...>350=9 u Call MD."</p> <p>The resident's Physician Order, dated 4/21/14, documented: "...[Change] accuchecks to one AM daily-DM..."</p> <p>The RHIT (Registered Health Information Technician) who also performed the transcription of orders provided a statement, dated 6/19/15, which documented: "Regarding [Resident #7] MAR for his Novolog Insulin order. There was a data entry error on the time. The order is for q [every] am not the BID. The nurses corrected the error on the MAR and never gave it BID..."</p> <p>The resident's Care Plan did not have a directive of care for diabetes mellitus.</p> <p>Resident #7's 4/2015, 5/2015, and 6/2015 MAR documented: 10/10/13 - "Lantus 100u/ml 30 units SQ QAM" The scheduled time was 7:00 AM. 4/16/14 - "Novolog Sliding Scale [SS] Insulin BID 150-199=1 u..." The scheduled times were 7:30 AM and 5:30 PM. Note: The Novolog SS Insulin for the 5:30 PM time had been manually crossed out on the computer generated MARs for April, May, and June 2015. There were no BGs obtained at 5:30 PM, nor were there any Novolog SS insulin</p>	F 309			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 309	<p>Continued From page 28 injections administered at 5:30 PM for the 3 months.</p> <p>On 5/18/15 at 9:50 AM, the DON was interviewed about the MARs being altered month after month. The DON acknowledged the 5:30 PM time had been crossed off the MARs by the LNs. The DON was having the RHIT provide the original order, which she stated could resolve the issue, however the physician's order addressed the BG accuchecks only and had no information regarding the Novolog SS insulin change from BID to once daily.</p> <p>4. Resident #10 was admitted to the facility on 12/8/10, and readmitted on 3/21/14, with multiple diagnoses, including diabetes mellitus (DM), polyneuropathy, and dementia.</p> <p>Resident #10's recapitulated June 2015 Physician's Orders documented: *3/21/14 - "Blood glucose of < [less than] 70...mild to moderate hypoglycemia with no symptoms: Treat with 15-20 G [grams] of carbs [carbohydrates] that contain glucose. Give 6-8 oz of orange juice. Then follow rest of protocol...1. After 15 minutes, recheck blood sugar. If still under 70, repeat treatment. 2. Once blood sugar returns to normal (>70), give a meal or a snack. 3. Treat per reference guide. 4. Hold P.O. or injectable diabetic injectable medications." *3/21/14 - "Blood glucose < 70...mild to moderate hypoglycemia alert with symptoms and able to swallow: Follow protocol in notes section...1. Give 6-8 oz O.J. = [equal to] 15-20 GM of carbs. 2. Hold P.O. or injectable diabetic medications. 3. Give a snack/meal. 4. Recheck B.S. [blood sugar] in 15 min. 5. If B.S. is < 40... follow severe</p>	F 309			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 309	<p>Continued From page 29</p> <p>hypoglycemia protocol. 6. If B.S. is > 40...follow mild to moderate protocol."</p> <p>*3/21/14 - "Lantus 10U SQ Q [every] day."</p> <p>*3/21/14 - "Glimepiride 4mg PO [by mouth] BID [twice a day]."</p> <p>*4/9/14 - "Accu check AC [before meals] & HS [at bedtime] Novolog SS [sliding scale]: 150-199=2 U...> [greater than] 400 or <70 Call MD."</p> <p>The resident's current Care Plan did not contain a directive of care for Diabetes Mellitus.</p> <p>Resident #10's 4/2015, 5/2015, and 6/2015 MAR documented:</p> <p>3/21/14 - "Lantus 10U [units] SQ [subcutaneously] Q [every] day." The scheduled time was 8:00 PM.</p> <p>3/21/14 - "Glimepiride 4mg PO [by mouth] BID [twice a day]." The scheduled times were AM and Evening.</p> <p>4/9/14 - "Accu check AC [before meals] & HS [at bedtime] Novolog SS [sliding scale]: 150-199=2 U...> [greater than] 400 or <70 Call MD." The scheduled times were 7:00 AM, 11:00 AM, 5:00 PM, and 8:00 PM.</p> <p>*April 2015 MAR -</p> <p>a) The resident's blood glucose (BG) was not checked on 4/16 at 8:00 PM or on 4/30 at 11:00 AM. No sliding scale insulin was administered on these dates/times.</p> <p>b) The MAR reflected the LN had administered the Lantus insulin on 4/16 at 8:00 PM without knowledge of the BG.</p> <p>*May 2015 MAR -</p> <p>a) The resident had a BG of 68 on 5/1 and a BG of 66 on 5/3/15. There was no documentation on the interventions, the values of the BG on the 15 minute recheck, or if the MD had been called.</p>	F 309		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 309	Continued From page 30 The MAR reflected the Glimperide 4mg was administered on 5/1 and 5/3 with BGs <70 and had not been held as ordered. b) The resident was not administered Lantus insulin on 5/4, 5/16, 5/22, and 5/29/15 at 8:00 PM. c) The resident's BG was not checked on 5/1 at 11:00 AM, on 5/12, on 5/15 at 8:00 PM, on 5/19 at 11:00 AM, or on 5/22 at 8:00 PM and thus no Novolog SS insulin administered. d) The MAR reflected the LN administered Lantus insulin on 5/12 and 5/15 at 8:00 PM without knowledge of the BG. *June 2015 MAR - a) The resident's BG was not checked on 6/7 at 5:00 PM or on 6/12 at 11:00 AM and thus no Novolog SS insulin was administered. On 6/18/15 at 9:50 AM, the DON was interviewed in regards to the resident's BGs and the administration of diabetic medications. The DON stated, "I know if it's not documented, then it's not done." The DON said the resident had been known to refuse, but the nurses needed to document the refusals. The DON acknowledged the LNs should have documented on the MAR or in the Nursing Progress Notes when a resident had a low BG, the interventions, and the result of the second BG taken 15 minutes later. On 6/19/15 at 4:30 PM, the Administrator and several other management staff were informed of the concerns.	F 309			
F 314 SS=G	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	F 314			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 314	<p>Continued From page 31</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review it was determined the facility failed to provide care needed to prevent pressure ulcers and/or prevent existing pressure ulcers from deteriorating. This was true for 3 of 4 residents (#9, #12, #13) reviewed for pressure ulcers. The failure to provide needed care resulted in harm to 2 of the 3 residents.</p> <p>*Resident #9 was harmed when 5 avoidable Stage II to Stage IV pressure ulcers developed while the resident lived at the facility, or increased in size and seriousness after the resident was admitted with them. *Resident #12 was harmed when 5 avoidable Stage II or greater pressure ulcers developed while the resident resided at the facility, ultimately worsened, and became infected. * Resident #13 was at risk for harm when facility staff failed to provide pressure ulcer treatment and care on a consistent basis.</p> <p>Findings included:</p> <p>1. Resident #9 was initially admitted to the facility on 10/25/10. His 2015 readmissions, following hospitalizations, occurred on 3/12/15, 4/14/15,</p>	F 314	<p>F314</p> <p>1-Resident #9 was placed on a specialized air mattress and is receiving wound vac treatment.</p> <p>Resident #12 was placed on a specialized air mattress and is receiving wound vac treatment.</p> <p>Resident #13's wounds have been resolved.</p> <p>Shower aides have been tasked to help monitor skin integrity during showers.</p> <p>The previous administration failed to oversee the wound care program. A wound care program is currently being implemented with appropriate oversight by nursing administration.</p> <p>2- All residents with a low Braden score have the potential to be affected. A Braden Scale audit has been completed to determine risk on all patients. All residents will be reviewed upon admission for risk. Current residents will be reviewed weekly by nursing staff to monitor</p>	

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	<p>Continued From page 32 and 5/6/15. The resident's diagnoses included traumatic brain injury (TBI), insulin dependent diabetes mellitus, diabetic neuropathy, Stage III renal insufficiency, venous insufficiency, left hemiparesis, chronic pain syndrome, bipolar disease, and schizoaffective disorder.</p> <p>The resident's 10/9/14 Quarterly MDS, through his 6/3/15 30 day MDS assessments, documented the resident's cognitive status varied from no cognitive impairment to significant cognitive impairment. All 2015 MDS assessments documented the resident required extensive-to-total assistance of at least 2 people with bed mobility and transfers, frequently resisted care, was incontinent of bowel and bladder, and had an increasing numbers of pressure ulcers (PUs).</p> <p>Resident #9's Medical Records, dated March 2015 through June 2015, including Wound or Pressure Sore Identification and Progress Notes (WPNs), Wound Clinic Notes (WCNs), Nurses Notes (NNs), Skin Assessment Forms (SAFs), Physician Discharge Notes and Physician Admission Notes, documented at least 5 Stage II or greater PUs that were either aquired while the resident resided at the facility or were present upon admit by worsened during the resident's stay. Three of these Stage III and IV PUs remained unhealed at the time of the survey.</p> <p>a. Stage II and III PUs left and right heels - Onset 3/12/15, unhealed at time of survey:</p> <p>A 3/12/15 WCN documented, "Resident has a 1.5 cm X 1.5 cm area at risk on left heel [medial side] and a 5.5 cm x 6.5 cm blister on right heel [Stage</p>	F 314	<p>skin integrity.</p> <p>A full-time nurse has been employed to monitor, assess, and treat wounds.</p> <p>Nursing staff will be in-serviced on completing dressing changes as ordered and the new system to address skin integrity (see below).</p> <p>3- Nursing staff will fill out Skin Assessment Form (SAF) weekly during resident showers to help with early detection of skin break down. The SAF's will be reviewed by the nurses on the floor, then will be given to DON/Designee each day, 5 days per week. When skin integrity issues are discovered the wound nurse will provide appropriate treatment as directed by the physician. Patients identified will be reviewed weekly during Nutrition at Risk/Wound meeting. Nursing staff will be in-serviced on ensuring wound dressings are being changed per order. The TARs will be audited 3 days per week x4 weeks, then 2x per week for 2 weeks, then weekly thereafter by the wound care nurse or designee. An ADL flow sheet will include basic skin assessments to</p>		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 314	<p>Continued From page 33</p> <p>II]." The clinic ordered bilateral heel Medix boots at all times and directed that the resident not wear shoes.</p> <p>Note: The resident was readmitted to the facility after a 10 day stay elsewhere (3/2/15 to 3/12/15). There was no documentation on his 3/12 Admission NN regarding bilateral foot ulcers or on his 3/13/15 SAF, which only documented, "Wraps on both legs." No visualization of the PUs was documented.</p> <p>A 3/13/15 Skin At Risk Care Plan (SARCP) listed potential problem areas as moisture, activity, mobility, friction/shear. The SARCP did not list the right or left heel PUs and included no indication of approaches staff were to follow.</p> <p>In addition, a 24 Hour Nursing Admission Care Plan was not completed or signed until 3/15/15, 3 days after admission. The 24 Hour Admission Care Plan did not list or address the PUs on the left or right foot. The assessment documented the resident was at risk for skin breakdown, but listed only "Excoriated Buttocks" as current skin issues. The approaches listed: skin assessment upon admit, barrier cream PRN after episodes of incontinence, high density mattress and weekly skin assessments. There was no mention of off-loading measures and other nursing interventions, such as Medix boots 24/7, or discouraging the resident from wearing shoes to prevent further injury to the heels.</p> <p>On 3/19/15 a WCN documented the size of the left heel wound had increased in size to 2.5 cm x 2.5 cm and the right heel blister increased to 7.0 cm x 10 cm.</p>	F 314	<p>help identify any potential skin integrity issues. The wound care nurse will provide as needed training to C.N.A staff to help them recognize potential skin breakdown problems and to also promote awareness.</p> <p>Labs will be tracked and reviewed daily x5 days per week by the in-house phlebotomist and/or LN, PRN as needed.</p> <p>4- Wound care nurse/Designee will bring results of skin assessment monitoring to the monthly QA meeting for discussion and oversight.</p> <p>5 Compliance date: 9/15/15</p>	

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	<p>Continued From page 34</p> <p>A 4/9/15 WCN documented the left heel had developed two additional reddened areas, one on the lateral side and one on the heel. The note stated the wound on the lateral side of the left heel measured 1.5 cm x 1.0 cm and was "Not open, [but] very much at risk.</p> <p>A 4/16/15 Wound Clinic Physician's note stated the resident had multiple factors that likely contributed to the non-healing of the wounds including pressure, excess slough in the wound bed, obesity, psychological problems, and infection. The physician debrided the wounds, started the resident on antibiotics, and documented, "To 'off-load' the ulcer or wound means to remove or decrease the amount of pressure or shear force exerted upon the wound. Off-loading is a critical part of this patient's management..."</p> <p>Off-loading was not added to the resident's wound or general care plans and staff did not document anywhere in the medical record that off-loading was occurring. In addition, psychological conditions referred to by the physician were not addressed on wound care plans related to resistance/non-compliance to pressure ulcer prevention and healing measures. Please refer to F280.</p> <p>WCN and WPNS, dated 4/16/15, 4/23, and 4/29, documented the wound sizes on both heels were increasing in size and the wound on the right heel presented with "undermining."</p> <p>On 5/2/15 Resident #9 was discharged to the hospital and readmitted on 5/6/15 with both</p>	F 314			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	<p>Continued From page 35</p> <p>legs/feet casted. WCNs documented the resident legs were casted to prevent further pressure and breakdown.</p> <p>The last WCN provided by the facility, dated 6/12/15, documented the bilateral heel wounds remained unhealed. The measurement of the left heel was 5.3 cm x 4.5 cm x 0.5 cm, the left medial heel was 0.6 cm x 1.1 cm x 0.1 cm. Both legs/feet were still casted at the time of the survey.</p> <p>b. Pressure ulcer/open area on Scrotum & Intergluteal cleft lesions - onset 3/16/15, resolved 4/23/15.</p> <p>The first documentation of the scrotum and intergluteal cleft issues occurred on the 3/16/15 SAF. The SAF documented reddness and excoriation in the two areas and on 3/17/15 the nurse completing the SAF documented, "Scrotum open sore..."</p> <p>On 3/19/15, a WCN documented, "Scrotal area 1.2 cm x 0.7 cm x 0.2 cm, total scrotum inflamed..." The WCN listed orders for pericare with cleansing and Calazine twice daily. The note also documented a "... buttock crack 4 cm X 0.3 cm X .01 cm ... scrotal area and buttock crack are due to unacceptable pericare."</p> <p>On 6/17/15, the former facility Wound Care Nurse stated the scrotum and intergluteal skin concerns originated during the resident's 3/2/15 to 3/12/15 hospital stay. However, the 3/12/15 nurse's admission notes and the 3/13/15 SAF did not document issues with the scrotum or intergluteal cleft.</p>	F 314			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	Continued From page 36 In addition, the former Wound Care Nurse stated that the Wound Clinic classified the sore on the resident's scrotum as a Stage II pressure ulcer (see WCN - Physician 4/27/15). He stated that both he and the facility nurses believed pressure was the primary cause for the ulcer rather than moisture and/or lack of adequate pericare. He said the resident's scrotum was often pinched between his legs and the resident would refuse staff access to his periaerea for pericare or checking for pressure sites. Nursing care documentation between March 2015 and April 2015, failed to consistently document staff assistance with pericare and/or monitoring the resident for pressure sites on the scrotum. No additional documentation of nursing cares specific to the scrotum was provided to surveyors upon request. WPNs, dated 3/19/15 - 4/23/15, documented both wounds healed after improved pericare and Calazime treatment, and resolved on 4/23/15. c. Stage IV Pressure Ulcer Left Low Back/Buttock - Onset 3/16/15, unhealed at time of survey A 3/16/15 SAF documented an "... abrasion 2 inches X 1 inch [left lower back/buttock]." Note: Resident #9 was readmitted to the facility on 3/13/15. Readmission nursing notes and skin assessments did not document the presence of any wounds on the resident's left lower back. On 3/17/15, the SAF documented, "Left Sacral	F 314			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	<p>Continued From page 37</p> <p>[lower back/buttock] sore open." A 3/19/15 WCN referred to the area as an "abrasion" with measurements of 2 cm x 4.4 cm x 0.1 cm.</p> <p>Between 3/19/15 and 4/9/15 WCN, WPN, and SAF forms documented the area on the lower back increased in size and depth to 6.5 cm x 7.5 cm x 1.5 cm.</p> <p>On 4/9/15 the Wound Clinic Physician ordered, "Keep off (L) hip buttock area." This intervention was not added to the care plans provided by the facility. In addition, minimal documentation was found between 4/9/15 and 5/2/15 NNS or MAR/TARs that indicated the resident was kept off his left hip, off-loaded in any way, and/or turned every 2 hours. On 4/16/15, the WCN documented the lower back had "Worsened!" and measured 7.5 cm X 8.6 cm X 1.6 cm with undermining</p> <p>A Patient Treatment Update Note written by the Wound Clinic Physician on 4/17/15 documented the abrasion/friction burn located on the lower back was "... assigned an outcome of converted." The physician stated the cause of the injury was probably immobility and new treatment orders were given. The physician described the wound as 7.5 cm x 8.6 cm x 1.6 cm, with undermining measuring 1 cm deep between 8:00 and 10:00, and exposed subcutaneous tissue and muscle tissue (Stage IV). Care planning included the application of a wound vac.</p> <p>The last WCN provided by the facility, dated 6/12/15, documented the wound was not healed, measured 5.1 cm X 4.1 cm X 1.2 cm) and continued to require wound clinic treatment</p>	F 314			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 314	<p>Continued From page 38 including Wound Vac therapy.</p> <p>d. Stage II Pressure Ulcer, Right Buttocks, 3 openings (Right buttock- distal medial, b. Right Buttock - distal lateral c. Right Buttock proximal)- Onset 4/21/15, resolved 5/28/15</p> <p>On 4/21/15 a SAF documented, "... a. 5.0 x 3.0 necrotic tissue, suspected deep tissue injury, b. 1.0 x 1.0 x less than 0.1 open, non-blanchable c. 1.0 x 3.1 x less than 0.1 surrounded on both sides by necrotic tissue, non blanchable of 3.3 x 2.0."</p> <p>On 4/23/15, a Patient Treatment Update by the Wound Clinic physician documented, "The unstageable pressure ulcer located on the right buttock ... is thought to be related to medical care [resident left on bedpan]. The pressure ulcer total area measures 7 cm x 6 cm x 0.1 cm. 5 x 0.8 curved area is Stage 2 pressure plus a 3 x 2 deep tissue injury. The patient scores the pain at 8 on a scale of 0 to 10..." The physician's 4/27/15 note documented the "Stage 2" pressure ulcer on the right buttock had decreased in size from the original measurement of 7 cm x 6 cm x 1.6 and he thought the base was deep tissue injury</p> <p>4/27/15 - 5/28/15 WPNs acknowledge a Stage II PU on 4/27/15, which slowly resolved and was "closed" on 5/28/15.</p> <p>On 5/29/15, a Primary Care Provider's History and Physical documented, "The resident has always been rather obstinate ... The obstinacy resulted in him refusing to get out of bed ... he at one point refused to get up and use the commode and was using a bedpan. It is believed that the bed pan may have been one of the</p>	F 314		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	<p>Continued From page 39 initiation events for the pressure ulcer on his left buttock."</p> <p>On 6/18/15, LN #7 stated the LNs generally documented the residents were turned every 2 hours on the MAR/TARs and/or in the NNs. She stated other interventions, such as off loading and floating heels, would be documented there as well.</p> <p>Throughout the survey the DON was asked to provide missing or additional information regarding care plan changes related to the pressure ulcers and documentation indicating the resident was turned every 2 hours, his heels floated, he was kept off his left side, etc. The DON was unable to provide the needed documentation.</p> <p>On 6/19/15 at 4:30 PM, the Administrator and DON were informed of the lack of pressure ulcer care and treatment.</p> <p>2. Resident #12 was admitted to the facility with multiple diagnoses, including diabetes mellitus, Non-Alzheimer's dementia, and stroke.</p> <p>The resident's Minimum Data Set (MDS), Weekly Skin Assessment forms (WSA), Nurses Notes (NN), Wound Nurse Notes (WNN), Treatment Administration Record (TAR), Skin Care Plan (SCP), Wound or Pressure Sore Identification and Progress Record (WPSIPR), Physician Orders (PO), and the Facility's Policy and Procedures were reviewed and documented: * The Annual MDS, dated 1/8/15, coded: Short and long term memory impairment; total</p>	F 314			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	Continued From page 40 dependence of two people for bed mobility and transfers; and not at risk for developing pressure ulcers. NOTE: The facility determined the resident, who was totally dependent on two staff for bed mobility and transfers, was not at risk for pressure ulcers. * WSA forms reviewed for 4/6/15, 4/13/15, and 4/20/15, did not identify concerns related to pressure ulcers. * NN, dated 4/7/15 through 4/21/15, did not identify concerns related to the development pressure ulcers. * WNN, dated 4/27/15, documented, The cart nurse notified the skin nurse about 5 pressure related ulcers found on the resident's heels which included: - Stage II open area to the left posterior heel - 1 cm x 1 cm x 0.2 cm; NOTE: There is no known anatomical description for either an "anterior" or "posterior" heel. - Stage II serum-filled blister left anterior heel - 5.5 cm x 4.5 cm x 0 cm; - Stage II serum-filled blister right anterior heel - 2.0 cm x 1.5 cm x 0 cm; - DTI [deep tissue injury] right medial heel - 1.5 cm x 2 cm x 0 cm; and - DTI to the right posterior heel - 3 cm x 2.5 cm x 0 cm. * PO, dated 4/27/15, documented: - Gel pad to wheelchair for pressure relief; - Air overlay to mattress for pressure relief, - Heel floaters while in bed; heel medix pillows to both feet at all times; - Cleanse wounds to left heel with normal saline, pat dry, apply skin prep, apply 44 optifoam silver, change every 3 days, and as needed to keep dressing clean and intact; and	F 314			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	Continued From page 41 - Cleanse wound to right heel with normal saline, pat dry, apply skin prep, apply 4 x 4 optifoam silver, change every 3 days, and as needed to keep dressing clean and dry. * Pressure Ulcer care plans, dated 4/27/15, documented the following interventions: Vitamin and/or minerals; daily evaluation of dressing status and surrounding area; weekly skin assessment with measurements; and dietician consult recommendation. * Physician Order Flow Sheets (TAR) from 4/27/15 to 4/30/15 documented: - Evening Shift: Cleanse wounds to left heel with normal saline, pat dry, apply skin prep, apply 4 x 4 optifoam silver, change every 3 days and as needed to keep dressing clean/dry/intact. From 4/28/15 to 4/30/15 there was no LN signature documenting the treatment had occurred. - Evening shift: Cleanse wounds to right heel with normal saline, pat dry, apply skin prep, apply 4 x 4 optifoam (not silver), and change dressing every 3 days to keep dressing clean/dry/intact. From 4/28/15 to 4/30/15 there was no LN signature documenting the treatment had occurred. - Night shift, day shift, and evening shift: Heel medix pillows on. On 4/28, 4/29, and 4/30, night shift; 4/27, 4/28, 4/29, and 4/30, day shift; and 4/27, 4/29, and 4/30, evening shift, there was no LN signature documenting the treatment had occurred. - Night shift, day shift, and evening shift: Heels floater when in bed. On 4/28, night shift; 4/27, 4/29, and 4/30, day shift; and 4/27, 4/28, 4/29, and 4/30, evening shift, there was no LN signature documenting the treatment had occurred. * The Quarterly MDS, dated 4/29/15, coded:	F 314			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 314	<p>Continued From page 42</p> <p>Moderately cognitively impaired; extensive assist of two people for bed mobility and transfers; at risk for pressure ulcer; one Stage I or higher pressure ulcers; three Stage II pressure ulcers; two unstageable deep tissue injuries; and three Stage II pressure ulcers that have worsened since prior assessment.</p> <p>NOTE: The 1/8/15 MDS coded the resident did not have any pressure ulcers; the 4/29/15 MDS coded, "Three Stage II pressure ulcers that had worsened since prior assessment."</p> <p>* NN reviewed from 4/29/15 day shift to 5/3/15 evening shift did not include documentation related to the left and right heel pressure ulcers.</p> <p>* Braden Scale, dated 5/4/15, documented the resident was at "moderate risk" for pressure ulcers.</p> <p>NOTE: On 6/16/15, the facility could not provide documentation that the resident had been assessed prior to 5/3/15 for pressure-related concerns.</p> <p>A 5/4/15, skin care plan documented the resident was at risk for impaired skin integrity. Documented interventions included, "Hall nurse to check skin per protocol; treatment nurse to observe; staff to observe skin with showers and toileting; RD to evaluate as needed; follow physician orders for the treatment of the pressure sores on his feet; measure the areas on his feet every week and document on weekly skin assessment form and also on the pressure sore identification and progress record; float heels while in bed; and dietary is going to start sending him large protein portions at lunch and dinner. Try to get him to eat the protein and assist him as needed."</p> <p>NOTE: On 6/16/15, the facility could not provide</p>	F 314		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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)	(X6) COMPLETION DATE
F 314	Continued From page 43 the skin care plan in place prior to the identified pressure ulcers on 4/27/15. * WNN, dated 5/6/15, documented, "Follow-up on res[ident's] heel pressure ulcers. Res had heel medix pillows on. L[eft] heel dressing soiled. Carefully removed to find large blister that covered the previously 2 separate noted areas. Medial/Proximal part of blister had open area where whole blister drained. Measured this at 5.0 cm x 7.5 cm blister area. Cleansed with normal saline. Replaced with optifoam Ag (Silver) as ordered. Replaced heel medix pillow. Removed R[ight] heel medix pillow. Removed dry and clean intact dressing to R[ight] heel. A single blister covered the 3 previously noted wounds. Blister closed/unopen [sic] fluid filled. Cleaned with normal saline blister measured 5 [cm] x 8 cm. Placed optifoam. Placed medix pillow." NOTE: It could not be determined from the resident's medical record when the identified wounds started to deteriorate, "combine," or increase in size. Additionally, wound nurse's notes indicated the resident's heels had not been assessed for 9 days. * WPSIPR, dated 5/6/15, documented: - The Stage II open pressure ulcer on the left posterior heel and the Stage II serum filled blister on the left "anterior" heel, "combined to form one pressure ulcer." The newly combined Stage II pressure ulcer on the left heel measured 5.0 cm x 7.5 cm, had moderate drainage of serous fluid, and no signs of infection. - The Stage II pressure ulcer on the right "anterior" heel and the DTI on the right medial heel and "posterior" heel "combined to form one pressure ulcer." The newly combined Stage II pressure ulcer on the right heel measured 5.0 cm x 8.0 cm x 0.0 cm, had no drainage and no signs	F 314		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 314	Continued From page 44 of infection. * The resident's skin care plan in place on 5/6/14 did not include revised and/or new interventions addressing the worsened pressure ulcers. * NN dated 5/8/15 to 5/10/15, did not include documentation related to the left and right heel pressure ulcers. * NN dated 5/11/15 documented, "Open wounds noted [with] moderate drainage noted odorous [sic]. heel protectors in place..." * WNN and WPSIPR dated 5/12/15 documented: - L[eft] heel blister [not] present and eschar [and] slough covering wound. Measures 3.0 [cm] x 4.5 [cm] unstageable. Black eschar mostly center [with] slough surrounding with Erythema peri whole [sic] wound. - R[ight] heel 4.0 [cm] x 6.5 [cm] unstageable covered with black eschar and slough [with] Erythema peri wound. Blister also no longer present. - Notified MD. MD ordered, Cont[inue] heel medix pillows to bilateral feet. * NN, dated 5/17/15, documented, "Dressing changed to R[ight] and L[eft] heel very foul drainage to R[ight] heel, green/yellow drainage, moderate amount." * WPSIPR, dated 5/19/15, documented: - The combined Stage II left heel pressure ulcer - 4.5 cm x 3.2 cm; - New onset Stage II left lateral proximal heel ulcer - 1.2 cm x 0.9 cm x 0.1 cm; - The combined Stage II right heel pressure ulcer - 3.2 cm x 2.2 cm; - New onset Stage II right lateral proximal heel ulcer - 1.3 cm x 0.8 cm x 0.1 cm. * Care plan interventions, dated 5/19/15, documented, the same orders and interventions mentioned above for the pressure ulcers identified on 4/27/15.	F 314		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	<p>Continued From page 45</p> <p>On 5/19/15 the resident was seen by the local wound care clinic which documented the following wound measurements:</p> <ul style="list-style-type: none"> - Combined left heel pressure ulcer with eschar - 4.5 cm x 3.2 cm; - New left lateral proximal heel ulcer - 1.2 cm x 0.9 cm x 0.1 cm; - Combined right heel pressure ulcer with eschar - 3.2 cm x 2.2 cm; - New right lateral posterior heel pressure ulcer, with surrounding erythema - 1.3 cm x 0.8 cm x 0.1 cm. <p>* Wound Clinic note, dated 5/19/15, documented the treatment provided and new orders, included:</p> <ul style="list-style-type: none"> - Debridement [of the wounds]; - Mepitel silver mesh with Tegaderm foam dressing was applied to the wounds with orders to change as needed; - Continue with bilateral heel medix boots on at all times; - Minocin 100 mg one by mouth twice a day for ten days; and - Return to clinic on an as needed basis. <p>* WNN, dated 5/21/15, documented, "Follow-up on res. heels. Res. heel wounds changing - originally was 5 wounds, then combined to 2, then divided into 4 wounds currently. Was seen at [Wound Clinic]. Do not have therapists [sic] notes from Wound Clinic yet. Wound Clinic has not staged these individual wounds as of this time, though with descriptions there are 2 unstageables with eschar and 2 Stage II's - descriptions from Wound Clinic order."</p> <p>* NN, dated 5/27/15, documented:</p> <ul style="list-style-type: none"> - "Left heal [sic] with slough odor strong. Brown/black eschar [sic] with pink edges about [sic] brown. Redressed. 	F 314			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 314	<p>Continued From page 46</p> <p>- Dressings changed bilaterally, right heel measured approximately 5.0 cm x 6.0 cm, old eschar [sic] brown/black without odor. New area to side of heel ulcer 2 cm diameter with white slough. Pink edges about [sic] brown/black. Redressed."</p> <p>Note: The resident's WPSIPR and WNN from 5/19/15 through 5/30/15 did not include documentation related to the pressure ulcers. The only note related to the wounds was a NN, dated 5/27/15, which did not provide clear and concise documentation and it could not be determined which wounds were assessed.</p> <p>* TARs dated 5/19/15 to 5/31/15, documented: - Evening Shift: Cleanse left heel wound with normal saline, pat dry, apply optifoam dressing and change every 3 days and as needed. * The scheduled dressing changes were missed for 5/14, 5/17, 5/20, 5/23, 5/26, and 5/29. - Evening Shift: Cleanse wound to right heel with normal saline, pat dry, apply skin prep, and apply 4 x 4 optifoam silver, change every 3 days and PRN to keep dressing clean/dry/intact. - The scheduled dressing changes were missed for 5/15, 5/18, 5/21, 5/24, and 5/27. - The orders for the bilateral heel medix boots, "on at all times," and the heel floater were not documented on the TAR; it could not be determined whether these interventions had been consistently provided.</p> <p>* WNN, dated 6/1/15, documented, "Follow-up on res heels. - Left heel dressing replaced. Measured at 3.5 cm x 4.1 cm x 0.1 cm. Much improved. [Zero] necrotic tissue on heels.</p>	F 314		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 314	<p>Continued From page 47</p> <ul style="list-style-type: none"> - Left lateral heel [measured] 1.0 cm x 1.2 cm x 0.1 cm. - Right heel [measured] 3.8 cm x 3.8 cm x 0.1 cm. Replaced [dressing]. - Right lateral heel [measured] 0.9 cm x 0.7 cm x 0.1 cm. <p>Replaced dressings. [Zero] drainage yellow and pink wound beds. Cont[inue] heel medix pillows, heel floaters, and air overlay [on bed]. Informed MD about progression. Pleased. Will continue to monitor."</p> <p>* WNN, dated 6/4/15, documented, "Notified MD about wounds. Order received to culture bilateral heels related to pressure with infection."</p> <p>* NN, dated 6/4/15, documented the wound cultures were obtained and sent to the lab.</p> <p>* NN for the week of June 8-12 did not include documentation related to the pressure ulcers on the resident's heels.</p> <p>Note: The resident's medical record from 6/8/15 to 6/14/15 did not include lab results and/or documentation related to the results of the heel cultures. On 6/16/15, the facility could not provide lab results and/or documentation for the ordered laboratory analysis.</p> <p>During the complaint survey, 6/16/15 to 6/18/15, the resident was observed in bed from 7:30 AM to 4:00 PM, except when he was up for lunch. The resident was observed with heel lift boots on most of the time, however the boots were askew and the openings for the heels were turned to the right or left side of the feet much of the time, creating direct pressure from the boot on the resident's heels.</p> <p>On 6/16/15 and 6/17/15 the resident did not</p>	F 314		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	<p>Continued From page 48</p> <p>provide consent when asked if the surveyor could look at his heels when the nurse next checked them.</p> <p>On 6/17/15 at 3:00 PM, when asked to describe his role in assessing, monitoring, and evaluating the resident's pressure ulcers, the wound nurse, LN #8, stated he "oversaw" the wounds, documented weekly measurements, and was an additional resource to answer wound related questions. He stated floor nurses were responsible for dressing changes, additional measurements, and treatment orders. He stated as of two weeks prior to the interview he was no longer the acting wound nurse and was, therefore, unsure of the pressure ulcers' present condition or treatment orders.</p> <p>On 6/17/15 at 3:30 PM, when asked who oversaw the wound care program in the facility, the DNS stated LN #8 was responsible for wound care management. The DNS was informed of the above interview and LN #8's stated primary function was to provide direction and additional resource for the floor nurses. The DNS confirmed that LN #8 had not been active in the wound nurse position for the previous two weeks and stated the charge nurses currently coordinated wound management. The DNS stated it was the facility's intention to have LN #8 become wound certified and take a more active "hands on" role in managing skin concerns.</p> <p>On 6/19/15 at 4:30 PM, the Administrator and several other management staff were informed of the concerns.</p>	F 314			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	Continued From page 49 3. Resident #13 was admitted to the facility on 7/30/12, and readmitted on 3/14/14, with multiple diagnoses, including epilepsy, cerebral palsy, morbid obesity, and hemiplegia and hemiparesis. The resident's Physician's Orders documented: 3/14/14 - "Skin assessment per facility policy." 11/4/14 - "Turn Q [every] 2 hrs for pressure relief." 1/14/15 - "Calazime paste to buttocks TID [three times a day] & PRN for skin protection." 3/2/15 - "Gel cushion to geri chair to be on at all times for skin integrity." 3/2/15 - "Vanderlift 2 person assist for transfers." 4/17/15 - "Silvadene topically to buttocks Q day and after bathing to begin on 4/17/15 and to end on 5/2/15." 4/27/15 - "Weekly body audit as scheduled." 5/4/15 - "Cleanse open area to left sacral area with NS [normal saline], pat dry, apply skin prep. Apply Optifoam AG 4 X 4. Change Q 3 days [and] prn to keep dressing clean dry and intact." 5/4/15 - "Bariatric Air overlay alternating adjustable to weight." Resident #13's Wound or Pressure Sore Identification and Progress Record documented: a) Left buttocks with a black filled blister - Onset date of 5/4/15 - Not present on admit. 5/4/15 - Black filled blister, Stage II with measurements of 1.5 cm X 1.0 cm X 0 depth, no drainage or odor, and treated with Calazime TID and bariatric air bed overlay. 5/15/15 - Open blister - drained, Stage II with measurements of 1.5 cm X 1.5 cm X less than 0.1 depth, scant drainage, and flat edges. 5/24/15 - Resolved	F 314			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 314	Continued From page 50 b) Left Sacral Wound - Onset date of 5/4/15 - Not present on admit. 5/4/15 - Stage II with measurements of 2.5 cm X 3.5 cm X less than 0.1 depth, 100% granulation wound bed, scant drainage, flat edges, and treated with Optifoam Ag with instructions of change every 3 days and PRN. 5/18/15 - Stage II with measurements of 2.3 cm X 3.0 CM X less than 0.1 depth, 95% granulation and 5% epithelialization wound bed, scant drainage, flat edges, and treatment documented as continuation of Optifoam. 5/24/15 - Resolved NOTE: The left buttocks pressure ulcer was measured, staged, and treated initially on 5/4, however staging and measurements were not completed until 11 days later on 5/15. The left sacral pressure ulcer was measured, staged, and treated initially on 5/4, however staging and measurements were not completed until 14 days later on 5/18. The resident's Nursing Progress Notes documented: 5/3/15 - "...still having issues with buttock. Informed RN that there needs to be something else done..." 5/4/15 - "...has an open non-blanchable area 2.5 X 3.5 X < [less than] 0.1 to L [left] sacral area pu [pressure ulcer] Stage II. Also has 1.5 C 1.0 X 0 blister to R [right] buttock - pu Stage II ..." Note: The right buttocks was documented to have the blister in the Nursing Progress Notes rather than the left side as identified on the Wound or Pressure Sore Identification Record diagram and assessment. 5/18/15 - "...bottom is dark [and] only slightly	F 314		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	<p>Continued From page 51</p> <p>blanchable. Very macerated in appearance. Some tenderness noted when cares done..."</p> <p>5/24/15 - "...Bottom still red ..."</p> <p>6/2/15 - "...resident continues with excoriation & open areas to buttocks..."</p> <p>Resident #13's May 2015 TAR documented:</p> <p>4/17/15 - "Silvadene topically to buttocks q day and after bathing to begin on 4/17/15 and to end on 5/2/15."</p> <p>*The Silvadene was documented as being administered on 5/2/15, but not on 5/1/15.</p> <p>11/14/15 - "Turn Q 2 hrs for pressure relief."</p> <p>*The TAR documented the resident had not been turned 34 times for May and 3 times for June.</p> <p>1/14/15 - "Calazime paste to buttocks TID & PRN for skin protection."</p> <p>*The TAR documented times of 8:00 AM, 4:00 PM, and 12:00 AM for the Calazime paste to be administered. The Calazime was not applied 31 times during May and 4 times during June.</p> <p>5/4/15 - "Cleanse open area to L sacral c NS [normal saline]. Pat dry. Apply skin prep. Apply Optifoam Ag 4 X 4, [Change symbol] q 3 days et prn to keep dressg [dressing] clean dry et intact."</p> <p>*The TAR documented the treatment was administered on 5/4 and 5/8/15, but not again until 5/25/15, at which time the ulcer was documented as resolved.</p> <p>On 6/16 at 9:07 AM and 10:15 AM, and on 6/17/15 at 9:00 AM, the resident was observed seated in his geri chair in the hallway and/or his room. The resident did not show signs or symptoms of distress.</p> <p>On 6/17/15 at 3:55 PM, the Wound Nurse was interviewed in regards to the resident's skin</p>	F 314			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 314	Continued From page 52 issues. The Wound Nurse stated the resident's wounds had resolved on 5/24/15, but he had not been working at the facility for a couple of weeks and was unsure of their current treatment or status. On 6/19/15 at 4:30 PM, the Administrator and several other management staff were informed of the concerns.	F 314	F322 1- Staff was educated on proper ostomy care to include using of the paste as required. An audit of the TARs was completed by nurse management to verify signatures of LNs. Previous administration failed to continue with the audit process when there was a staff change. Staff who failed to properly document on the TARs were educated on the importance of documenting ostomy care. Resident #7 is receiving the appropriate care to include use of the ostomy paste.		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, it was	F 322	2- All residents with feeding tubes have the potential to be affected. 3- Audits of the TARs for those with feeding tube treatments will be completed two (2) times per week for two (2) months, then once weekly thereafter by DON/designee. Staff who are non-compliant with documentation will receive appropriate discipline.		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 322	<p>Continued From page 53</p> <p>determined the facility failed to ensure ostomy paste was applied to PEG (percutaneous endoscopic gastrostomy) sites and dressings changed as ordered. This was true for 1 of 1 residents (#7) reviewed for care and services related to feeding tubes. This deficient practice created the potential for harm if the resident developed complications and/or infections. Findings included:</p> <p>Resident #7 was admitted to the facility on 10/10/13 with multiple diagnoses, including traumatic brain injury with permanent disability, hiatal hernia, and chronic dysphagia with PEG tube feeding.</p> <p>The resident's June 2015 recapitulated Physician's Orders documented: 7/30/14 - "Glucerna 1.2 continuous feed @ [at] 95 cc/hour X [times] 6 hours from 0000-0600 [12:00 AM-6:00 AM]" 11/11/14 - "Clean PEG tube site with warm washcloth Q [every] shift & prn." 1/28/15 - "Ostomy paste to PEG site cover with drain sponge change BID [twice a day] minimum & prn." 3/2/15 - "NPO [nothing by mouth] R/T [related to] tube feeding status."</p> <p>Resident #7's 1/28/15 Physician's Progress Note documented: "Subjective...has had an ulcer noted near his PEG tube...has not responded to a barrier cream...patient states that it stings and burns, but not severely. He has not had fever or chills..." "Objective...PEG tube in place, and there is apparent weeping possibly of gastric fluid coming along the tract that the PEG tube is within.</p>	F 322	<p>4- Results of the audit will be brought to the monthly QA meeting for review and oversight.</p> <p>5: Compliance date: 9/15/15</p>		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 322	<p>Continued From page 54</p> <p>Inferior to that on the skin it appears that the ulceration is most likely caused by contact with gastric juices..."</p> <p>"Plan...base was cleansed and culture was taken...will be started on Septra DS...and we will place ostomy paste on the ulcer itself to prevent further contact...I do not wish, however, to seal the drainage from the stomach coming out. I am afraid that might have unintended consequences..."</p> <p>The resident's current Care Plan documented: "Observe [PEG] sit [site] for S/S [signs/symptoms] of infection (pain, redness, drainage) around tube insertion site and report to MD prn. Site care as ordered..."</p> <p>Resident #7's 4/2015, 5/2015, and 6/2015 TARs documented: **"Ostomy paste to peg site cover with drain sponge change bid minimum & prn...origin 1/28/15."</p> <p>The TAR lacked LN initials attesting that the 9:00 AM and 9:00 PM scheduled ostomy paste and dressing changes were provided for 4/2015 on 23 occasions, for 5/2015 on 39 occasions, and for 6/2015 on 1 occasion.</p> <p>On 6/17/15 at 9:45 AM, Resident #7 was observed while seated in his wheelchair in his room. The resident showed the surveyor his feeding tube and ostomy site. The site had a clean and intact dressing surrounding it. The resident said he was unable to have anything by mouth and had become sick when there was a trial to see if he could swallow.</p> <p>On 6/19/15 at 12:30 PM, the DON was shown</p>	F 322			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 322	Continued From page 55 the documentation and asked about the ostomy paste application and dressing changes. The DON stated, "I can't say it was being done." On 6/19/15 at 4:30 PM, the Administrator and several other management staff were informed of the concerns.	F 322	F323 1 Resident #3 was placed on q15 minute checks and PRN 1:1 as needed.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, staff and resident interview, review of the facility's occurrence reports, and the facility's policy and procedures, it was determined the facility failed to consistently ensure residents received adequate supervision to prevent elopement and falls with and without injury. This was true for 3 of 7 (#s 3, 8, & 17) residents sampled for falls and 1 of 2 (#17) residents sampled for elopement. * Resident #8 was harmed when he fell out of his wheelchair and sustained an acute fracture of the right proximal 5th metacarpal and the application of a ulnar splint. * Resident #3 had the potential for harm when she fell with inadequate supervision due to lack of staff. * Resident #17 had the potential for harm when	F 323	Resident #8 was placed on 1:1 supervision and a pommel cushion was placed on his wheelchair to help prevent falls and increase safety. Skills checks were completed on staff members who were working with resident at time of the fall to ensure they were competent to provide care. Resident #17 had a Wanderguard placed on her to help prevent elopement. There was a failure of previous administration to give proper oversight and direction to staff. The DON failed to report and investigate accidents and incidents. A new administrative staff was hired to help monitor and direct staff. 2- All residents at risk of elopement, and falls have the potential to be affected. A review of elopement and	

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 323	<p>Continued From page 56</p> <p>she exited the building, fell out of her wheelchair, and required emergency room treatment. The facility also failed to investigate and determine the root cause for a fall the resident experienced in her room or her eventual elopement and fall outside of the facility.</p> <p>Findings included:</p> <p>The facility's Falls and Fall Risk, Investigating and Managing policy documented: * "The facility will utilize root cause analysis to identify the reason for the fall and will include an interview of the resident by the licensed staff. * The staff, with the input from the physician will identify appropriate interventions to reduce the risk of falls. * Staff will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, Activities of Daily Living capabilities, activity tolerance, continence and cognition. * If underlying causes cannot be readily identified or corrected, staff will try various interventions...until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable."</p> <p>1. Resident #8 was admitted to the facility with diagnoses of ischemic stroke with occlusion, hemiplegia affecting right side, below knee amputation, osteoarthritis, and chronic pain.</p> <p>The Quarterly MDS, dated 4/9/15, coded the resident required extensive assist of two people for transfers; not steady when moving from a seated to standing position; no impairment in upper extremity; impairment on one side of lower</p>	F 323	<p>fall assessments was completed on all residents to determine those at risk. Additional staff has been hired to include more 1:1 staffing and floor monitors to perform room checks for each hall.</p> <p>An audit of residents' assessment was completed to ensure documentation/justification was in place. LNs were in-serviced on documentation and justification of Wanderguard placement.</p> <p>3- After residents are identified at risk for falls and elopement, they will be placed on Q15 minute checks. Audits of Q15 minute checks will be reviewed each day x5 days per week by nurse management for 2 weeks, then 2x per week thereafter. A review of all accidents and incidents will be completed daily x5 days per week to include root cause analysis of incidents and accidents. A review of staffing will be completed each day at stand-up meeting to help ensure staffing is adequate.</p>	

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 323	<p>Continued From page 57 extremity.</p> <p>A 3/4/15 Incident/Accident Report (I&A) documented, "[Resident #8] reached down to something on floor, fell out of w/c (wheelchair)." It was unclear how the facility determined the cause of the fall as all 11 witness statements documented staff had not witnessed the incident. The I&A documented the resident received a skin tear to his right elbow, a lump to the right side of his head and forehead. The I&A identified the "root cause" for the fall as "mood - agitation." The I&A further documented the resident was roaming the halls looking for food at various times during the three hours preceding the fall, however the I&A did not identify these observations in its "root cause" analysis. The initial intervention to prevent future falls documented, "Try to get a better w/c. w/c bows needs to have maintenance."</p> <p>On 6/16/15, the facility was unable to provide documentation that the wheelchair had been assessed for safety and integrity. When asked, the DNS reviewed the I&A report and stated the facility had failed to conduct a complete and thorough investigation of the fall.</p> <p>A 3/6/15 I&A documented, "Resident was attempting to enter a room and was rocking w/c back and forth to get over threshold and fell forward out of chair." It was unclear how the facility determined the cause of the fall as each of the 10 witness statements documented they had not witnessed the fall. The initial intervention implemented to prevent future falls included placement of a tab alarm.</p>	F 323	<p>4- Audits of the Q15 minute checks and staffing patterns will be brought to the monthly QA meeting for review and oversight.</p> <p>5 Compliance date: 9/15/15</p>		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 323	<p>Continued From page 58</p> <p>On 6/16/15, the DNS was asked to review the I&A report, which she stated was neither thorough nor complete. The DNS said the facility was working improving its I&A processes.</p> <p>A 3/7/15 I&A documented the resident was found on the floor of his room. A staff witness statement attached to the report documented, "...I was next to his room when I heard a crash so I walked in and he was on the floor..." The I&A identified the "root cause" for the fall as, "Res[ident] is unballanced [sic] and impulsive due to medical status, and loses ballance [sic] when bending over in wheel chair, puts things from counter and off of the floor in mouth. With no staff available, he has no one to redirect the impulses." The I&A further documented that in the three hours preceding the fall, the resident was observed in a chair, attending lunch, in the hall, and in his room. The report documented a nurse requested reinstatement of 1:1 supervision for the resident and/or a wheelchair lap belt. Additionally, Physical Therapy and Occupational Therapy were to evaluate the resident for further potential interventions.</p> <p>A Physical Therapy (PT) Note dated 3/27/15 documented a lap belt to the wheelchair was to be implemented for safety and to enhance the resident's quality of life by decreasing the level of caregiver assistance. Additionally, the PT note did not document the seatbelt had been assessed for safety, and the resident's record did not document less restrictive interventions had been attempted prior to adding the seatbelt to the resident's wheelchair.</p> <p>On 6/16/15, the DNS, when asked to review the</p>	F 323			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 323	<p>Continued From page 59</p> <p>I&A report, stated the lack of documentation indicated a thorough investigation of the fall had not been conducted.</p> <p>A 4/25/15 Occurrence Report (I&A) documented the resident was transferring and fell next to his bed. A Nurse Note (NN) attached to the Occurrence Report, also dated 4/25/15, documented, "Resident was being put into his bed and Nurse Assistant lost balance and resident fell to the floor."</p> <p>Note: The resident's 4/9/15 Quarterly MDS coded the resident was a two-, rather than one-person extensive assist for transfers.</p> <p>On 6/16/15, the facility was asked to provide the witness statement from the Nurse Assistant involved in the fall and documentation the resident had been assessed and changed from a two-person extensive assist to a one-person assist for transfers. A second copy of the same Occurrence Report was provided, which did not document the resident's transfer status had upgraded to a one-staff level of assistance.</p> <p>Note: The facility was unable to provide the name of the Nurse Assistant involved in the fall to allow suveryors the opportunity to assess the aide's training and competency evaluation for transferring residents with lower extremity amputations.</p> <p>A 4/26/15 Occurrence Report (I&A) documented, "Resident wheeled himself out the front doors and went down the driveway. Stopped at the bottom [was ejected] from his wheelchair and fell to the ground." A witness statement, dated</p>	F 323			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 323	<p>Continued From page 60</p> <p>4/26/15, documented, "My husband was driving me to work. We were traveling east on [an identified street]. My husband shouted out that a wheelchair was in the road. We pulled up and I said, 'Oh, my gosh that's [Resident #8]!' Meanwhile, two other vehicles had pulled over to help. My husband then drove me up to the facility, let me out to get help, and went back down to [Resident #8]. While coming into the facility I called 911...I told the Charge Nurse that [Resident #8] had apparently rolled down the long driveway out front, and I found him tipped over in his wheelchair. He had blood coming from his head/face/hand. He wasn't making any sounds, but his facial expressions were that of a person in shock. The nurses ran outside and evaluated [Resident #8] before moving him inside to wait for the ambulance."</p> <p>The resident's 15-minute checks were reviewed for 4/26/15 and documented:</p> <ul style="list-style-type: none"> * 8:15 AM - 10:00 AM, the resident was in the hallway walking; * 10:15 AM - The resident was in the front lobby and/or sitting/laying down and * 10:30 AM - 1:45 PM - The resident was out of the facility. <p>Review of the Emergency Room report, dated 4/26/15, documented the following injuries:</p> <ul style="list-style-type: none"> * Acute mildly comminuted fracture is seen at the base of the 5th metacarpal and is placed in an ulnar gutter splint. * "Abnormally widened scapholunate joint space worrisome for scapholunate ligament injury." * Right temporal wound area, 6 cm "going down toward the eyebrow." * Multiple lacerations on the right arm, 1 cm laceration on the right elbow, and multiple 	F 323		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 323	<p>Continued From page 61</p> <p>lacerations on the right hand.</p> <p>* "Most significant wound to dorsum R[ight] hand with approximately 4-5 cm (centimeter) macerated area...Wound care indicated for wound debridement and cleansing, repair, and to promote healing."</p> <p>On 4/26/15 at 1:30 PM the resident returned to facility and continued on 15-minute checks until 5:05 PM, at which time he was placed on 1:1 supervision.</p> <p>A 5/7/15 Occurrence Report (I&A) documented, "Aid believed she couldn't use seat belt because he had 1:1. [CNA] looked away when he [Resident #8] leaned forward to straighten sock. Pt realized [he was] falling forward straightened self but w/c without seatbelt [fastened] scooted back out from under him, landing on his bottom."</p> <p>On 6/18/15 at 11:00 AM, the DON was interviewed regarding the resident's multiple falls and fall with injury. The DON acknowledged the following concerns related to Resident #8's falls: Incomplete investigations; failure to identify the root cause; inadequate supervision related to insufficient staff; and interventions were not reviewed and revised to address the resident's individualized needs.</p> <p>On 6/19/15 at 4:30 PM, the Administrator and several other management staff were informed of the concerns.</p> <p>Resident #8 was harmed when he sustained a comminuted fracture at the base of the 5th metacarpal; abnormally widened scapholunate joint space with possible scapholunate ligament</p>	F 323			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 323	<p>Continued From page 62</p> <p>injury; right temporal wound; multiple lacerations on the right arm, elbow, and hand. The facility's failure to ensure interventions were implemented correctly and consistently; evaluate the effectiveness of those interventions; modify and/or replace interventions as needed; and evaluate the effectiveness of new interventions contributed to Resident #8's repeated falls and injuries.</p> <p>2. Resident #17 was admitted to the facility on 8/28/12 and readmitted on 4/7/15 with multiple diagnoses which included dementia without behavioral disturbances, anoxic encephalopathy, and mood disorder.</p> <p>The resident's 4/21/15 readmission MDS assessment documented: *BIMS of 3-cognition severely impaired; *Locomotion on and off the unit-extensive assistance with one person assistance; *Bed mobility, transfer, and dressing-extensive assistance with 2 person assistance; and, *No limitation in range of motion for bilateral limbs.</p> <p>Resident #17's current Care Plan documented: *Problem: Potential to fall related to lack of safety awareness. Interventions: "Analyze previous fall by resident to determine whether pattern/trend can be addressed...Wear non skid socks when in bed... 15 minute checks... Pressure alarm to bed and W/C to alert staff of unassisted transfers...Floor mat placed by bed while resident is in bed to prevent injury in event of self transfers..."</p>	F 323			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 323	<p>Continued From page 63</p> <p>*Problem: Self-care deficit-mobility related to anoxic brain injury, impaired cognition, and impaired mobility.</p> <p>Interventions: "...requires limited to extensive assist with 1-2 persons with mobility/transfers. May use Vander Lift as needed...uses a W/C for long distances, She is able to propel herself very short distances. Staff to assist as needed...alarm to bed and WC to alert staff when [resident] attempts to self transfer."</p> <p>The resident's Nursing Progress Notes documented: 4/18/15 at 4:00 PM - "Res [Resident] found alert orient X [times] 1 on her mat on the floor...Denied discomfort. No injuries noted. Res had reportedly had increased days of altered mental status during the week where the Cymbalta & Abilify were in a bubble pack in the med cart, possibly given, MD ordered to hold Cymbalta & Abilify..." 4/19/15 at 11:30 AM - "Res was able to get out of front door of facility [and] rolled halfway down the driveway. Her W/C hit the curb and she fell onto the grass. Once upon the scene VS [vital signs] obtained...Asked resident what happened. She reported "I fell." C/O [complains of] pain in her back [and] pelvic area - EMTs called - Res alert et able to answer questions...EMTs arrived [and] assessed. Res transported to [hospital] ER [emergency room]. Assistant DON, acting DON, administrator, [and] PCP [primary care provider] notified - transport to ED [emergency department]..." 4/19/15 at 3:30 PM - "Res returned to [facility from hospital]. No new orders received...x-rays were obtained et [and] results are noted as WNL [within normal limits]..."</p>	F 323			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 323	<p>Continued From page 64</p> <p>A nine-page Incident/Accident report, dated 4/19/15, documented:</p> <ul style="list-style-type: none"> -The resident on 4/19/15 at 11:00 AM was able to get out the front facility door, rolled halfway down the drive, hit the curb, and fell into the grass. -The physician was notified at 11:15 AM and new orders were received to transport the resident to the emergency room. -The facility's Incident/Accident Committee Review form was blank except for Resident #17's name, the date of occurrence documented as 4/19/15, and the time of 11:00. There were no committee signatures on the review form. <p>Note: There was no Incident/Accident report nor an investigation provided for the fall that occurred on 4/18/15. The nine pages of the 4/19/15 Incident/Accident report were not complete. The Occurrence Report was dated 4/19/15, but contained one page of a staff's statement for the fall on 4/18/15. The rest of the report dealt with the elopement. Two of the staff statements documented they had not seen the occurrence since they were with other residents as a 1:1, and an LN's statement documented she was told about the resident's incident by another staff member and sat with the resident until the ambulance arrived.</p> <p>On 6/19/15 at 2:30 PM, Resident #17 was observed lying in her bed. The resident had a Wanderguard bracelet on her right wrist. The resident acknowledged the Wanderguard bracelet had been placed on her recently.</p> <p>During an interview on 6/19/15, LSW #1 stated she had recently noticed the resident trying to exit the building through the front doors. The LSW stated she observed the resident to see if</p>	F 323			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 323	<p>Continued From page 65</p> <p>she could open the front doors and exit by herself on 6/17/15; the resident was able to open both doors and propelled herself out the doors without any assistance in less than 10 seconds. The LSW stated the resident was initially thought to have had a visitor or a resident allow her to leave the building on 4/19/15.</p> <p>Note: The resident had a Physician's Order for a Wanderguard and the Wanderguard was in place as of 6/17/15. There were no Nursing Progress or Social Service Progress Notes made on 6/17/15 regarding why the Wanderguard was placed. There was a late entry by Social Services on 6/19/15 at 6:30 PM in regards to the event of the resident exiting the building and provided to the surveyors on 6/22/15.</p> <p>3. Resident #3 was admitted to the facility on 2/18/15 with multiple diagnoses, including dementia with behavioral disturbances, decubitus buttocks ulcer, neurogenic bladder, and chronic kidney disease.</p> <p>The resident's June 2015 recapitulation Physician's Orders documented: "1:1 staffing 24 hrs/day r/t [related to] falls, impulsive behavior, poor safety awareness...Origin 2/27/15." "1:1 to be in arm's length...Origin 2/27/15." "Straight cath [catherization] BID [twice a day] for post void residual...Origin 5/4/15."</p> <p>The resident's admission MDS, dated 3/14/15, document: *BIMS score of 3-Cognition severely impaired; *Total assist of 1 person for locomotion on- and off unit; and, *Total assist of 1 person for dressing, eating,</p>	F 323		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 323	<p>Continued From page 66 toilet use, and personal hygiene.</p> <p>Resident #3's current Care Plan documented: - Problem-Self Care Deficit in mobility and potential to fall related to impaired cognition, long-term disease progression, and significant impaired physical function. Interventions: 1. Ensure no environmental barriers. 2. 1:1 24 hrs a day to assist in mobility. 3. Use 1-2 assist for transfers/bed mobility as needed. 4. WC for mobility and staff to assist in propelling. 5. Call light within reach. 6. Foot board to WC for leg/foot support. - Problem-Altered patterns of urinary/bowel elimination related to impaired cognition, intermittent catheterizations, neurogenic bladder, significant impaired physical function, and constipation. Interventions: 1. Resident has mixed continent/incontinent episodes of bowel and bladder. Staff to assist her to the toilet before/after meals, nighttime, and prior to each catheterization. 2. Encourage fluid intake. 3. Monitor for signs and symptoms of urinary retention, difficulty starting to urinate, and inability to feel when bladder is full.</p> <p>The resident's Nursing Progress Notes documented: 3/25/15 4:00 PM - "...on 1:1 staffing for safety. Res [resident] very confused today. Yelling out off and on. [No] void today. Cathed [catherized] for 400 cc [cubic centimeters]..." 3/26/15 7:00 AM - "...continue [with] 1:1 staffing for safety & needs...intake of 1080 cc noted this shift [with] 100 cc of output on own & 350 cc cathed output..." 3/27/15 2:45 PM - "...cont. [continued] [with] 1:1</p>	F 323			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 323	<p>Continued From page 67</p> <p>staffing for safety...output of 50cc when toileted...cathed...475 cc noted." 3/28/15 3:00 PM - "Res fell @ [at] 1230 [PM]. C/O [complains of] R [right] hip pain...Non emergent ambulance called...Res assessed by paramedics. Paramedics recommended that res would remain @ the facility." 3/28/15 11:00 PM - "Resident cont. 1:1 staffing for safety. Resident on fall charting..."</p> <p>The resident's 1:1 Shift Behavior Narratives for 3/28/15 documented: 6:00 AM - "Sleeping in bed." 7:00 AM - "Sleeping in bed." 8:00 AM - "Sleeping in bed." 2:15 PM - "[Resident] is sleeping." 3:30 PM - "[Resident] got cathed." Note: The Shift Behavior Narrative forms were completed for day, evening, and night shifts. The 3 entries were the only such notes documented on the day shift for the resident. The 1:1's listed hours were 6:00 AM to 10:00 AM. The 1:1 signed the form and made a slash behind her name to indicate another 1:1 staff member would be scheduled for the next 4 hour shift (10:00 AM to 2:00 PM). There were no documented entries by the 1:1 staff after 8:00 AM until the evening 1:1 staff member documented at 2:15 PM. There was consistent documentation for the remainder evening and night shifts on 3/28/15 by the 1:1 staff..</p> <p>The facility's Occurrence Report for Resident #3, completed on 3/28/15 at 1:00 PM, with date of occurrence as 3/28/15 and time of 12:30 PM, documented: "...Res stated she fell..."</p>	F 323		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 136071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 323	<p>Continued From page 68</p> <p>The facility's investigation of the 3/28/15 occurrence documented:</p> <p>*Committee Review: Resident #3 had "no 1:1 in place", no injury sustained by the resident, and the facility's plan to prevent further occurrences was to have "immediate placement of a 1:1. Nurses instructed to never leave her without a 1:1 - importance of safety d/t [due to] dementia..."</p> <p>Note: There were no committee members signatures on the Occurrence Committee Review form.</p> <p>*Occurrence Investigation: "...According to the resident's care plan, what special devices should be in place?...Side rails were up. Alarm was not in place, short staffed, no 1:1...Plan of care initiated...Keep 1:1 with her at all times..."</p> <p>*Resident Interview: "I fell." What were you trying to do? "Get out of bed...I have to pee. I still do..."</p> <p>On 6/16/15 at 8:10 AM, 10:15 AM, and 4:00 PM, and 6/17/15 at 9:15 AM, the resident was observed in her room or the hallway with a staff member, who identified him/herself as Resident #3's 1:1 CNA/NA. The staff member was observed to be within arm's reach of the resident at all times. The 1:1 CNA/NA stated he/she would have another staff member take care of the resident while the 1:1 took his/her breaks. The resident was not observed without a 1:1 present.</p> <p>On 6/18/15 at 9:50 AM, the DON was interviewed regarding the resident's fall. The DON acknowledged the form addressed staff shortage as an issue and an insufficient number of staff could affect resident supervision.</p> <p>On 6/19/15 at 4:30 PM, the Administrator and several other management staff were informed of</p>	F 323		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 323	Continued From page 69 the concerns.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on review of medical records, abuse investigations, as worked staffing reports, and staff interviews, it was determined the facility failed to provide sufficient nursing staff between 4/6/15 and 5/10/15 to meet residents' needs and promote their physical, mental and psychosocial well-being. This was true for 3 of 17 sampled residents, who were harmed (#8, 9, and 12) and had the potential to affect all residents living at	F 353	1 Staff levels have increased. The facility has hired an additional LN; Hall monitors to perform Q 15 room checks; additional shower aides, and an additional aide per hall. Previous administration failed to properly staff facility. 2- All residents have the potential to be affected. 3- Staffing levels will be reviewed daily 5 days per week during the morning Stand-up Meeting. The newly hired staffing coordinator will work on filling vacancies on a daily basis. 4- Staffing ppd will be reviewed at the monthly QA meeting for oversight. 5 Compliance date: 9/15/15	

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 353	<p>Continued From page 70 the facility during that period of time:</p> <p>* Residents #9 and #12 were harmed when the facility failed to develop and implement systems for prevention and treatment of pressure ulcers. Refer to F314.</p> <p>* Residents #8 and #12 was harmed when the facility failed to ensure the residents had the necessary supervision or interventions in place to prevent incident and accidents from occurring. Refer to F323.</p> <p>Findings include:</p> <p>1. As worked nursing staff reports for the weeks of 4/6/15 through 5/10/15 documented the facility staffed 18 to 20 residents with 1:1 staffing for 16 hours (morning and evening shifts) a day and 11 to 16 residents with 1:1 staffing during night shifts. Excluding the number of residents on 1:1 staffing and the number of 1:1 hours worked per day, the non- 1:1 as-worked nurse aide hours were calculated to determine the actual nurse aide coverage available to assist with resident cares. Between 4/6/15 and 5/10/15 The non- 1:1 resident census ranged between 61 and 72 on the four nursing halls. During that time frame:</p> <p>* No non- 1:1 nursing aides worked on 6 shifts * Only 1 non- 1:1 nurse aide worked on 2 shifts * Only 2 to 2.4 non- 1:1 nurse aides worked on 8 shifts.</p> <p>2. Of the eight CNAs/NAs who were interviewed, three stated the facility had been short-staffed "frequently" during the previous four months, especially on weekend shifts; four CNAs/NAs stated they had been "pulled off the floor" to provide 1:1 supervision due to low staffing; and</p>	F 353			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 353	Continued From page 71 four CNAs/NAs stated they had been "pulled" from their 1:1 assignments to "work the floor" due to staffing shortages, which left those residents requiring that level of close supervision without it. 3. Short staffing was addressed as a concern in a written complaint alleging a resident was secluded to his room. The 5/4/15 statement documented, "It was safer for the resident to be in his room, when we were short on staff and only one person on the hall. The resident is a fall risk and could get hurt walking in the hall ... We didn't have the people on the floor to walk with him ... some nights he would ... go into other's room and take things off the nurses cart and other things he shouldn't have ..." 4. The facility's CEO and the Corporate Human Resources Director acknowledged on 6/18/15 that staffing hours were short during the months of April and May 2015. On 6/19/15 at 4:30 PM, the Administrator and several other management staff were informed of the concerns. The facility did not provide any additional information to alleviate the issues.	F 353			
F 490 SS=G	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 490			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 490	<p>Continued From page 72</p> <p>Based on staff interviews, resident and family interviews, review of grievances and occurrence reports, medical record review, and review of the facility's policies and procedures for incidents and accidents, it was determined the facility's systemic failures failed to provide sufficient implementation, monitoring, evaluation, and continued oversight to maintain a safe environment and services for 10 of 17 (#s 1, 3, 7, 8, 9, 10, 11, 12, 15, & 17) sampled residents. This failure had the potential to adversely impact the quality of life and quality of care of residents in the facility. Findings Include:</p> <p>* F314 - The facility failed to ensure residents with pressure ulcers received thorough wound assessments and interventions, or to develop and implement systems for prevention of pressure ulcers. Two residents were harmed when they developed multiple and/or recurrent pressure ulcers while living at the facility. Additionally, the facility failed to ensure resident pressure ulcers present upon admission did not deteriorate.</p> <p>* F323 - The facility failed to ensure residents had the necessary supervision and/or interventions in place to prevent incident and accidents from occurring. In addition, the facility failed to ensure incidents were fully investigated, root cause determined, and interventions implemented to prevent future occurrences.</p> <p>* F353 - The facility failed to employ an adequate number and fully trained staff to provide residents adequate care and/or supervision.</p> <p>* F157 - The facility failed to ensure legal representatives were notified of residents' accidents resulting in injury.</p>	F 490	<p>F490</p> <p>1- A new administrator has been hired who has approximately 15 years of LTC/Administrator experience, and understands the QA process, and in particular, root cause analysis format.</p> <p>2- All Residents have the potential to be affected.</p> <p>3- A new, root cause analysis QA program has been implemented at the facility. The nurse consultant and corporate VP of Operations will be added to the QA committee to help provide oversight of the QA process until the QA committee is performing as required.</p> <p>4- The Corporate VP of Operations will review the QA process monthly x 3 months, then quarterly thereafter.</p> <p>5 Compliance date: 9/15/15</p>		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 490	Continued From page 73 * F221 - Safety devices/restraints were not evaluated for safety and/or effectiveness. * F226 - Allegations of possible abuse/neglect were not thoroughly investigated. * F280 - Care plans were not revised per physicians' orders to provide facility staff adequate directives for preventing/healing pressure ulcers * F309 - Physician's orders and Care Plans were not followed to ensure diabetic residents were administered treatment and medications as need and a resident's physician orders and care plans were not followed to ensure the resident had one-on-one staffing 24 hours per day. * F322 - The facility failed to provide a resident with adequate ostomy care and treatment. * F494 - Nurse aides providing care to residents were not certified and/or enrolled in training to become certified. * F498 - Nurse aides did not receive specialized training to provide appropriate care and interventions to residents with significant behaviors and/or dementia. * F520 - The QA committee failed to identify and resolve system problems affecting resident care and the operation of the facility. On 6/19/15 at 4:30 PM, the Administrator and several of the management team were notified of the identified concerns.	F 490		
F 494 SS=E	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has	F 494		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 494	<p>Continued From page 74</p> <p>completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b).</p> <p>A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.</p> <p>Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and review of employment records, it was determined the facility employed and utilized nurse aides who had not completed an approved C.N.A. course within the prescribed timeframe per regulatory requirement. This was true for 6 of 11 nurse aides reviewed (Staff #s A - F). Findings include:</p> <p>Employment records for Staff #s A - K were reviewed on 6/17/15 and 6/18/15. These records revealed:</p> <p>1. N.A. #A, who was employed by the facility as a nurse aide on 8/11/15 was not certified as a</p>	F 494	<p>F494</p> <p>1 All staff in question were enrolled in a state approved CNA course, and are not providing direct, hands-on care. A new HR person was hired to oversee and audit all staff certification as well as enrolling them into approved state courses. Any staff who did not meet the criteria were not allowed to provide direct patient care.</p> <p>2- All residents have the potential to be affected. An audit was completed by HR to determine which staff were not enrolled in an approved course and ineligible to provide direct care.</p> <p>3- The facility HR will ensure all new and existing staff are eligible to provide care and meet the state and federal guidelines prior to employment. Audits will be completed by the facility educator (SDC) prior to new staff being allowed into orientation, and will create a system to review all certifications for CNA's on an on-going basis.</p>		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 494	<p>Continued From page 75</p> <p>nurse aide at the time of hire and was not enrolled in an approved nurse aide training program. As of 6/18/15 N.A. #A had still not successfully completed a C.N.A. program.</p> <p>2. N.A.s #B and #C were hired as nurse aides in November 2014. Neither was certified as a nurse aide when hired, nor was either enrolled in an approved nurse aide training program when hired. Neither aide had successfully completed a CNA coarse as of 6/18/15.</p> <p>3. N.A.s #D, #E, and #F were hired as nurse aides in April 2015. They were not certified as nurse aides upon hire and were not participating in an approved C.N.A. course as of 6/18/15.</p> <p>On 6/18/15 the facility's CEO and the Human Resources Coordinator (HRC) acknowledged 4 of the above staff were past their 4 month employment date, were considered permanent employees, and had not completed an approved C.N.A. course. The CEO and HRC also acknowledged staff #s 4, 5, and 6 did not have their C.N.A. upon hire and were not enrolled in a C.N.A. program upon hire. The CEO stated the facility was "hiring an instructor" to provide an accelerated nurse aide training program, which would "hopefully" start on 6/23/15 and 6/25/15. Six of the identified nurse aides would be enrolled in the course, a 7th nurse aide, hired on 11/24/14, was currently enrolled in a course. The CEO also stated staff had been instructed to use only non-certified N.A.s as sitters who were not to provide direct resident care. On the early evening of 6/18/15 surveyors observed a flyer posted on each unit that directed staff to use only nurse aides as sitters until otherwise directed.</p>	F 494	<p>4- Review of staff audits will be completed during the monthly QA meeting for compliance, analysis and oversight.</p> <p>5 Compliance date: 9/15/15</p>	

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 498 SS=E	<p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS</p> <p>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on employee record review, review of the Resident Census and Condition and Roster Matrix, and staff interviews it was determined the facility failed to ensure newly hired nurse aides were provided specialized training to work with residents with dementia and/or behaviors and residents receiving 1:1 staffing. This was true for 9 of 11 employees reviewed (Staff #s A - I). The failure to provide adequate behavioral and 1:1 training put residents at risk for injury and psychosocial harm and staff at risk for injury and frustration in not having the tools necessary to effectively meet the needs of residents. Findings include:</p> <p>The facility's Resident Census and Conditions report (CMS-672), dated 6/15/15, documented the facility had a total census of 82 residents, 62 of whom had documented psychiatric diagnosis (excluding dementia and depression), 42 were diagnosed with dementia, 73 were assessed as having behavioral health care needs and 55 who received antipsychotic medications.</p> <p>The facility's Roster Matrix (CMS-802), dated 6/15/15, documented 69 of 82 residents had behavioral symptoms affecting others and/or</p>	F 498	<p>F498</p> <p>1 Staff members A, B, H & K are no longer employed by the facility</p> <p>A new staff development coordinator was hired to provide training on behaviors, dementia, and 1:1 care.</p> <p>Staff members C, D, & E have received specialized training for patients with dementia and behaviors.</p> <p>Staff members C, D, E, F, G, I, & J Will receive skills checks and 1:1 training.</p> <p>Staff members G, I, & F are currently enrolled in specialized training for dementia, behaviors, and 1:1.</p> <p>2- All residents with dementia and behaviors have the potential to be affected.</p> <p>3- Facility HR will enroll all new hires into a certified CNA course if they are not certified.</p>	

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 498	<p>Continued From page 77 themselves.</p> <p>Interviews with Social Workers #s 1 & 6 and the Administrator on 6/15/15 and 6/16/15 indicated the facility had an unlocked men's unit (Cape May) that currently housed 23 residents who could be physically aggressive towards themselves or others, destructive of property, and/or sexually aggressive.</p> <p>As-worked nursing staff reports for the weeks of 4/6/15 through 6/15/15 documented the facility regularly staffed 19 to 20 residents facility-wide with 1:1 supervision for 16 hours (morning and evening shifts) and 11 to 16 residents with 1:1 supervision during night shifts only. For example, information provided regarding 1:1 staffing on 6/15 documented:</p> <ul style="list-style-type: none"> * Cape May hall had 5 resident's who had 1:1 staffing 24 hours per day. * Cape Elizabeth hall had 3 residents who were 1:1 staffed 24 hrs per day. * Cape Cod hall had 1 resident who was staffed 1:1 24 hours per day. * Cape Hatteras hall had 4 residents who were staffed 1:1 for 24 hours per day and 1 resident who was staffed 1:1 16 hours per day. <p>One-to-one residents' physician's orders and Care Plans documented 1:1 staffing was necessary to prevent falls/injuries from falls, intervene with behaviors and assure residents safety as well as the safety of their peers and staff. For example:</p> <ul style="list-style-type: none"> * Resident #15 physician's orders and Care Plan documented, "1:1 staffing due to lack of safety awareness, impulsive behavior. 1:1 is to be within arms [sic] length at all times ..." (3/1/15) 	F 498	<p>All new staff will automatically receive specialized training during general orientation that includes behaviors, dementia, and 1:1.</p> <p>An audit by the SDC will be completed to determine existing staff members who have not received specialized training, and will enroll them into the BCU training program.</p> <p>A review of employees who have completed, or have not completed the BCU will be completed each month during the QA meeting.</p> <p>5 Compliance date: 9/15/15</p>		

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 498	<p>Continued From page 78</p> <p>* Resident #3 physician's orders and Care Plan documented, "1:1 staffing 24 hrs/day r/t [related to] falls, impulsive behavior, poor safety awareness... 1:1 to be in arms [sic] length... " (2/27/15)</p> <p>* Resident #6 Physician's orders and Care Plan documented, " Staffing 24 hrs/day r/t falls, impulsive behavior, poor safety awareness... 1:1 to be at arms [sic] length." (4/9/15)</p> <p>During review of employee records and training information it was determined staff hired between 2/19/15 and 5/4/15 had not consistently completed specialized training in working with residents with cognitive losses, mental illness, and/or behavior disturbance.</p> <p>On 6/22/15, LSW #6 faxed information to the Bureau of Facility Standards (BFS) documenting the facility's policy for training newly hired nurse aides. Based on the facility policy statement, new nurse aides must complete three days of basic orientation as well as an 8-hour behavioral training class (BCU). New hires would then be paired with a senior C.N.A. for a total of 9 days on the floor and 1 day of 1:1 training.</p> <p>The facility's three-day orientation included review of basic information, such as standard precautions and hand hygiene, resident rights, resident abuse, department overviews, chain of command, retaliation, employee concerns, employee handbook, dietary, housekeeping, maintenance information, etc.</p> <p>At the conclusion of orientation, new employees and their mentors signed a Skills Check-Off List indicating skills that were successfully</p>	F 498			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 498	<p>Continued From page 79</p> <p>demonstrated by the new employee. The skills list did not include working with residents with cognitive losses, behavioral management or intervention skills for aggressive and/or unsafe behaviors. The skills list only addressed working with 1:1s as a sitter. Note: Per interview with the CEO on 6/18/15 and N.A.# K, sitters did not provide direct care for their residents. If nursing care or behavioral management was needed then other staff would be called.</p> <p>The 8 hour BCU (Behavior Care Unit) Training course included staff training on understanding behaviors and care plans, crisis cycle and safety techniques, and staff behaviors and stress management.</p> <p>New employee files for Staff #s D, E, F, and G documented they did not consistently receive training to work with 1:1 residents. During interviews, Employee #s D, E, F, and G confirmed they did not receive the 1:1 training prior to being assigned to work with 1:1 residents.</p> <p>Employee records for Staff #s F, G, H, and I documented they did not receive behavioral training (BCU). During interviews, Staff #s F, G, and H confirmed they did not attended the BCU course prior to working with residents with dementia and/or known behavioral concerns.</p> <p>In addition, between 8/14/14 and 5/4/15 the facility hired non-certified nurse aides and allowed them to provide nursing care to residents aware that the aides were not enrolled in a C.N.A. training program and/or had successfully completed competency testing within the required 4-month timeframe per regulatory</p>	F 498			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201	
(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 498	Continued From page 80	F 498	F520	
F 520 SS=D	<p>requirement. (Refer to F494). Two of these newly hired employees (Staff #s F & G) stated they had no previous NA experience prior to employment at the facility.</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and a review of the facility's compliance history, it was determined the</p>	F 520	<p>1- A new administration team has been hired with an administrator who has approximately 15 years of LTC/Administrator experience, and understands the QA process, and in particular, root cause analysis format.</p> <p>2- All Residents have the potential to be affected.</p> <p>3- A new, root cause analysis QA program has been implemented at the facility. The nurse consultant and corporate SDC will be added to the QA committee to help provide oversight of the QA process until the QA committee is performing as required.</p> <p>4- The Corporate SDC/Educator will review the QA process monthly x 3 months, then quarterly thereafter.</p> <p>5 Compliance date: 9/15/15</p>	

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 520	<p>Continued From page 81</p> <p>facility's Quality Assessment and Assurance (QAA) committee failed to take actions that identified and resolved systematic problems for 9 of 16 sampled residents (#s 1, 3, 7, 8, 9, 10, 11, 12, & 15) and 1 random resident (#17), with the potential to affect all residents in the facility. This failure resulted in the QAA committee providing insufficient and necessary direction and control over the facility to ensure residents' quality of life, assessments, and quality of care needs were met. Findings included:</p> <p>The QAA committee failed to provide sufficient monitoring and oversight and the ability to sustain regulatory compliance, as evidenced by the recitation of the following citations for the complaint survey, dated 6/19/15.</p> <p>a. Refer to F226 as it related to the QAA committee's failure to ensure there was not the risk of abuse. The facility was previously cited at F226 during the annual recertification survey, dated 1/16/15, as well as for the current complaint survey, dated 6/19/15.</p> <p>b. Refer to F280 as it related to the QAA committee's failure to ensure care plans were revised and reflected the care needs of the residents. The facility was previously cited at F280 during the annual recertification survey, dated 1/16/15, as well as for the current complaint survey, dated 6/19/15.</p> <p>c. Refer to F309 as it related to the QAA committee's failure to ensure the facility provided the necessary care and services to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being.</p>	F 520			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 520	<p>Continued From page 82</p> <p>The facility was previously cited at F309 during the annual recertification survey, dated 1/16/15, as well as for the current complaint survey, dated 6/19/15.</p> <p>d. Refer to F314 as it related to the QAA committee's failure to ensure the facility provided thorough wound and/or pressure ulcer assessments, wound and/or pressure ulcer care interventions, and the development and implementation of systems for prevention of pressure ulcers. The facility was previously cited at F314 during the annual recertification survey, dated 1/16/15, as well as for the current complaint survey, dated 6/19/15.</p> <p>e. Refer to F323 as it related to the QAA committee's failure to ensure residents' environment remained as free of accident hazards as is possible and ensure residents receive supervision to prevent accidents. This failure was evidenced by residents harmed with injuries and increased pain after their falls and residents being at risk of injury when the facility did not have adequate and fully trained staff available for providing care for the residents. The facility was previously cited at F323 during the annual recertification survey, dated 1/16/15, as well as for the current complaint survey, dated 6/19/15.</p> <p>f. Refer to F353 and F494 as it related to the QAA committee's failure to ensure the facility had sufficient and adequately trained staff to provide care and services for the residents. The lack of sufficient and adequately trained staff harmed residents when they were not provided services in the areas of quality of life, resident</p>	F 520			

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

PRINTED: 07/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135071	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/19/2015
NAME OF PROVIDER OR SUPPLIER SAFE HAVEN CARE CENTER OF POCATELLO			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HOSPITAL WAY POCATELLO, ID 83201		
(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 520	<p>Continued From page 83</p> <p>assessment, and quality of care categories. The facility was cited at F353 and F494 during the current complaint survey, dated 6/19/15.</p> <p>On 6/19/15 at 3:00 PM, the Administrator was interviewed regarding the facility's QAA process, as well as concerns with the Incidents and Accidents (I & As) reports and the facility's investigation process. The Administrator stated the I & As in review had not been completed and the investigations were not complete. The Administrator stated, "I can see there's a break in our QAA process." The Administrator stated the management staff had become aware of several of issues during the complaint investigation survey.</p> <p>The facility was unable to demonstrate its QAA process was effective and sustained as evidenced by the repeated deficiencies in four areas of quality of life, resident assessment, and quality of care categories.</p>	F 520			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: lsb@dhw.idaho.gov

October 8, 2015

Troy Thayne, Administrator
Safe Haven Care Center Of Pocatello
1200 Hospital Way,
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Thayne:

On **June 19, 2015**, an unannounced on-site complaint survey **OR** investigation of an entity-reported incident was conducted at Safe Haven Care Center Of Pocatello. The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint or Entity-Report Incident #ID00007026

The following allegations were investigated during a complaint survey conducted between June 15, 2015 and June 19, 2015.

ALLEGATION #1:

A resident did not have his/her dentures in and the dentures could not be found.

FINDINGS #1:

During the survey, observations and residents and staff interviews were conducted. Records, including resident clinical records, incident reports, grievances, and Resident Council meeting minutes were reviewed with the following results:

The facility's incident reports, grievances, and Resident Council Meeting minutes were reviewed from February 20, 2015 through June 2015. None of the records included concerns regarding missing dentures or inadequate oral care.

Troy Thayne, Administrator
October 8, 2015
Page 2 of 6

Observations of thirteen sampled residents were conducted throughout the survey. No concerns with the resident's oral care were noted during the observations. Multiple staff and residents, the Licensed Social Worker, Director of Nursing Services, and the Administrator were interviewed.

The Licensed Social Worker identified concerns related to the missing dentures and was in the process of having the dentures replaced.

The records of thirteen residents were reviewed. No concerns with oral care and/or missing dentures were identified for any of the residents.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

A resident was not protected from a roommate who attempted to make inappropriate physical contact; The facility did not conduct a complete and thorough investigation of the alleged incident; and the resident advocate and State Agency were not immediately notified regarding the incident. Additionally, a resident advocate was not immediately notified after potentially inappropriate physical contact occurred between two residents.

FINDINGS #2.

Based on a complaint from the community, staff interview, record review, review of policies and procedures, and investigation reports, it was determined the facility failed to follow its abuse policies and procedures to ensure all allegations of abuse were thoroughly investigated. The facility failed to ensure that all allegations and investigation results were reported to the State Survey Agency/ Bureau of Facility Standards (BFS) in accordance with state law; ensure residents and/or resident representatives were informed of the allegations and outcomes of investigations; and, ensure all witnesses, including residents, were interviewed and written statements obtained.

During the survey, observations and staff interviews were conducted. Records including resident clinical records, abuse reports, incident and accident reports, and grievances were reviewed from February 20, 2015 to June 2015.

The facility's abuse reports documented two occurrences of potentially inappropriate physical contact occurred on the same day, between the same residents. The occurrence report did not include immediate interventions implemented after the first occurrence to remove the potential for additional inappropriate contact between the two residents. A second incident occurred the same day, however there was not a second occurrence report completed the information was added to the first report.

The State Agency's reporting line did not include notification of either incident. Additionally, the facility did not fax the State Agency a completed investigation of the incidents.

It was determined the facility did not operationalize policy's and procedures to ensure all allegations of abuse (inappropriate touching) were thoroughly investigated and reported to the State Agency. Therefore, the allegation was substantiated and cited at F226.

It was determined the facility did not immediately report the two identified incidents to the resident(s) advocate(s); therefore, the allegation was substantiated and cited at F157.

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

ALLEGATION #3:

A resident advocate was told a resident who experienced a severe choking incident could not be transported to the Emergency Room for evaluation related to the resident receiving hospice services.

FINDINGS #3:

During the survey, resident and staff interviews were conducted. Records including resident clinical records, incident and accident reports, and grievances were reviewed with the following results:

The facility's incident and accidents reports from February 20, 2015 to June 2015 were reviewed and did not include information related to the identified incident.

The facility's contract with the Hospice provider was reviewed and did not document a person receiving hospice services could not be transported to the Emergency Room if requested by resident or resident advocate.

The resident's medical record documented the physician and the hospice provider were notified related to the incident; the resident was assessed by a Licensed Nurse from the Hospice Agency; and a new order was received for a mechanically altered diet.

Multiple staff, the Licensed Social Worker, the Unit Manager, and the Director of Nursing Services were interviewed and acknowledged the concern related to the choking incident and verbalized the actions taken to correct it. The Licensed Social Worker and Director of Nursing stated a resident receiving Hospice services could be transported to the Emergency Room if the resident or the resident advocate requested it or the resident had an acute incident not related to the hospice diagnosis.

It could not be determined the resident was denied transportation to the Emergency Room related to receiving hospice services. The allegation was unsubstantiated and no deficient practice was identified.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents clothes are not returned after being laundered at the facility.

FINDINGS #4:

During the survey, observations and residents and staff interviews were conducted. Reports including resident clinical records, grievances, and Resident Council Meeting minutes were reviewed with the following results:

The facility's grievances and Resident Council Meeting minutes reviewed from February 20, 2015 to June 2015 documented concerns related to missing articles of clothing and the action taken by the facility to replace and/or find the clothing.

It could not be determined the facility had failed to address laundry concerns when identified by residents and/or resident advocates. The allegation was unsubstantiated and no deficient practice was identified.

CONCLUSION: Substantiated. No deficiencies related to the allegation are cited.

ALLEGATION #5:

Residents do not receive scheduled breathing treatments as prescribed by the physician.

FINDINGS #5:

During the survey, observations and residents and staff interviews were conducted. Records, including resident clinical records, Medication Error reports, and Incident and Accident reports were reviewed with the following results:

The Incident and Accident Reports and the Medication Error reports were reviewed from February 20, 2015 to June 2015. None of the records included concerns related to missed breathing treatments.

Observations of thirteen residents were conducted throughout the survey. No concerns related to missed medications were observed. The Unit Manager, Primary Nurse on the unit, and the Director of Nursing Services were interviewed. No concerns related to missed medications, scheduled breathing treatments were expressed during the interviews.

The records of the thirteen residents were reviewed. Concerns related to missed medications, specifically breathing treatments, were not identified for any resident.

It could not be determined residents had missed scheduled medications. The allegation was unsubstantiated and no deficient practice was identified.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

A resident's hearing aides "disappeared" and the facility did not offer to replace them.

FINDINGS #6:

During the survey, observations and residents and staff interviews were conducted. Records, including resident clinical records, grievances and Resident Council Meeting minutes were reviewed with the following results:

The facility's grievances and Resident Council Meeting minutes were reviewed from February 20, 2015 to June 2015. None of the records included concerns related missing hearing aides.

The Licensed Social Worker, Primary Nurse on the unit, multiple staff members, and the Administrator were interviewed. The staff identified during the interviews the resident did not like to wear his hearing aides and would take them out despite attempts to explain the benefits of wearing them. The hearing aides were observed stored on the nurse's cart.

The resident's record included documentation of the resident's refusal to wear the hearing aides despite multiple attempts by the staff.

The survey team observed the resident's hearing aides during the survey. The allegation was unsubstantiated and no deficient practice was cited.

CONCLUSION: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

A resident advocate had to direct staff to check a blood sugar on a diabetic resident who showed symptoms of low blood sugar.

FINDINGS #7:

During the survey, observations, record review including resident clinical records, incident reports, and grievances were reviewed with the following results:

Observations of nine sampled residents were conducted throughout the survey. Two residents were identified to have concerns related to diabetic management and treatment.

Resident records, incident reports, and grievances reviewed from February 20, 2015 to June 2015 and included concerns related to diabetic management and treatment.

Troy Thayne, Administrator
October 8, 2015
Page 6 of 6

It was determined diabetic residents were not receiving appropriate diabetic management and treatment. The allegation was substantiated and cited at F309.

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

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

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

Sincerely,

A handwritten signature in black ink, appearing to read "Nina Sanderson". The signature is fluid and cursive, with a small circular mark at the end.

NINA SANDERSON, LSW, Supervisor
Long Term Care

NS/pmt



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK--ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T -- Chief
BUREAU OF FACILITY STANDARDS
3232 Eker Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1889
E-mail: fsb@dhw.idaho.gov

FILE COPY

August 20, 2015

Troy Thayne, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Thayne:

On **June 19, 2015**, an unannounced on-site complaint survey was conducted at Safe Haven Care Center of Pocatello.

This complaint was investigated during a complaint survey on June 15, 2015 through June 19, 2015, along with three other complaints. The allegations in this complaint pre-dated the date of the last recertification survey. The complainant had spoke to the surveyors while they were in the facility, and many of these items were already investigated and substantiated as part of the previous recertification survey process. At the time the complaint was lodged, the facility had not yet been found to be in substantial compliance with regulatory compliance on many of the same issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID6945

ALLEGATION #1:

The Reporting Party (RP) identified the following concerns related to the lack of care and services provided to an identified resident:

Resident did not receive prescribed medications, including Aricept for seven to eight days.

FINDINGS:

The resident's and 15 other residents' medical records were reviewed for medication and treatment

Troy Thayne, Administrator
August 20, 2015
Page 2 of 4

administrations and nursing staff were interviewed in regards to medications and treatments for the 16 residents. The facility's policy and procedures on Medication Administration was provided and reviewed.

The identified resident's Medication Administration Record (MAR) was reviewed in order to determine if the resident had failed to receive the prescribed medications. The facility's documentation showed the resident had a MAR dated February 1, 2015 through February 18, 2015 and also another MAR dated February 18, 2015 through February 25, 2015. The resident discharged from the facility on February 25, 2015. The period of time of when the facility was in compliance only could be reviewed; The resident's MAR for February 19 through February 25, 2015 reflected the resident received the prescribed medications, although the resident's medication blister packs was not consistent with this documentation. The resident refused medications in January and February as evidenced by the nurses' initials being circled.

However, the facility had been found to be out of compliance during this complaint survey for two other residents' medication administrations. The two residents' MARs documented they had not received their medications/treatments as ordered, thus the complaint was substantiated and the facility was cited at F309. Refer to Federal Report 2567 for details.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The Reporting Party (RP) identified the following concerns related to the lack of care and services provided to an identified resident:

Feces and urine was observed on the floors and walls in the bathroom and bedroom of the identified resident. Garbage cans in room and bathroom had soiled adult briefs left in them. The resident's bed was not made during the day.

FINDINGS:

During the complaint survey process, the residents' rooms and bathrooms were observed for clutter, cleanliness, garbage cans being emptied, and the beds being made. The residents' rooms and other common areas of the facility were clean and clutter-free throughout the five day complaint survey process. The residents' beds were observed to be made daily.

The surveyors met with some of the residents individually and as a group and there were no concerns presented in regards to their rooms being cleaned, garbage cans being emptied, or the beds not being made. The residents at the group interview stated they were happy with the housekeeping staff and felt they were doing a great job. The residents also stated they were pleased with the CNAs and were aware

Troy Thayne, Administrator
August 20, 2015
Page 3 of 4

of their hard work in keeping the rooms picked up and organized to the residents' preferences.

This complaint could not be substantiated for the February time period, during the current complaint survey process.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The Reporting Party (RP) identified the following concerns related to the lack of care and services provided to an identified resident:

Staff would bring meal trays to the identified resident's room with the cover on the food and leave it for him until the food would get cold. The identified resident has dementia and required cueing and assistance to eat.

FINDINGS:

During the complaint survey process, staff and residents were interviewed, medical records were reviewed for residents' needs for activities of daily living (ADLs) to include assistance with eating, meal observations in the dining room and in the residents' rooms were performed, and the availability and training of staff for ADLs was reviewed.

Based on review of the above items, it was determined the facility did not have enough staff to assist residents with their daily needs, nor did the facility ensure newly hired nurse aides were provided specialized training to work with residents who had dementia and/or behaviors. During the complaint survey process, the meal observations did not reflect the residents were not provided assistance with eating. However, this complaint was substantiated and the facility was cited at F353 for inadequate staffing and at F498 for inadequate staff training, which impacted quality care needs. Refer to Federal 2567 report for details.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The Reporting Party (RP) identified the following concerns related to the lack of care and services provided to an identified resident:

Resident's laundry was sent to the facility laundry not returned.

Troy Thayne, Administrator
August 20, 2015
Page 4 of 4

FINDINGS:

During the complaint survey process, staff and residents were interviewed, a resident group interview was conducted, observations were made of the laundry personnel bringing laundry to the units, and distributing it to the to the residents' rooms.

The residents in the group interview stated they had laundry items that were not promptly returned and clothing would get lost and not be returned. Residents said the laundry supervisor would talk with residents and then alert the laundry staff and CNAs of any missing item/s. The staff attempt to locate the missing items. The staff look in other residents' closets and drawers and if clothing had been distributed to the wrong resident, then staff would take the items to the rightful owner. If the items missing were not found, the facility would replace or try to find a similar item in their donated clothing supply.

The Laundry Supervisor stated he worked very closely with residents and staff. He made rounds on the residents every morning to address their laundry needs, and informed CNAs who assisted the residents with dressing to see him if the residents were missing items or did not have the clothing items they needed.

The Social Worker stated the facility had a large supply of donated clothing and when missing items could not be found, they tried hard to replace the items with something comparable.

Based on observations and the facility's efforts in addressing the laundry concerns, it was determined the complaint could not be substantiated during the time period reviewed.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

August 20, 2015

Troy Thayne, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Thayne:

On **June 19, 2015**, an unannounced on-site complaint survey was conducted at Safe Haven Care Center of Pocatello.

The complaint survey took place June 15, 2015 through June 19, 2015.

During the survey, staff and residents were interviewed, and resident medical records, as-worked staffing records, staff training records, Resident Council Meeting Minutes, Grievance reports, Resident Census and Condition reports, and the Federal Roster Matrix forms were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007000

ALLEGATION #1:

The complainant stated that newly hired staff are assigned to work with residents requiring one-on-one staffing without adequate training or information.

FINDINGS:

Based on review of these records and staff interviews, it was determined the facility failed to ensure newly hired nurse aides were provided specialized training to work with residents with dementia and/or

Troy Thayne, Administrator
August 20, 2015
Page 2 of 6

behaviors, and residents receiving one-on-one staffing. The facility was cited at F498 for failing to assure staff were trained and competent to perform resident services. Refer to Federal 2567 report for details.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated nurse aides are not informed before working with residents who have MRSA infections and the facility does not require staff to take special precautions when working those residents. Specifically, the complainant stated an identified resident with MRSA was "supposed" to wear gown and gloves at all times when out of his/her room. The staff working with the resident allowed the resident to walk through the facility without a gown and gloves because the staff was not told about the need for precautions.

FINDINGS:

The identified resident's medical record documented the resident was diagnosed with MRSA and treated with antibiotics. Follow-up urine testing indicated the acute infection was resolved but colonized. According to the medical record, the resident was incontinent of urine, wore adult briefs to contain the urine and was on a scheduled toileting program. There was no documentation indicating the resident attempted to remove her briefs in public and/or have her hands in the brief in public. Because the urine was contained with no risk factors for cross contamination in the public, CDC infection control guidelines indicated the resident can be in public without wearing a gown and gloves.

In addition, four nurse aides/certified nurse aides were interviewed and asked how they would know what infection control precautions to take with specific residents. They all stated that information would be shared during shift change report and there would be a poster on the resident's door alerting staff and visitors to check with the nurse before visiting or working with the resident.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility is "so understaffed" the nurses instruct non-licensed nurses and certified nurses aides to apply over the counter antibiotic and medicated creams to residents and to do blood glucose checks (BGs).

FINDINGS:

Based on review of medical records, abuse investigations, as worked staffing reports, and staff interviews, it was determined the facility failed to provide sufficient nursing staff between April 6, 2015 and May 10, 2015 to meet residents' needs and promote their physical, mental and psychosocial well-being. The facility was cited at F352. Refer to Federal 2567 report for details.

Refer to Findings 4 regarding non-licensed staff applying antibiotic creams and ointments.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4:

The complainant stated nurses aides and certified nurses aides (CNAs) have been asked to perform services they are not qualified to perform such as checking blood sugars and applying ointments and creams to residents.

FINDINGS:

Interviews with three licensed nurses who worked Cape Hatteras, Cape May and Cape Elizabeth indicated the facility's policy allowed CNAs to perform blood glucose checks once they pass a competency test. Nurses aides are taught how to check blood glucose levels in their certification program and it is up to the facility to ensure they are competent to do so in the facility. Two of the three licensed nurses stated they rarely asked a CNA to check a resident's blood glucose levels. They would rather do it themselves before administering the residents' insulin. The third licensed nurse stated she has used CNAs to check blood sugars if they have passed the competency test.

Interviews with three nurses aides and three CNAs revealed that two of the three CNAs passed the competency test and performed blood glucose checks in the facility. Two of the three nurses aides stated they had never been asked to do blood glucose checks. One of the three nurses aides stated she had been asked to check a blood sugar, but did not check it once she told the nurse she was a nurses aide and not qualified to do so.

The CNAs interviewed also stated they did not administer medicated creams or ointments, but did apply barrier creams after residents were incontinent if it was part of the residents' care plan. Two of three nurses aides interviewed stated they never applied creams or ointments to residents. One of the nurses aides stated she had applied a cream to a resident's buttock after changing her adult brief. She indicated a CNA was with her at the time.

Although there was insufficient evidence to substantiate nurses aides and Certified nurses aides were

applying medicated ointments and creams, this allegation was substantiated based on other findings in the investigation that staff were not properly trained to perform their jobs. Refer to F498 in the Federal 2567 report.

CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

On May 6, 2015, a one-on-one staff was observed talking on her cell phone rather than assisting an assigned resident to eat his lunch. After the issue was reported, the same staff was again observed on her personal cell phone at the nurses station.

In addition, on May 12, 2015, the staff on Hatteress Hall ordered pizza and ate it in front of residents. An identified resident who is tube fed by PEG became upset when he couldn't have pizza.

FINDINGS:

The identified residents were observed throughout the complaint survey including morning, noon, and evening meals.

The first identified resident was observed with one-on-one staff in his room actively supervising and assisting the resident to eat. At least four additional residents assigned one on one staffing were observed multiple times during the survey. No instances of staff using personal cell phones were observed.

During interviews, nurses aide and certified nurses aide staff stated they had not heard or observed any other nurses aides/certified nurses aides using their personal cell phones and not attending to their assigned residents. One licensed nurses stated he/she knew of one nurses aide in the past four months who was disciplined for making calls on her personal cell phone. The licensed nurse stated it was against facility policy for the staff to carry a personal cell phone on duty. The LN was not able to remember when the situation had occurred but knew the staff person was quickly disciplined by administration for not following the policy.

The second identified resident was interviewed about staff bringing pizza into the facility and eating it in front of him. During the interview, the resident stated he missed eating but knew it only caused him problems. The resident stated it would not bother him for staff to bring in pizza.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Complainant stated that during the first week in May 2015 on the evening shift, an identified resident was "put to bed" by an identified nurses aide. The nurses aide pushed the resident's geri chair up at the side of the bed. When asked if they were supposed to do that an aide said, "Yes... to stop her from getting out of bed." The resident fell out of bed a little while later and was found on the floor between the bed and the geri-chair.

FINDINGS:

The identified resident was observed throughout the day on June 15 - 17, 2015. The resident was observed in the geri chair and laying in a low bed in her room. When in bed, the geri chair was placed by the side of the bed with two to three feet between the bed and the chair. The placement of the geri chair did not restrict the resident's movement in or out of bed.

The resident's care plan noted she was at risk for falls and the care plan addressed keeping the resident's bed in a low position rather than at a normal bed height. The resident's medical records included consent forms for the geri chair and low bed.

Accident reports and nurses notes for May 1, 2015 documented the resident rolled from the low bed to the floor on the evening shift. No injuries were sustained. Neither the accident report nor the nurses notes indicated the geri chair was positioned in a way to prevent the resident's movement in or out of bed.

Interviews with licensed nurses, nurses aides, and certified nurses aides between June 16, 2015 and June 17, 2015 indicated the nurses aides and certified nurses aides knew placing a geri chair next to a bed to prevent movement in or out of bed would be considered a restraint. The aides and CNAs said to their knowledge this did not occur with the identified resident or any other resident. Licensed Nurses on day and evening shifts, and on the identified resident's hall, stated they had not received reports of staff using geri chairs to restrict the movement of the identified resident or any other resident.

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The complainant reported several staff do not wear name tags/badges.

FINDINGS:

This allegation was not investigated; there is no Federal or State regulation that requires staff to wear name badges.

Troy Thayne, Administrator
August 20, 2015
Page 6 of 6

CONCLUSION:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The complainant stated that all the allegations of this complaint were reported to Administration and to a Licensed Practical Nurse (LPN) who hired and trained staff. The complainant stated Administration and the LPN said the problems would be fixed, but it did not happen.

FINDINGS:

This allegation was substantiated based on the overall findings of the survey including the lack of sufficient staffing, the failure to thoroughly investigate potential abuse, not assuring nurses aides were properly certified within four months of hire, and staff not receiving sufficient training. Refer to the Federal 2567 report and related citations, including F226, F353, F490, F494 and F498.

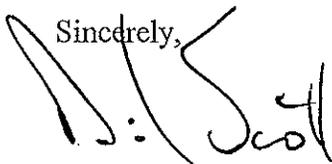
CONCLUSION:

Substantiated. Federal deficiencies related to the allegation are cited.

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

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

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Eder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1688
E-mail: tsb@dhw.idaho.gov

FILE COPY

August 11, 2015

Troy L. Thayne, Administrator
Safe Haven Care Center of Pocatello
1200 Hospital Way
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Thayne:

On **June 19, 2015**, an unannounced on-site complaint survey was conducted at Safe Haven Care Center of Pocatello. The complaint survey was conducted **June 15, 2015 through June 19, 2015**.

During the complaint survey residents were observed and interviewed, staff were interviewed and nursing care was observed. Individual medical records, Incident and Accident Reports and Investigations, grievance logs, medical and as-worked staffing records were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #6973

ALLEGATION #1:

Complainant stated residents did not receive adequate care to prevent pressure ulcers.

FINDINGS #1:

Based on observations, staff and resident interviews, and record reviews, it was determined the facility failed to provide care needed to prevent pressure ulcers and/or prevent existing pressure ulcers from deteriorating for three residents. The facility was cited at F314 for failure to prevent pressure ulcers and/or keep pressure ulcers from deteriorating. Please refer to Federal 2567 report for details.

Troy L. Thayne, Administrator
August 11, 2015
Page 2

CONCLUSIONS:

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

ALLEGATION #2:

The complainant stated the facility does not have adequate staffing and staff are pulled from one-on-one assignments to work the floor due to the lack of staff.

FINDINGS #2:

Based on review of medical records, abuse investigations, as worked staffing reports and staff interviews, it was determined the facility failed to provide sufficient nursing staff between April 6, 2015 and May 10, 2015, to meet residents' needs and promote their physical, mental and psychosocial well-being. The facility was cited at F353 for failure to provide adequate staffing. Please refer to Federal 2567 report for details.

CONCLUSIONS:

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

ALLEGATION #3

The complainant stated the facility secluded residents to their room because they did not have sufficient staff for residents who require one-on-one staffing.

FINDING #3:

Based on staff and resident interviews, medical record reviews investigations of reports of abuse and review of worked staffing hours, it was determined that a resident was secluded to his/her room for brief periods of time. The involved staff stated they were instructed to do so by an on-duty charge nurse because they did not have sufficient staff to place the resident on one-on-one staffing. Following the facility's investigation, the charge nurse was disciplined and staff re-educated on resident rights.

The facility was cited for insufficient nursing staff at F353 and for not following the resident's care plan and physician's orders for one on one staff at F309. Please refer to Federal 2567 report for details.

CONCLUSIONS:

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

ALLEGATION #4:

The complainant stated residents do not receive pain medications within a reasonable timeframe.

Troy L. Thayne, Administrator
August 11, 2015
Page 3

FINDING #4:

A private resident group meeting was conducted by surveyors on June 14, 2015. Eleven residents attended the group meeting. The residents were asked if they experienced pain on a regular basis and/or occasional basis. If they did experience pain and requested pain medication, did they receive it within a reasonable timeframe? The consensus of the group was they usually received their scheduled pain medications on time and as-needed pain medications within a reasonable timeframe. Two residents stated they have had to ask for pain medications more than once before receiving them, but this did not happen all the time.

Additionally, five individual residents were interviewed. These resident interviews indicated residents usually received pain medications within 10 to 15 minutes of asking for it. Occasionally it took longer, but not habitually.

There were no issues listed in the Grievance files for February, March, April, and May 2015, or in the Resident Council minutes, dated March 12, 2015 through June 11, 2015, that indicated residents had concerns with not receiving pain medication within a reasonable timeframe.

There was not enough evidence to substantiate residents did not consistently receive pain medication in a timely manner. During an interview with the Director of Nursing, she was told there are some residents who have the perception that their pain medications are sometimes not given in a reasonable timeframe. The Director of Nursing acknowledges the concern and that she would follow-up on it.

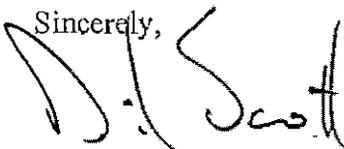
CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

November 12, 2015

Troy Thayne, Administrator
Safe Haven Care Center Of Pocatello
1200 Hospital Way,
Pocatello, ID 83201-2708

Provider #: 135071

Dear Mr. Thayne:

On **June 19, 2015**, an unannounced on-site complaint survey was conducted at Safe Haven Care Center Of Pocatello. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006966

This complaint was investigated in conjunction with four other complaints during a complaint survey conducted from June 15, 2015 to June 19, 2015.

Seventeen residents' medical records were reviewed;
Grievances and Incident and Accident reports from February 20, 2015 to June 2015 were reviewed;
Resident Council Meeting minutes from February 2015 to June 2015 were reviewed
Completed Abuse Investigations were reviewed from February 2015 to June 2015;
Observations were conducted from June 15, 2015 to June 19, 2015;
Fifteen staff interviews were conducted on various shifts from June 15, 2015 to June 19, 2015;
Five family interviews were conducted from June 15, 2015 to June 19, 2015;
Various facility Policies and Procedures were reviewed; and
A Quality Assurance interview was conducted.

Allegation #1: A resident advocate was not notified after a resident experienced a change in condition.

Findings #1: Based on grievances, incident and accident reports, medical record review, and staff interviews, it was determined the facility did not ensure residents' legal representatives or family members were notified when there were accidents involving residents which resulted in injury and/or had the potential for requiring physician intervention.

During the survey, observations, resident and staff interviews, and record review were conducted with the following results:

Two of seventeen records reviewed throughout the survey documented concerns related to failure of notification.

The facility's Grievances and Incident and Accident reports reviewed from February 20, 2015 to July 2015 were reviewed and documented concerns regarding failure to notify a resident(s) advocate.

It was determined the facility did not notify the resident(s) advocates when resident(s) experienced a change in condition. Therefore, the allegation was substantiated and cited at F157.

Conclusion #1: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: Resident injuries were more "severe" than reported to the resident advocate.

Findings #2: During survey review of the identified resident's record, and sixteen other resident records documented resident's advocates, guardians, and concerned family members had been appropriately notified regarding changes in condition and/or injuries.

It could not be determined the facility had not appropriately reported the the extent of the resident's injuries to the resident advocate. Therefore, the allegation was unsubstantiated and no deficiencies were cited.

Conclusion #2: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #3: A resident was unable to feed himself due to a casted arm and increased pain.

Findings #3: During the survey, observations and residents and staff interviews were conducted. Records, including resident records, incident and accident reports, and grievances were reviewed with the following results:

Troy Thayne, Administrator
November 12, 2015
Page 3 of 5

The facility's Incident and Accident reports and grievances were reviewed from March 2015 to July 2015 and did not include concerns regarding pain affecting residents ability to feed themselves and/or increased need for assistance during meals related to immobilization devices. Thirteen residents observed during the survey and four meals observed did not identify concerns related to pain and/or immobilization devices affecting residents ability to eat.

The records of 13 observed residents were reviewed and did not include concerns regarding pain affecting residents ability to feed themselves. Records reviewed documented appropriate pain control and staff assistance during meals.

Multiple residents, resident advocates, certified nursing assistants, licensed nurses and the Director of Nursing Services were interviewed and did not verbalized concerns related pain and/or immobilization devices affecting residents ability to feed themselves.

It could not be established a resident was not adequately medicated for pain prior to meals and/or an immobilization device caused a resident to require additional assistance during meals. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: A resident advocate was concerned the facility did not provide adequate supervision which resulted in a fall with injury.

Findings #4: During the survey observations and residents and staff interviews were conducted. Records including sample resident records, abuse reports, incident and accident reports, grievances and Resident Council meeting minutes were reviewed with the following results:

Incident and Accident reports and grievances were reviewed from February 20, 2015 to June 2015 and included concerns regarding inadequate supervision of a sampled resident resulting in a fall with injury.

The records of thirteen sampled residents were reviewed and included concerns regarding inadequate supervision resulting in fall(s) with injury.

It was determined the residents were not being adequately supervised to prevent falls and/or falls with injury. Therefore, the allegation was substantiated and cited at F323.

Conclusion #4: Substantiated. Federal and State deficiencies related to the allegation are cited.

Troy Thayne, Administrator
November 12, 2015
Page 4 of 5

Allegation #5: A seatbelt attached to a resident's wheel chair restricted a resident's movement.

Findings #5: During the survey, observations and residents and staff interviews were conducted. Records, including resident records, incident and accident reports, and grievances were reviewed with the following results:

The facility's Incident and Accident reports and grievances were reviewed from March 2015 to June 2015 and did not include concerns regarding the inappropriate use of restraints and/or positioning devices.

The records of multiple observed residents were reviewed and did not document concerns regarding positioning devices and/or restraints. Records reviewed documented safety assessments had been completed prior to the implementation of the devices.

Multiple residents, resident advocates, certified nursing assistants, licensed nurses and the Director of Nursing Services were interviewed and did not verbalized concerns related to the inappropriate use of positioning devices/restraints which had the potential to affect a residents ability to move.

It could not be determined resident(s) restraints/positioning device(s) restricted movement of the resident(s). Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion #5: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: A resident advocate was concerned the facility did not answer questions and withheld information.

Findings #6: Based on staff interviews, resident and family interviews, review of grievances and occurrence reports, medical record review, and review of the facility's policies and procedures for incidents and accidents, it was determined the facility's systemic failures failed to provide sufficient implementation, monitoring, evaluation, and continued oversight to maintain a safe environment and services for 10 of 17 sampled residents. This failure had the potential to adversely impact the quality of life and quality of care of residents in the facility.

This allegation was substantiated and cited at F490.

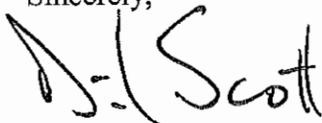
Conclusion #6: Substantiated. Federal and State deficiencies related to the allegation are cited.

Troy Thayne, Administrator
November 12, 2015
Page 5 of 5

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

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

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, stylized initial "D" and "S".

DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/pmt